On Medicine's Periphery

The privatization of medical care – caveat medicus!

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For a long time the influence of medicine on economics has held the centre of the stage: inflation of cost, impact on social expenditures, and resulting inequities in services and shortages with consequent rationing, government measures aimed at cost containment and budgetary controls. A litany of complaints is heard from economists, against medicine and its practitioners. And a long list is then provided on what has to be done to rescue the nation's economy from inflated and uncontrollable medical costs. Now the shoe is about to be put on the other foot. This is the time to begin questioning what economics is doing, or is about to do, to medicine.

In the USA the seemingly timid intrusion of government into paying for some, but hardly all, medical care services for a minor segment of the population, just 20 years ago, has turned out to have enormously fateful consequences for medicine and for society. Because Britain made a much bolder intrusion, providing, and not just paying for, *total* medical care services for the *total* population, one would have expected even heavier and more menacing consequences. The contrary is the truth. The lesser event bodes greater change for medical practice in the USA. However, Britain is threatened by its present political leadership, with an 'American solution' – privatization. If the Tories succeed in imposing their political philosophy on the British people, diminishing, or perhaps even eliminating the National Health Service, British physicians may suffer the same fate that awaits their American colleagues.

When the USA entered upon its experiments with Medicare and Medicaid, the fee-for-service system of reimbursement prevailed for doctors, and the *per diem* cost/charge reimbursement for hospitals. It is a leaky system, and before long, the inflationary nature of this method of reimbursement created a storm of controversy over the management – or lack of it – of this huge and apparently uncontrollable inflation. A variety of tentative measures were aimed at first

reducing costs in hospitals, because there were the largest single segment of medical care cost along with the highest degree of inflation of these costs. These early efforts centred chiefly on utilization controls, and were not too successful. Eventually, however reluctantly, the government undertook to control the supply of hospital care – reducing the reimbursement for aspects of services, and denying the hospitals heretofore easy opportunities to add beds, equipment or services. Eventually, just about 2 years ago, the government undertook the most drastic step of all, to fix payments by way of a complex reimbursement mechanism known as DRGs, an acronym for Diagnosis Related Groups.

At the moment, hospitals are being paid on this controlled system, practically a budget, which is cumbersome and not entirely equitable, although it does offer a better measure of cost control. The hospitals that had difficulties in making ends meet before, are in worse trouble now – city hospitals, with inadequate budgets, teaching hospitals with heavy loads of very sick patients. The government's controlled reimbursement is not shaded for the special problems. Community hospitals, which may be serving non-insured patients, suffer. Older and sicker patients are finding themselves out of hospital long before they are well enough to leave; others are not admitted, but 'dumped' elsewhere, because there is a suspicion on the part of the admitting officer that the patient may require longer stay or a greater concentration of care costing more than the flat sum, the DRG 'average', will allow.

Yet, strangely enough, private hospitals (those operating under private ownership, for profit) prosper. And chains of private hospitals, so enormously wealthy that shares are being sold on their activities in the stock market, are buying up these failing hospitals. The regulatory system allows a percentage over costs (profit margin), because after all, America is the premier capitalist country! The for-profit institutions – they call themselves 'investor-owned' – restrict their services to the care of paying and insured patients. The poor and non-insured are left to be looked after by the local government or community hospitals. Eventually, if the government reimbursement policy becomes even

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stricter, these hospitals too will have to seek out a buyer.

In the meantime, as government reimbursement policies for doctors are less sympathetic, many physicians are reluctant to commit themselves to patients the government pays for – Medicare and Medicaid patients. But the private market for the independent entrepreneurial practising physician is dwindling. More and more of the commercial enterprises are building 'vertical' companies – clusters of group practices to feed the hospitals; free-standing ambulatory centres, like walk-in clinics, day-surgical units; hospices and nursing homes to relieve pressures on the hospitals, or allow less expensive care in company-owned institutions. In the entrepreneurial atmosphere of medical practice in the USA 'surgicenters', 'walk-in centers', ('Doc-in-the-box' as they are referred to) located off main highways and in shopping malls are flourishing.

American health insurance, except for the government segment, has been private – industrial health insurance for employed workers. Nearly 80% of the population is covered to some extent, by such private insurance. Most are covered for hospital services, a somewhat lesser number for in-hospital medical services, and far fewer for home and office costs or for the cost of prescribed medications. Industry, which bears the bulk of the cost of the health insurance premiums, is now seeking less expensive insurance. The industries and their associated trade-unions buy their policies where they can get the best rates. The for-profit companies with the vertical integration offer the best deal, and so the independently practising physician is out in the cold.

