

The Radical Solution to Rising Healthcare Costs

JOSEPH COATES

THE HAPPIEST AND MOST SELF-SATISFIED BUSINESS entrepreneurs I've ever been with are the CEOs I met at a convention of health maintenance organizations (HMOs). They had done exactly what their business customers wanted—namely, halt the increasing costs in the provision of healthcare.

They were resistant to any long-range views about the effects of healthcare costs, not on the companies that were their clients, but on the consumers. They were indifferent to what effects they were having on consumers—that is, their customers' employees and retirees. Reinforcing that indifference for many, if not most of them, was the pace of aggregation within the HMO community. There was a fair chance that any one of their HMOs would be absorbed, and they would walk away with an immodestly large fortune. The benefits that they worked on for their corporate customers were real but only temporary.

As the costs of healthcare have risen, companies have tried many cost-containment stratagems, all of which are likely to be only partly effective and only for a little while. More important, the new gambits make enemies, cause workers to be suspicious of the company's goodwill and intentions, subvert positive attitudes on the part of the workforce, and severely degrade the attitude and esprit of retirees with regard to the company.

The current approaches all amount to cutting benefits and shifting costs. The most common practice is to push up the workers' contributions while, at the same time, reducing the available benefits in the company's insurance plan. The abuse of retirees is even more severe, because there was most often only an implicit or tacit agreement between the company and its former employees, the retirees, about what assistance in terms of healthcare could be expected. As those retirees get the bad news, they are powerless as individuals, although there is some hope for them organizing either ad hoc or under the auspices of the American Association of Retired Persons (AARP) or another group to get what they see as their entitlements.

Workers and retirees suffering reduced benefits are, by the hundreds of thousands, if not tens of millions, becoming hostile mouthpieces about the penury, shortsightedness, stinginess, and, from their point of view, immoral behavior of their current or past employers. From the corporate perspective, the worst effect of ineffective tactics is to politicize healthcare, with business on the wrong side of the issue.

A study done by the Kaiser Family Foundation reports a 48 percent jump over a three-year period in employees' costs for healthcare. According to the study, as reported in the *New York Times*,¹ two-thirds of large employers raised the workers' contribution, and 79 percent thought they would do the same in 2004, marking the fourth straight year of double-digit percentage-rate increases in insurance

premiums for workers. From the workers' perspective as well as elementary economics, that amounts to a cut in wages.

The increases are generally attributed to three factors: advances in drugs and in healthcare technology and "a loosening of managed care restraints during the prosperous 1990s."² The employers are increasing the range of benefits over which the employee must co-pay, such as prescription drugs and hospital care. Some specifics of the increased costs are shown in **EXHIBIT 1**.

This article reviews some economic factors that explain why the U.S. healthcare system needs to be revamped, provides a description of a consumer-driven healthcare model that is not likely to succeed, and, finally, offers details on implementing a universal healthcare system to resolve the problems of rising healthcare costs and ineffective delivery of healthcare services.

Exhibit 1. Paying More for Health Care. Workers' out-of-pocket expenses have risen sharply over the last three years, according to a new study. Here are the estimated expenses for a family in a preferred-provider plan.

	2000	2003	Increase
Premium	\$1,619	\$2,412	49%
Deductible			
Using Preferred Provider	\$175	\$275	57%
Using Out-of-Network Provider	\$340	\$561	65%
Drug Co-payments			
For Preferred Drugs	\$13	\$19	46%
For Nonpreferred Drugs	\$17	\$29	71%

Source: Kaiser Family Foundation, Health Research and Educational Trust, cited in Freudenheim, M. (2003, September 10). Employees paying ever-bigger share for health care.

The New York Times.

THE ECONOMICS OF POOR HEALTHCARE COVERAGE

The National Academy of Sciences' Institute of Medicine (IOM), in a recent report of a three-year study, recommends that by 2010 we have a universal health insurance plan in effect in the country. The study points out, "The economic cost to the country from the poorer health and premature deaths of uninsured people is in the range of \$65 billion to \$130 billion a year." The study also notes, "about 18,000 people die each year as a result of not having insurance..."³ Although Secretary of Health and Human Services Tommy G. Thompson said it was not realistic to expect a universal healthcare system by 2010, it is interesting that Bob Dole endorsed the IOM's call for action.

