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Introduction: Fixing Healthcare in the United States

Pamela Davis, CEO of 427 bed Edward Hospital in Naperville, Illinois was instructed by the FBI to wear a wire in her bra to collect evidence of a shakedown that had held up the state health planning approval of a hospital expansion. That investigation initiated by Davis eventually led to the uncovering of then Governor Blagojevitch's efforts to sell President Obama's Senate seat. The hospital expansion has yet to be approved (Burleigh, 2009).

A multinational corporation, Siemens, whose subsidiaries include Siemens Healthcare, this nation's largest vendor of computerized medical information systems for hospitals and office practices, agreed to pay \$1.6 billion in fines to settle charges that it routinely used bribes to gain contracts on every continent on the globe. The annual budget for bribes, which according to the New York Times account "was just a line item," was about \$40 to \$50 million a year (Schubert and Miller, 2008). Indeed, it was such an accepted operating procedure within the corporation, that it was routinely reported as a business expense. Up until 1999, such expenses were a legitimate deductible business expense under the German tax code.

Schools that train the people who work in healthcare do not cover this aspect of the industry. Those involved in these events rarely discuss them

openly. They are part of a dark underside of professional life that is not unique to the health sector. There is a large gray area between the bribery engaged in by Siemens executives and the extortion attempt faced by Pamela Davis and the ideals that shape professional codes of ethics. There is an even larger gap between how well healthcare in the United States performs and how well it could. How do we fix this? In essence, we can begin to fix it by learning from history, mistakes and a growing appreciation of the complex interconnectedness of the U.S. health system. This book helps by presenting cases that contain three common elements: (1) a history that places the case in the context of the evolution of healthcare in the United States, (2) serious ethical lapses or mistakes and (3) concrete examples of that interconnectedness. Taken together, the cases make a compelling argument for both the necessity and capacity for corrective treatment.

Whether you are a nurse or doctor in training, a lawyer involved in representing a client, a manager in a healthcare plan, hospital or clinic, a regulator, an interest group lobbyist, a legislator concerned about influencing policy, or a patient or relative of a patient trying to ensure the provision of adequate care, there are lots of troubling surprises.

In the United States, as in other countries, health is our most precious national resource. It is essential for our individual “pursuit of happiness” as embodied in our Declaration of Independence. As a nation, it helps determine our productivity, our ability to compete in the global marketplace, our military capacity to defend ourselves and our credibility in world affairs. We regularly take stock of how we are doing relative to other countries and the numbers trouble us.

We certainly spend enough money. We spent more per person — \$6,401 per capita in 2005 — representing a higher percent of our gross domestic product (15.3%) than any other nation in the world (Organization for Economic Cooperation and Development (OECD), 2007). The United States now spends more than \$2 trillion dollars on healthcare, exceeding the total Gross Domestic Product (GDP) of all the other 30 developed countries providing information except Japan. It accounts for close to a staggering *half* of all the health expenditures in the world. While we are the only one of these 30 developed nations that lacks a system of assuring universal health insurance coverage for all its citizens, we still spend more in public dollars alone per capita for healthcare (\$3,041 in 2005) than the

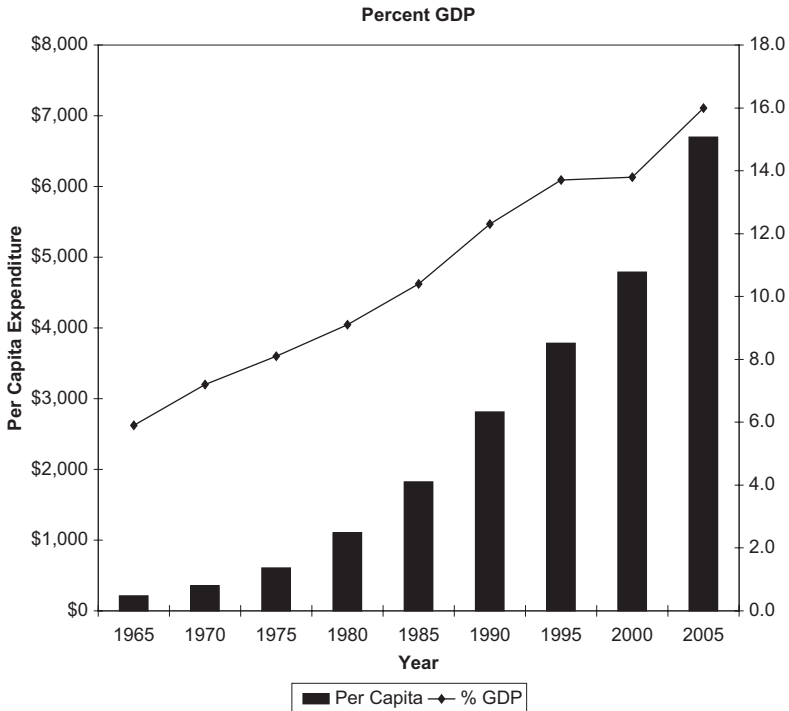


Fig. 1.1. U.S. Per Capita Health Expenditures and Percent of Gross Domestic Product 1965–2005 (Source: CMS, Office of the Actuary, 2007).

