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Health of the Nation — Coverage for All Americans

Panelists: Arnold Epstein, Charles Baker, Arthur Caplan, Karen Davis, Susan Dentzer, Bill Frist, Robert Galvin, Stephen Schroeder, Reed Tuckson, Ruben J. King-Shaw, Jr., Thomas Lee, Jonathan Oberlander, Sara Rosenbaum
Moderator: Arthur Miller

Chapter 1: The Challenge to American Health

Arthur Miller: Panelists, let's start with the proposition that it is springtime, 2009. We're in the city of Metropolis in the facilities of a suburban doctor, Harry Oldman.
He's got to get to Washington for some professional thing. And he's got a few patients this morning. He wants to get through and get to the airport. He's seeing Robert.
Robert's about 50. He's in for a sinus condition. The real problem with Robert is that he's 80 pounds overweight. And he smokes like crazy. Steve— in the couple of minutes you've got, what do you say to him?

Stephen Schroeder: How long have you been smoking?

Arthur Miller: 25, 26 years.

Stephen Schroeder: Do you know what it does to you?

Arthur Miller: Yeah, I know it's bad for me, but it makes me feel— good. I like it.

Stephen Schroeder: Ever— ever try to stop?

Arthur Miller: Eh— five, six times.

Stephen Schroeder: 'Kay. Would— would you like some help in trying to stop?

Arthur Miller: This morning?

Stephen Schroeder: Yeah. (NOISE)

Arthur Miller: I thought you were going off to (LAUGHTER) Washington.

Stephen Schroeder: I'll stay in— I'll stay around and help you. This is the most important thing that I could do for you. I could add 10, 12 years to— to your life, give you the opportunity to watch your grandchildren get— get married. Have you and your wife have a, have a good time after you stop working. Very, very important for you.

Arthur Miller: Reed, if you were— Dr. Oldman, what's going through your mind?

Reed Tuckson: I think what's first going through my mind is how tough this is going to be. Because you've heard the message on a whole bunch of times.
So, what am I gonna be able to (COUGHING) offer you that's different and unique? What kind of resources are available in the community. What kind of partners I can get together. And I'm also thinking about your family, 'cause I know I gotta get to your wife. I gotta get to your kids. I'm gonna have to put together a combination of punches to knock this problem out.

Arthur Miller: Reed, you're making this sound like a full-time job. I'm only one of your patients.

Reed Tuckson: Well, that's why I say that as a doc, thinking about this for the five minutes that I've got, I've gotta be worried about you as a person, I also now am starting to think "What are the combinations of things that can come together," to not only help you, but I got a bunch of other people I gotta be a part of.

Arthur Miller: Alright. The good doctor heads off to the airport. He's on his way to DC. Actually, we're in DC and we're walking on the Mall. And you're talking about healthcare and reform. And you're saying to yourself, "What is it we want for Americans, in terms of their health status?"

Bill Frist: Well, for— for a— old Robert back there I'd say, "We're gonna work on you. Come with me to Washington." I'm a heart and lung transplant surgeon. Do that, have done that for 20 years, everyday. And in truth, I don't determine health— (COUGHING) for people listening. The determinants of health, how do you define it? How long you live? Their determinants of genetics? Pretty good impact. Socioeconomic status. How rich, how wealthy somebody is. Not that important, it ends up being. In terms of environment, some impact, but not that great. The big one is going back to Robert. Behavior.

Arthur Miller: Behavior.

Bill Frist: If, how long you're gonna live is— is one measure of health, it probably has a 40, almost 50 percent (NOISE) impact on how long you live. The one thing I hadn't mentioned is what I spent most of my life doin', until I lost my mind and went into politics. In (LAUGHTER) medicine, and the impact of hospitals, doctors, health insurance, it's tiny.

Arthur Miller: Hmm.

Bill Frist: Only about 10 percent.

Karen Davis: I have a bit of a contrarian—

Arthur Miller: Karen?

Karen Davis: —view. I really reject the notion that healthcare doesn't make any difference in— in the—

Karen Davis: —population—

Arthur Miller: —the Senator—

Karen Davis: —itself.

Arthur Miller: —said a small wha— compared to behavior, wel— wha— what we might loosely call culture?