Nevertheless, the report is only a halfway measure in that it calls for a continuing health insurance plan, which is, as it now stands, bureaucratically cumbersome, ineffective, and a bottomless sump for wasted money. No insurance plan is likely to contain or reduce costs or give

us dollar value. Although universal healthcare should be everyone's goal, it is by no means clear that the conservative view of holding on to decades of dreadful experience with unworkable insurance schemes magically can be made workable in the public interest. Insurance allows only insurance companies to prosper.

The recently published healthcare costs to both General Motors and Ford are a real attention-getter in terms of the problems of the large corporations and the need for getting to the root of the problem with a radical solution. GM's annual report announced that "future healthcare obligations for retirees rose last year to \$63.4 billion from \$57 billion in 2002." GM is "the largest private purchaser of...Viagra and Lipitor. It pays benefits for 1.2 million workers, retirees, and family members in the United States. Its healthcare costs are about \$1,400 for each vehicle sold in the United States. That's more than the cost of the steel." To get those costs under control would incidentally help to establish a greater competitive advantage.⁴

A similar but less extreme case applies to Ford Motor Company with "healthcare liabilities...grown by over \$2 billion last year." The direct cost to companies is only a portion of the total cost to the nation. The cost to companies overlooks the psychological and social consequences of rising healthcare costs for the individual.⁵

Although increasing healthcare costs dramatically affect big corporations, the effect can be even more severe on small companies and their employees. Only about 47 percent of small companies offer health insurance, according to surveys by the National Federation of Independent Business, an advocacy group in Washington. As reported in the *New York Times*, "about 70 percent of companies with more than 20 employees offer healthcare insurance. By contrast, 98 percent of businesses with more than 200 employees offer coverage."⁶

According to information reported in the *Times*, "a Kaiser Family Foundation study of 2,800 companies found that insurance premiums increased 15.5 percent in 2003 for companies with fewer than 200 employees, and 13.2 percent for larger enterprises." Healthcare cost containment is an even greater need for small businesses and for their employees⁷ (see **EXHIBIT 2**).

Professor Rexford E. Santerre of the University of Connecticut School of Business has developed a new metric he calls the "Healthcare Misery Index."⁸ This is a takeoff on the well known Economic Misery Index created by Arthur Okun in the Carter administration in 1976.

The Economic Misery Index combines the percentage of inflation with the percentage of unemployment. Santerre's Misery Index adds two measures: the percentage of people in the United States without health insurance plus the excess of healthcare inflation—that is, "the percentage by which annual increases of medical costs exceed general price inflation."

The Misery Index dropped substantially, from 35 percent in 1960 down to a low of 5 percent in 1980, and then it continued to rise and oscillate so that, through the

1990s, it hovered around 17 percent to 20 percent.

Incidentally, the percent of uninsured people has stayed fairly flat, 13 percent to 15 percent. The cost of Medicare has remained stable. The cost of medical spending for the nation rose from 5 percent of the gross domestic product 40 years ago to about 14 percent today. The Misery Index rose from its low of 5 percent in 1980 to 17 percent to 18 percent today. In 2002, it was 17.9 percent.

Exhibit 2: The Coverage Curve Large companies tend to offer health-care coverage more often than small ones.

Company Size	Percentage Offering Health-Care Benefits
3-9 Workers	55%
10-24 Workers	76
25-29 Workers	84
50-199 Workers	95
200 or More Workers	98

Source: Kaiser/HRET Survey of Employer-Sponsored Benefits, 2003, cited in Andrews, E. L. (2004, February 24). Health care heights: Soaring rates leave little companies in a bind.

The New York Times.

CONSUMER-DRIVEN PROPOSAL

A new and quite different kind of approach to containing healthcare costs has come out of some business schools, notably Harvard's, which attempts to bring the cost-containment techniques that operate in manufacturing to the healthcare system. The technique is referred to as "consumer-driven healthcare." The basic strategy is to offer more and more choices to the individual under a corporate insurance plan and thereby hope that the individual's informed choices will contain costs.⁹

The same article shows the tie to industrial thinking in a quote from Regina Herzlinger, a healthcare professor at the Harvard Business School: "If you are buying steel for a car, you are right on the main part of the company. If you are buying health insurance, organizationally you are off to the sidelines. So the revolution of healthcare will have to come from the CEOs; we are finally seeing this beginning to happen."