Physicians are being herded into enclosures as salaried employees, of non-profit groups (HMGs), teaching hospitals (medical practice units) or commercial enterprises – for-profit groups or hospitals. The earlier extravagant inflation of medical costs resulted in very high levels of reimbursement of physicians, which in turn encouraged the commercial enterprises to enter the field. As the commercial enterprises attract the insured patients, there are fewer non-insured available for the independently practising doctor. And there is now what is described as a 'glut' of doctors; in New York City, for example, approaching 300 doctors per 100,000 patients, double what it was 25 years ago.

How can physicians resist the remorseless pull of the salaried job? Many medical school graduates are leaving with large debts from paying for their medical education. It is increasingly expensive to establish and equip an office in beginning a practice. And overall, there is the surplus of graduates going into practice, increasing competition for patients, and the earning capacity to pay off these heavy obligations is slow.

The commercial organizations don't have to risk the slow development of a practice because they can use

their reserves to bankroll a start-up for a medical group, sell insurance to groups of subscribers as industry increasingly seeks bargains in health insurance for their workers, and begin to make money right away. Because they can be selective, the commercial organizations have no poor people or old people or very sick people to look after. Their profits are handsome. They can offer secure salaries, working conditions, vacations, pensions and the like to attract the young physicians who are in financial difficulties.

Medical care business is big business, even when it is a government enterprise. But when it becomes a private sector activity its size is awesome in its overwhelming profitability. Johnson and Johnson, leading hospital supply company in 1984, had \$6.1 billion in revenues. American Hospital Supply, \$3.4 billion; and Baxter Travenol Laboratories, with whom American Hospital Supply has just merged, \$1.8 billion. AHS controls 50% of the sales of cardiovascular surgical supplies in the *world* (worth \$200 million); BTL 45% of the intravenous solutions market (worth \$675 million). Hospital Corporation of America, the leader of the proprietary hospital ownership and management industry, had *revenues* of \$4.2 billion last year; the runner-up was Humana Incorporated at \$2.6 billion. American Medical International Incorporated had \$2.4 billion.

A spokesman for the investor-owned hospital industry has described the scenario he envisages for the medical care corporation of the future which is to be based on a hospital the corporation owns, or a group practice – the HMG, 'health maintenance group' – (preferably both) whose physicians will be the basic medical care element for the commercial health care system. An important first step will be the purchase of a health insurance company, which will offer either medical care through its own group or through selected practitioners or free-standing clinics which have elected to accept the insurance fee-schedule (called PPO, 'preferred provider option'); ownership or contracts with nursing home and hospice. Each piece is uniquely profitable by itself, but in combination, each piece enhances the possibility of profitability in each of the other pieces.

Poor people will have to find some other resource for medical care. The government is talking about separate but equal facilities for the poor, the handicapped, the poor risks and the elderly that the for-profit medical organizations do not want. There are about 25 million Americans who have no or little insurance, and who are not eligible for the government paid medical care. As people lose their jobs, they lose their health insurance. They will have to be looked after in this secondary line as well.

So far this sounds like standard social problem fare. But the special character of this event is in the impact on the doctor. The physician is gradually being

converted from a professional to a white collar worker. The heavy costs have diverted the politicians' attention from problems of access and quality to problems of cost containment, almost exclusively. The growth of the commercial organizations is now in the range of many billions of dollars. It will not be easy to dislodge the entrepreneurs. They now hold 15% of the hospitals and more hospitals are offering themselves for sale daily, or contracting with the commercial outfits for management – essentially to the same effect. They are making continuing inroads into the group practice field, buying up small units and creating their own.

Once other insurance carriers are driven out, and the doctors meekly coopted, the private commercial organizations will have captured the market. At that point they can demand whatever they like in the way of premiums. Refusal to meet their demands leaves the government or industrial participants helpless. There will be no alternative to their services. The doctors will be pressed to do whatever cost saving is feasible within the limits of their consciences. Not patient need or professional requirements will determine the doctors' behaviour. This is true of the non-profit, as well as the for-profit institutions as the pressures for cost control continue. Physicians, as salaried employees, will be required to concern themselves with profit and loss at

the expense of quality of care.

Governments and their economic advisors sometimes behave as if medical care is nothing more than a supermarket shelf item. Patients know the intimate personal nature of medical care. Privatization is not just an economic measure.

Britain has already gone through the organizational development for the provision of medical care through a hierarchical system: family practitioners single-handed or in groups; hospital based consultants and the hospitals and long-term care institutions in a tiered referral system. The government's role in providing the cash for such a system of operation has permitted both effective cost-control, professional practice freedom and universal patient access to medical care. Whatever defects the system has – management or professional incentives – they cannot begin to match the enormous deficiencies of the public/private mix characteristic of the American system. Millions of Americans are deprived of appropriate access to modern medical care – some people almost totally deprived. Cost control in the USA is in the process of degenerating into encroachment on professional practice and deprivation of service availability. What benefit can possibly attach to conversion of the NHS from a public to a private enterprise?