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How Did We Get Here? What Now?

Dr. Jerome H. Grossman *spoke June 12, 2000, at a Pioneer Forum in connection with the release of a Pioneer* White Paper *he authored entitled "The Economic History of Health Care in Massachusetts 1990-2000." The paper explores the economic forces shaping health care in Massachusetts today and offers market-based recommendations. Dr. Grossman served as Chairman and CEO of New England Medical Center from 1979 to 1995. Currently a Fellow at Harvard's Kennedy School of Government and Chairman and CEO of Lion Gate Management Corporation, a health care information technology and consulting firm, he was named to the Institute of Medicine at the National Academy of Sciences in 1983 and served as Scholar-in-Residence at the Institute in 1996. The following is an edited transcript of his Forum remarks.*

Speaking at a Pioneer Forum, Dr. Jerome H. Grossman holds up an issue of the Boston Herald *to illustrate a point about the economic forces affecting health care in Massachusetts today.*

This *White Paper* is to some extent an oral history. I have had the opportunity to speak with probably 100 people over the last six months and then do a good deal of homework. My goal has been to show clearly how we arrived where we are. A core message here is that there are no villains.

My mentor, John Dunlop, was the one who found some references that suggested Roosevelt considered very strongly adding health to Social Security in 1935. But he was convinced that the health care industry was too powerful to permit such a government program. At that time, doctors and hospitals formed the beginnings of private health insurance with Blue Cross and Blue Shield. That's the first explanation for why this country went in a different direction than every other developed country. The rest chose universal entitlement with government funding. We alone chose a different system.

The next step was the offer, in the 1940s, of private insurance as an employment-based benefit. The Wage and Price Stability Board permitted the health care benefit because it accounted for less than 5 percent of wages. Insurance became permanently linked to employment, was part of collective bargaining, and was also offered voluntarily by non-union corporations. This post-World War II development set the stage for the ongoing debate over employment-based versus government-based insurance.

Get the full text of Dr. Grossman's *White Paper* by calling Pioneer Institute at 617-723-2277 or accessing **www.pioneerinstitute.org/research/whitepapers/wp11cover.cfm**.

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During this period, the government also became involved in building the health care infrastructure. Massachusetts benefited more than most states, both in terms of teaching hospitals and funding for research. Some would say the government over-built the infrastructure. At no point did we do a real economic analysis of where we were going, or of what was going to happen. Then, in a burst of public social feeling, we created Medicare and Medicaid and matched the private program with a public program.

We became accustomed to having everything. We have the highest number of physicians per capita by almost a factor of two, and the highest number of specialists.... We saw rapid, unchecked growth in medical schools; need was not an issue. This state has mandated more benefits than any other state in the country.

Nothing that was done was consistent with a market. The hospitals were nonprofit, and they were reimbursed for their costs, because we didn't want anybody to skimp on the care they gave. Physicians set the fees for their services independently. It was a wonderful system for patients because someone else paid for as much health care as they wanted. It was a wonderful system for doctors because the more care you gave, the more payment you received. The same was true for the hospitals. The country wanted it that way. The country felt rich and successful, and one of the things it wanted to do was extend health and medical care, make it better through the National Institutes of Health, and make it available. And that's what it did.

Some of the details became really important. Even with unpaid interns, care was more expensive in the teaching hospitals—there were teachers and other extra expenses, and it just was not as efficient as in community hospitals. And it was perceived that it was appropriate for public programs to pay for the activity of teaching. Teaching hospitals received special teaching allotments. We looked at the costs in teaching hospitals in 1965 and found them to be higher than community hospitals. Statistically the best measure was residents per bed, so the special teaching allotments were calculated on that basis. It came out to some pretty good payments for the teaching hospitals.

Another important detail was the provision that Medicare cover all debt—principal and interest—on any buildings you built. There were attempts to control costs, but public support of capital expenditures continued. Massachusetts rose to the top by any measure, including costs per capita. We tried to address costs through rate regulation and through determination of need, but to no avail.