As reported in the same *Financial Times* article, a substantial number of companies are trying out, or beginning to try out, this new concept, including General Electric, United Parcel Service, Ford, Humana, Procter & Gamble, and many others. The programs cannot succeed, because they are premised on a false assumption that medical services are merely another business and, therefore, are subject to the kinds of treatments that make a business successful.

It would be instructive to see what the consensus is among physicians, patients, and economists about the extent to which healthcare services and their delivery are

merely businesses, or whether there are other social and institutional goals that cannot be taken into account by any microeconomic business school model.

Another flaw in these systems that is likely to make them far from satisfactory is that people vary widely in their desire, will, and capability to make economically and medically sound judgments on their own behalf. The area of health is particularly obscured by ignorance, uncertainty, and erroneous perceptions. We already know from endless experience in the general economy that people simply are not the textbook's "economic man." What hope can there be for economic man to suddenly appear in that aspect of our lives dominated by fear, ignorance, and uncertainty? It is likely that there will be an unnecessarily protracted period of trial and failure before the consumer model goes the way of the HMO and perhaps does even more damage. We simply do not have the time to tarry over ideologically driven beliefs that all organizational functions with a human interface can be cast into a business model of manufacturing.

For example, in a 2000 survey of women over age 25, the greatest health threats the women perceived were breast cancer (34 percent); stroke (1 percent); and heart disease (7 percent). The numbers for each of these conditions in terms of deaths are breast cancer, 43,000; stroke, 97,500; and heart disease, 234,000.¹⁰ Any proposed healthcare system, such as that out of the Harvard Business School, would not be taking into account the gross misperception in the causes of death.

Causes of death are an interesting measure of what we should be paying close attention to. McGinnis and Foege, in a 1993 article in the *Journal of the American Medical Association*, and a later one by McGinnis, Russo, and Knickman in *Health Affairs* (2002), show the relative importance of factors shaping premature mortality (see **EXHIBIT 3**.) What it amounts to is that behavior accounts for 40 percent and environment 20 percent of premature death, whereas the genes that we carry account for only 30 percent and healthcare a mere 10 percent.

Exhibit 3: Determinants of Health The relative importance of factors shaping health (affecting premature mortality)

	1993	2002
Behavior	50%	40%
Environment	20%	Social: 15%
		Physical: 5%
Genes	20%	30%
Health Care	10%	10%

Source: McGinnis, J. M., & Foege, W. H. (1993). Actual causes of death in the United States. *Journal of the American Medical Association*, 270, 2207-2212; McGinnis, J. M., Russo, P. W., & Knickman, J. (2002). The case for more active policy attention to health promotion. *Health Affairs*, 21(2), 83.

If flipped over, those numbers imply that the greatest long-term social benefit comes from changing behavior; that is, things like smoking, exercise, overeating, and

altering the physical and social environment in which we live, reducing stress, and reducing environmental pollution. The present healthcare maintenance programs and those innovations proposed by business schools clearly do not take into account these factors in an intelligent way.

The third flaw in the business school's new plan is that it overlooks the large number of people who have no resources, are not employed, are handicapped, mentally enfeebled, or for some other reason do not fit the neat and tidy upper middle class consumer choice model.

A different perspective on the kinds of needs in healthcare comes from consideration of the ten most significant causes of death. While they vary by age, the overall pattern is clear.¹¹ The top ten causes of death in the United States account for 79 percent of all deaths. They are, by percentage:

- | | |
|--|------|
| 1. heart disease | 29.6 |
| 2. cancer | 23.0 |
| 3. cerebral-vascular diseases | 7.0 |
| 4. lower respiratory diseases | 5.1 |
| 5. accidents | 4.1 |
| 6. diabetes mellitus | 2.9 |
| 7. pneumonia and flu | 2.7 |
| 8. Alzheimer's | 2.1 |
| 9. nephritis-inflammation of the kidneys | 1.5 |
| 10. septicemia-blood poisoning | 1.3 |

What health maintenance organizations have moved away from supplying—namely, lifestyle changes and preventive healthcare—could have a profound impact on the conditions leading to these primary killers and the often long-term associated morbidity (illness and decline) before death.