average *total* per capita expenditures for healthcare in all of these countries. As indicated in Fig. 1.1, those expenditures continue to rise at a rapid rate with no end in sight. If health expenditures were to continue to rise at roughly the same rate as they have over the last 40 years, healthcare would devour more than 40% of our Gross Domestic Product in 2045. If that pattern were to continue another forty years after that, national expenditures would exceed the entire GDP creating an implausible science fiction world where it would be impossible to sustain life — ironically the very purpose of these expenditures.

Almost as troubling, we spend a substantially larger share of our healthcare costs, not on providing healthcare services, but on trying to manage them. In large businesses, there are administrative economies of

scale. In the largest and most expensive health system in the world, the United States, there are diseconomies. In 2005, administrative costs (excluding those costs incurred by service providers which are also much higher), amounted to \$465 per person, seven times the median of other developed nations reporting this information, and higher than any other nation except Luxembourg (Angrisano and Farrell *et al.*, 2007). Others have estimated that the total administrative costs in 1999 were \$294.3 billion (\$1,389 per capita and about 30% of the total costs) and that there is the potential for saving as much as \$982 dollars per capita by eliminating the fragmented healthcare and fiscal intermediary system in the United States (Himmelstein *et al.*, 2004).

The United States has the most costly healthcare system in the world and we would like to think we have gotten what we paid for — the best health system and the best healthcare and health in the world. The bottom line is the health of the population cared for by a health system. Yet, any report card rating the United States to 28 other developed countries it competes with, both diplomatically and in the market place, would put us near the bottom of the class. In 1960, we ranked 14th in the world in life expectancy at birth and in 2005 our rank on this measure had fallen to a dismal 24th. On a more troubling measure, premature mortality (the potential years of life lost before age seventy due to deaths before this age), the United States ranks 27th for women and 24th for men among these 28 nations. A combination of higher rates of infant mortality, homicide and death from accidents contribute to this poor showing. In general, the amount of money expended per capita on healthcare correlates with better health and life expectancy. As noted in Fig. 1.2, however, the United States is the lonely outlier, spending more and getting much less in return.

We are quite defensive about these statistics and try to dismiss them. Some argue, it is not the fault of our health system — rather it is people's lifestyles and personal behavior, together with social and economic problems beyond the responsibility of healthcare providers, that produce these poor results. This is certainly a part of the problem and it is interwoven into many of the cases in this book. Others would argue that we provide the access to services that Americans demand, whereas the publicly dominated financing mechanisms in these other countries ration services in

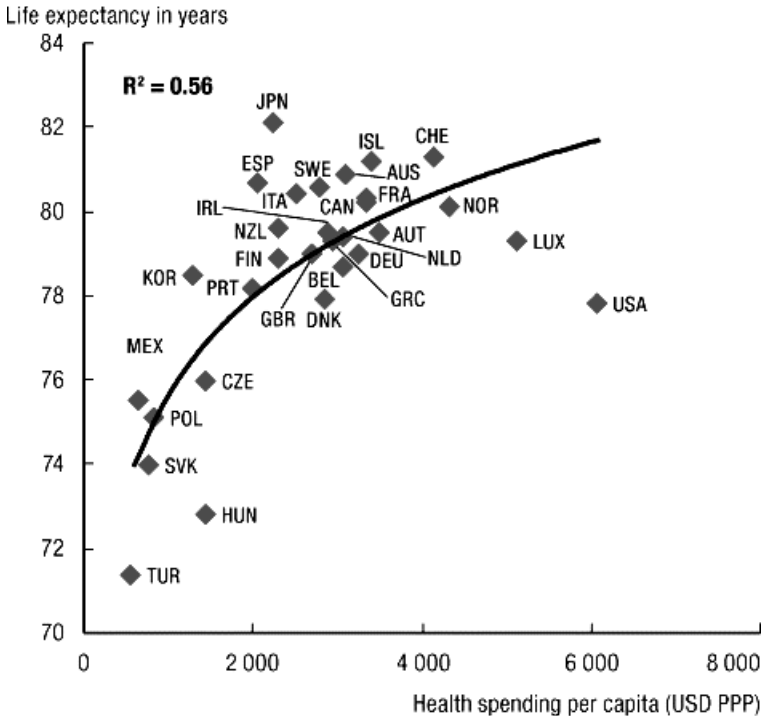


Fig. 1.2. Life Expectancy at Birth and Per Capita Health Expenditures (*Source: OECD, 2007*).