Development of Health Maintenance Organizations (HMOs)

For a description of recent legislative debate over HMO oversight, go to **www.slif.org/papers/wps_v1/069807.html**.

When Harvard Community Health Plan was founded in 1966, it was really designed for research on the delivery system, modeled on the research into human biology. I built the first automated medical records system, because one of the things we were going to do was follow populations of people and understand what happened. We didn't get that far. Then, President Nixon approved an HMO bill in 1973 for coverage of more than 25 employees. Next came the shift from closed salaried arrangements to simply leaving private practice in community hospitals and grouping them together under contracts, which then contracted with HMOs.

We created Bay State, which was an open model, but it charged HMO fees to companies. We all knew Bay Sate was going south, but there were no laws or oversight or regulation in place that could do anything about it until 1992, when it finally collapsed. By that time, every HMO was basically offering every provider to everybody. And so we never got to a point where different groups of people were competing with each other based on quality and cost for customers.

For a previous *White Paper*, "Nonprofit to For-Profit Conversions by Hospitals and Health Plans," by Jack Needleman, go to **www.pioneerinstitute.org/research/whitepapers/wp5cover.cfm**.

We became accustomed to having everything. We have the highest number of physicians per capita by almost a factor of two, and the highest number of specialists. It's the latest and best, and this is what Americans want. We saw rapid, unchecked growth in medical schools; need was not an issue. This state has mandated more benefits than any other state in the country. So the benefit package which is offered is wider and deeper than anywhere else.

The 1990s

Let's look at the last decade. It was made a little easier in Massachusetts because we went into a deep recession, with high unemployment. People were fearful of losing their jobs and so were willing to be moved into managed care. Co-payments were introduced. If you wanted to stay in indemnity or more expensive plans, you had to pay the difference in your premium. Then the Commonwealth turned Medicaid into managed care, breaking one of the "budget busters," and directed people to community hospitals.

The big issue in the 1992 national campaign was health care. Bill Clinton said managed competition was the answer. We deregulated prices in 1992. People running hospitals, particularly, began to recognize the issue and to work to figure out just what happens when there is deregulation. We had a combination of cost reductions and consolidation. It wasn't that we didn't take a big chunk of capacity out of our system, but it was also a pretty rich and dense system. I collected data showing that while the price of community hospitals and teaching hospitals is below the national average, we still have many more of our hospitalizations in teaching hospitals. Adding to this, we have a dominant player in each third of the state, and in the east, we have more people, obviously, and a greater number of larger players.

I believe we are the only industry that has not taken advantage of information systems and technologies and telecommunications to improve operations.... We don't have the improved quality and cost reduction that should flow from intense application of technology.

The state keeps going forward to minimize the uninsured—we already have fewer uninsured than almost any other state. There is still the problem of free riders—people with incomes over $50,000, who choose not to buy insurance. They are included when we measure the uninsured.

One useful idea for minimizing the uninsured is subsidies for low-income companies with low-income workers. You can go to the insurance partnership board office, and if you can show you're a low-income company, they'll pick up 50 percent of the benefit you offer to your employees. And if you're a low-income employee, you can get $50 a month toward insurance. If insurance is going to remain employment-based, here's a way to take care of this bottom third, and the other two-thirds can get it the other way. They agreed to add prescription benefits for the elderly.

It is my firm belief you cannot have a market unless you know what it is you are buying. In exchange for reclaiming doctor/patient ownership of how to give care, physicians and hospitals have to produce public data about their outcomes in ways everyone can understand. Patients as consumers will choose plans based in part on these outcomes.

The state has absolutely stayed the course and has consistently chosen to improve coverage over pay to providers. But you do get to the point where you're making a decision between two groups of people. A recent *New York Times* article, for example, described the fight between Medicare elders and hospitals over prescription money. The hospitals were complaining, "We now have a million people in Medicaid." Obviously, being paid poorly for a million people is different than being paid poorly for 350,000. There's good reason for hospitals to be concerned.