CREATING A UNIVERSAL SYSTEM

The solution to the continuing rise in healthcare costs cannot lie in shifting responsibilities, creating hostility among workers, and tightening the managerial screws on the system; it must lie in dealing with healthcare in a truly radical way. Radical here has nothing to do with crimson banners, jackboots, or running-at-the-mouth bushy-haired street mobs. It simply means getting at the root of the problem. The only solution I see is for corporations to organize a strong consensus among both large and small firms, urging the government to take over all healthcare, creating a "universal healthcare system."

One of the main stumbling blocks to such corporate action is the emotional and political response to the term socialized medicine and the misperceptions that have endured regarding such healthcare systems. Once business gets over responding only like a bull to a red flag when this alternative is mentioned, corporate leaders will realize that they can get out from under a continually rising financial burden and extinguish the increasing hostility on the part of their employees, retirees, and the expanding ring of

friends and relatives who see many companies as double-dealing.

From a corporate point of view, I see the implementation of a universal healthcare system as relatively simple and straightforward. Corporations would make a fixed annual contribution to the national healthcare system as a percentage of the salary and wages of all employees, for example, only as a talking point, 7.5 percent of all salaries and wages. To start the process, I would average those salaries and wages from years 2001 to 2004 or the most recent four-year period before startup. In the legislation creating universal healthcare, I would also include provisions that would limit increases in business contributions so that they would occur no more than every three or five years and would be tied to real increases in the cost of living, inflation, and any independently established true costs in the delivery of health services.

There would be many significant questions of how to treat the current health plans and what the future role would be of the existing HMOs. After a transition period, I see their abolition. Although those are significant problems, they are not insuperable. As I see it, corporations are now so beleaguered by the uncertainties of healthcare costs and their inability to contain them that they would be open to virtually any plan or program that would control cost increases.

How the insurers would respond is another question that links to an issue beyond the scope of this article—how services would be institutionally organized. But again, that's not an insurmountable limitation once one sees the new system's value for everyone.

With regard to retirees and those who are not working or are not now part of an insured worker's program, the health services would range from free to a fee as described below. Firms without current health plans would be assessed the national average corporate assessment, 7.5 percent as suggested above. The problem that must be dealt with simultaneously is the large number of people, approximately 43 million, who are not now or have not been for several years covered by any healthcare plan¹² (see **EXHIBIT 4**).

Exhibit 4: The Uninsured The percentage of people in the United States without health insurance for the entire year 2002, by characteristics.

TOTAL	15.2%
Male	16.7%
Female	13.9%
White	14.2%
Black	20.2%
Asian	18.4%
Hispanic *	32.4%
17 or Younger	11.6%
18-24	29.6%
25-34	24.9%
35-44	17.7%

45-64	13.5%
65 or older	0.8%
Native	12.8%
Foreign Born	33.4%
Northeast	13.0%
Midwest	11.7%
South	17.5%
West	17.1%

*can be of any race

Source: Census Bureau, cited in Strom, S. (2003, November 16). For middle class, health insurance becomes a luxury.

The New York Times.

The key elements of the proposed program would be, first, to radically reduce the bureaucratic costs of our present system, which are 100 percent overhead. This could be done by giving each physician a register of patients for whom he or she would have responsibility, with the patients' concurrence.

Further, there would be no charges and no paperwork reported to any central agency for any visit that dealt with routine checkups, disease prevention, and public health measures such as vaccinations or any other treatments. Service would be linked to the Social Security card or to a new truly universal healthcare card. The universal healthcare card would be the only connection between the patient and the doctor and the doctor and the institutional payment system. The physician would be paid on the basis of the number of patients he or she carried on his or her roll.

It is generally believed that 80 percent of the visits to a primary-care physician are for symptoms and conditions that can easily and straightforwardly be handled by a nurse, a nurse practitioner, or a paramedic, so that the physician's time and knowledge can be focused on the other 20 percent. That 20 percent does not come clearly labeled, so there will have to be an explicit system of training of the nurses, the nurse practitioners, and others to be sure to highlight problems or constellations of problems or symptoms that must be brought to the physician's attention.