a way that Americans would not tolerate and this accounts for the higher cost. However, at least in terms of supply of physicians, nurses and hospital beds, which are crude measures of ease of access, we are well below the average for these developed countries. Indeed, on average, citizens of these other countries receive *more* services in terms of both physician visits per year and admissions to hospitals per year than Americans. Others argue that Americans like the kind of responsiveness of the care they get, while citizens of other countries are unhappy with the “rigidity of government controlled” systems of care. The Commonwealth Fund conducted a detailed study, including surveys of physicians and the population as a whole ranking the performance of the health systems of six countries (Australia, Canada, Germany, New Zealand, the United Kingdom, and the United States) (Davis, Schoen *et al.*, 2007). The United States health system

came in dead last on almost all measures of performance. It ranked 5th in reported patient centeredness of care as reported by a survey of patients and 6th in access.

The United States has a problem with healthcare and part of that problem is how we are taught to think about it. Much of what is written about healthcare helps contribute to this problem. The books written to help patients, healthcare professionals, lawyers and policy makers navigate the healthcare system in the United States focus too narrowly and simplify the problems. Many prescribe the choices of clinicians and managers as if they were unencumbered by system-wide pathologies that constrain those choices. They often address problems insulated from a history that would encourage skepticism about proposed solutions and raise more fundamental questions. While, in recognition of health care's richness and complexity, medical, nursing, business and law schools use the case method or problem-based learning to teach students, they rarely take full advantage of it, focusing within the confines of their own discipline.

The aim of this book is to provide a broader critique of the United States health system in the form of vivid, actual cases about its pathologies. Such stories have more impact on readers than abstract critiques. Perhaps the best way to learn how to do things right is by learning how wrong things can go. The cases that follow involve the more substantive stories, those buried beneath headlines and the casual retelling of personal frustrations by those who work or receive care in health settings. They involve sometimes Byzantine intrigues that have shaped the widening disparities in treatment, escalating costs, unsafe and inadequate care for patients, and the growing demoralization of the many decent and committed people who work within the system.

While each of the cases could be read separately, together they address most of the basic structural problems faced by healthcare in the United States. These include the problems of: (1) ownership and governance, (2) the limitation of existing mechanisms of quality control, (3) the cyclical shortages of nursing staff and other providers of care, (4) the failure of government controls to regulate healthcare or to eliminate racial and ethnic disparities in treatment, (5) the failure of market forces to address the escalating cost and fragmentation of care, and (6) the political barriers to effective collaboration toward improving the health of communities.

Each case will be introduced with a preface that explains how the case fits with the others and into the evolution of the health system in the United States. Where appropriate, a postscript will bring the issues illustrated in the case up to date.

The book will be of interest to the general reader, but is designed to serve as a companion text to introductory courses in health management and policy for students in sociology, political science, public health, medicine, management, allied health, and law.

I wanted to provide a readable book with plenty of interesting stories. The stories are not typical of what happens in healthcare settings on a day to day basis. They are stories where people involved in the provision of healthcare find themselves pushed into a grey area, raising professional, ethical, legal, and sometimes criminal questions.

I wanted, however, to do more than just provide entertaining stories about the ethical dilemmas faced by those organizing, financing and delivering healthcare. I wanted to provide an antidote to approaches to healthcare that rob it of its complexity, historical ironies and human drama that make the healthcare setting such an interesting place to work. The cases or stories in this book raise fundamental questions not just about healthcare, but about who we are, how we should live our lives and what we should strive to be as communities and as a nation in an ever more interconnected world.

The fundamental lesson of these stories is that, while healthcare in the United States has profound pathologies, we also have the capacity to address them. In an academic health center, patients dread when the doctors providing care really get interested in their case, and bring in their students to learn and colleagues to consult. It is surely a sign that they have a complex and potentially fatal illness. Yet, through marshalling all the best of what we know, all the best of our resources and all the best of our intentions, it may be one that is possible to cure. That same combination of dread, fascination and hope draws people to healthcare and is woven through the cases in this book.