In addition, there is the critical issue of having built the premier research industry in the world. When we gave the people who did the research the ownership rights to patent their discoveries, not only did it give those institutions an asset, it gave companies a reason to take those advances and turn them into products. Add our venture capital pool to this to catalyze it, and we're off and running. We now have 240 companies, and several of the remaining pharmaceutical firms in the world are moving to California and Boston. On one hand, hospitals have been hurt and have had to cut jobs; on the other, we clearly have a structurally high-cost system.

Suggestions for Change

The way I would go forward is to make it a real market, a structured market that gives physicians, patients, companies, everyone a fair chance. I believe we are the only industry that has not taken advantage of information systems and technologies and telecommunications to improve operations. We basically used a two-by-four to reduce costs.

For alternative discussions of health delivery reform, read "Protection of the Health Care Consumer: The 'Truth' Agency" by Regina Herzlinger at **www.dlcppi.org/texts/health/herzlinger.htm** and "Universal Comprehensive Coverage" by Alan Sager and Deborah Socolar at **www.massmed.org/physicians/resource/report2.pdf**.

It is not one professional who gives care. It's a raft of people, and we've cut out a raft of people without having a quality management system. Worse still, it didn't improve productivity. Say you took away the night pharmacist; that meant the nurse had to go downstairs at night and be off the floor. That is not more productive.

We don't have the improved quality and cost reduction that should flow from intense application of technology. There are several improvements we could expect—for physicians and for patients. I'm extremely big on self-management and empowering the patient. Technology has changed society and empowered consumers in general.

It is my firm belief you cannot have a market unless you know what it is you are buying. In exchange for reclaiming doctor/patient ownership of how to give care, physicians and hospitals have to produce public data about their outcomes in ways everyone can understand. Patients as consumers will choose plans based in part on these outcomes.

It is clear that change is needed—we need a safety net, built on information systems that make clinical performance data accessible to consumers. Doctors and hospitals should have a hand in creating the system. As recent history has shown, we need to monitor financial performance of insurers and providers as well. I favor the creation of something on the idea of the SEC (Securities and Exchange Commission) or the Federal Reserve System to ensure financial soundness. Low-cost loans or

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grants might spur some groups to invest in information systems if the market doesn't create the incentive right away.

I believe we can redo the actuarial system of insurance companies to be output-driven, to take the DRG (diagnostic-related groups) concept and move it to capitation. But we must be sure to avoid adverse risk, which means we must develop a way to cover catastrophic care. We have to cover chronic illness and have to make sure everybody buys it.

I believe there is a host of changes we could make modeled on what has happened in financial services. Think of the 401(k) in which you have a wide choice of plans. Your employer makes a defined contribution, and we're now seeing employers doing the same thing in health care. The employee may contribute up to a pre-tax cap and choose from a lot of different plans. An insurer could offer a wide variety of plans, differentiated by cost, degree of self-management, and by the provider's record. Think of Fidelity and mutual funds; health insurers could offer such a range of options with clear track records. The key is that consumers would be making an informed choice; they would know what they were getting.

Also, patients increasingly want different kinds of care. We could provide care according to "style points." If you want a doctor in your house, and you want to pay for it, be my guest. Other groups of patients never want to see a physician. They want to get everything on the Internet. Gaining information, asking questions, managing illness, could all be done without an office visit. People who prefer this type of self-managed care should have that option. They can have a relationship with a physician, but it is one that costs a lot less. Putting technology in people's homes would enable them to track their own status by performing such procedures as testing blood. Automated monitors linked to a database would ensure complications were caught in time. Patients should have a whole range of care options.

You can discuss Dr. Grossman's *White Paper* and other relevant health care research online at Pioneer Network at **www.pioneernet.org/forums_view.cfm?forumid=3**. Pioneer Network is a virtual community of scholars, policy experts, journalists, and opinion leaders which is dedicated to providing a forum for leading edge scholarship and market-oriented solutions to public policy issues.