When dealing with conditions that may incur substantially greater cost in time for the physician, additional payment would not be necessary because of the following provision. It would be a requirement that the doctor provide satisfaction to the patient and demonstrate unequivocally an improvement in the patient's condition. If that did not occur within a prescribed time, the patient would be bumped up to an appropriate specialist who would be paid by the system for specific services rendered.

Exhibit 5: Losing Coverage According to the U.S. Census Bureau, the proportion of the U.S. population without health insurance increased to 15.2 percent in 2002.

	Percent Uninsured	Change from 2001 in Percentage Points
Total	15.2	+ 0.6
Men	16.7	+ 0.9
Women	13.9	+ 0.4
By Household Income		
Less than \$25,000	23.5	*
\$25,000 to \$49,999	19.3	+ 1.5
\$50,000 to \$74,999	11.8	+ 0.4
\$75,000 or more	8.2	+ 0.5
By Work Status, Ages 18 to 64		
TOTAL	19.5	+ 1.0
Worked During Year	18.0	+ 1.0
Worked Full Time	16.8	+ 0.8
Worked Part Time	23.5	+ 1.5
Did Not Work	25.7	+ 1.0

*Not Statistically Significant

Source: Census Bureau, cited in Pear, R. (2003, September 30). Big increase seen in people lacking health insurance. *The New York Times*

PLAN GOALS

The goals of a universal health system, from the point of view of a corporation, might include the following:

- Stabilize and even drop the cost in healthcare for the society at large and for corporate employers.
- Enhance the reputation of big business as socially responsible. This is a great need in a time when the reputation of big business has fallen to a low point.
- Relieve the long-term commitment of many firms for healthcare, as found in their pension plans.
- Build consensus for radical alteration of the current healthcare system among all stakeholders, including members of the embedded and politically powerful HMOs, corporations committed to their present arrangements, and those who are ideologically indisposed to the putative dirty words, socialized medicine.
- Institutionalize a new structure for the delivery of healthcare to all residents in the United States.
- Bring about an improved situation for all the citizenry in terms of healthcare.

The reorganization of the healthcare system would include, as suggested above, no cash payments by the patient for the basic healthcare services provided by his or her physician for prevention, diagnostics, and routine treatment—for the top approximately 125 to 200 common conditions. The general practitioner (GP), with limitations on his or her skills, would make recommendations as needed for seeing specific types of specialists. Access would

be by Social Security number or a new universal healthcare card.

The payment system through government would be organized roughly as follows: Companies, as suggested above, would make an annual payment set as a fixed percentage of their average costs over a fixed number of years. For those companies that did not have healthcare plans, the average costs of all healthcare-paying companies per capita would apply to them.

For those people who are not employed, the maximum amount they would pay in any year would be X percent—let us say 3 percent of their wealth—excluding the value of their primary residence. For example, someone having \$1 million would pay a maximum of \$30,000 per year. One with wealth of \$100,000 would pay a maximum of \$3,000 per year.

Others, mostly the self-employed, would at most pay 2 percent of pre-tax income. For a \$20,000 a year income, that would be \$400; for \$50,000 a year income, it would be \$1,000; for \$100,000 a year income, it would be \$2,000; and for \$200,000 a year income, it would be \$4,000. Obviously, those numbers would have to be determined more reliably by a broadly based, sophisticated, and diversified panel of experts and interest groups. For example, my estimates of payment sizes may be off. Also it may be better and fairer to go to a sliding scale rather than a fixed percent.

Those who have no healthcare now, some 43 million people (see **EXHIBIT 5**), create a massive burden on emergency rooms and hospitals. They generally receive no preventive healthcare. Their situation too often leads to bankrupting a family or an individual. A look at **EXHIBIT 5** suggests how easily one could move into bankruptcy from a medical problem as a function of household income.¹³

A random or arbitrary mix of physicians and patients would be disastrous. There must be some mechanism whereby the linkages can be made on a rational and satisfactory basis. We see, therefore, that both hospitals and individual physicians would have to undergo an annual or biannual evaluation, which would be published in ways, places, and formats that give the optimal information to the consumer about reliability of treatments and about the effectiveness of prevention and public health measures (e.g., the percentage of children vaccinated or the number of obese clients losing a fixed percentage of their body weight and holding it for at least two years). Similar data is available implicitly at hospitals and should be made explicit.

There are numerous problems connected with the reorganization of healthcare to put it on a more rational, equitable, and effective footing for all of us. For example, the condition of medicinal drugs today is troublesome. However, because drugs are generally purchased through a commercial drug store, the universal healthcare card could be used to deliver those drugs while minimizing bureaucratic overhead by just tallying up the total purchases at the drug store. Electronics on the card would be, of course, the key to making that element successful.

There is also the question of the government hospitals, particularly those not involved with the active military, such as the Veterans Administration (VA) system. It could be timely and appropriate to integrate the VA hospitals into the general universal healthcare system, simply because many veterans would welcome the opportunity to have their families enjoy the same high-quality service that the VA hospitals deliver. It would also provide the VA hospitals with a more continuing and stable baseline.

Turning back to the continuing cost of healthcare, insofar as it's attributed to new technologies, there are several noteworthy things to say. A number of years ago, the Institute of Medicine of the National Academy of Sciences issued a report in which they noted the increase in cost of new advanced, high-technology medical aids, mostly diagnostic. They came to a solid, common-sense solution that high-cost diagnostic tools should not be used unless results of their use in diagnosis made a difference in treatment.

We see an interesting example today of a potential new abuse of high-tech diagnostics. There is a movement by physicians in small group practices to acquire their own MRI machines to be able to do these high-cost diagnoses right in their own facilities. Some of these machines cost up to \$1 million. Physicians are trying to capture a greater piece of the profit, at the expense of the current provider systems. It is easy—maybe too easy—for the individual physician to order an MRI when it may not be appropriate.¹⁴

We need to have both a firm national policy on the use of high-tech diagnostic devices—and for some high-tech treatments—that is open-ended, continuously explored, and set up to optimize the payoff from the use of

technology, while depriving no one when there truly is a value in its use.¹⁵

LEADING THE CHANGE

U.S. business has too long played around the edges of the healthcare cost problem, trying various business economic strategies for containment and reduction of cost while paying little attention to the social, economic, and attitudinal effects on employees and the people with whom they interact. In the last 20 years, those corporate efforts have failed to achieve their goals and are now backfiring on the corporate reputation.

We also have the larger problem of healthcare services delivered in the United States being simply more expensive and less effective than those delivered in numerous other advanced nations. The situation is one in which cut-and-fit and trial-and-error cannot be the long-term answer.

Corporations have to wise up to the fact that the solution to their and the nation's problem is to totally integrate the healthcare system and make it effective for everybody. Leadership—real leadership—in healthcare's radical reform, would go a long way to restoring the corporations' long-lost reputation for integrity, foresight, and public responsibility.

NOTES

1. Freudenheim, M. (2003, September 10). Employees paying ever-bigger share for healthcare. *The New York Times*.
2. Id.
3. Pear, R. (2004, January 15). Academy of sciences calls for universal healthcare by 2010. *The New York Times*.
4. Hakim, D. (2004, March 12). G.M. says costs for retiree care top \$60 billion. *The New York Times*.
5. Rigby, E. (2004, March 13-14). Ford's health costs rise by \$2 billion. *Financial Times*.
6. Andrews, E. L. (2004, February 24). Healthcare heights: Soaring rates leave little companies in a bind. *The New York Times*.
7. Id.
8. Santerre, R. E. (2003, December 1). The state of healthcare in one easy number. *The New York Times*.
9. Roberts, D., & Kelleher, E. (2004, March 19). Alternative therapy: U.S. companies search for radical ways to cut the spiraling cost of employee healthcare. *Financial Times*.
10. Top 10 causes of death in the U.S. by age. (2003, July). *Discover*, pp. 42-43.
11. Id.
12. Strom, S. (2003, November 16). For middle class, health insurance becomes a luxury. *The New York Times*.
13. Pear, R. (2003, September 30). Big increase seen in people lacking health insurance. *The New York Times*.
14. Abelson, R. (2004, March 13). An M.R.I. machine for every doctor? Someone has to pay. *The New York Times*.
15. See note 13.