Karen Davis: Well—

Arthur Miller: Go ahead, Karen.

Karen Davis: —it's hard to deny that smoking, diet, and exercise matter. But if you look at mortality that's related to medical care, the US is 19th out of 19 countries. The Institute of Medicine said 18,000 people die every year because they're uninsured. They can't afford medications. People report that they go without needed care. So, until we as a nation deal with the problem of 47 million uninsured, 16, 20 million people with inadequate insurance, we're gonna be the only country— where significant numbers are not getting the care that could be beneficial in helping them lead healthy, productive lives.

Chapter 2: Payment of Physicians

Arthur Miller: All right, as we walk down the Mall we see a group of people in white coats carrying signs. "A fee for service is fairness." "Capitation will decapitate healthcare in America." Who are those people?

Susan Dentzer: Ah well, as the editor of *Dismal Medical Economics Magazine*, (LAUGHTER) I've— I've heard from these folks for quite a long (COUGHING) time. And they essentially see this through the— lens, as most normal American capitalists would, of income. It's protecting their incomes. And—

Arthur Miller: So—

Susan Dentzer: —perhaps—

Arthur Miller: —I take it you're telling me they're doctors?

Susan Dentzer: Well—

Arthur Caplan: Or beauticians.

Susan Dentzer: (LAUGHTER) That's right. Yeah.
A certain group of doctors. (LAUGHTER)
But you see them as just one of the many competing interests—

Arthur Miller: Bob?

Robert Galvin: I'm trying, still, to get my mind off of that first patient, Robert. Because as a general internist, I'm wondering about his sinuses. I'm (LAUGHTER) just wondering.
My experience was you better deal with the problem that they came in with, and then get into the— the weight and the smoking. So, I'm hoping the sinuses are okay. But, look, Susan, I— I don't think you're wrong. And I think the way you framed it is one way to look at it. I also think you look at a group of dedicated— physicians who kind of are watching the world change. And they don't get paid for talking about smoking. And they don't get paid for helping with obesity.

Arthur Miller: Instead of talking in the third person, let's get closer to that little group. And lo and behold, who's there? It's our friend, Harry Oldman.

Arthur Miller: Art, you're Harry. Tell us why you're here.

Arthur Caplan: Cherry blossoms. (LAUGHTER)
I'm here because I went to medical school. I'm loaded with debt that I still haven't quite paid off. I got an office full of— people pushing paperwork everyday. I don't have time to talk to anybody. I'd— listening to this conversation, I heard about, in the abstract, about smoking and weight. I don't have that five minutes to do that. I'm— irritated that no one in Washington seems to care what I think about as a doc, so I came down here to try and bring some real world perspective to the fact that you're crushing my practice. I can't function this way. I don't get reimbursed enough. I'm swamped by paperwork. I don't have time for anything. And I answer to a bunch of— non-MD folks who are telling me what to do half the time.

Bill Frist: And on top, on top of that, on July 1st of this year, I'm gonna cut you 10 percent—

Arthur Caplan: Any— anyway.

Bill Frist: —and—

Bill Frist: —right now, you're dependent about 50 percent of your practice, on average, maybe more, on Medicare. And I, government, am gonna cut you. Ten percent then, and then if the legislation passes that these congressional leaders here in Washington wanna pass, I'm gonna cut you 20 percent, a year and a half from now.

Arthur Caplan: And this reminds me, I—

Bill Frist: And that's— that would be the law.
(OVERTALK)

Arthur Caplan: —this reminds me, I haven't had anybody to go talk to in Washington since Frist left. (LAUGHTER) (APPLAUSE)

Arthur Miller: It's funny. Everybody's in Washington today.
Well, there's an explanation. When the '08 campaign was run— the person elected President did so on a platform of coverage for all Americans. Indeed, every candidate was pushing that idea. Well, the new President has appointed an incredibly high-level commission. The hearings are scheduled on access, sure. But hearings are also scheduled on payment for doctors, costs— the mode of medical practice. A whole range of subjects. Are they interrelated?

Thomas Lee: Well— All these things are tied together—

Arthur Miller: Okay.

Thomas Lee: There's no question about that.

Arthur Miller: Okay. Well, this morning's hearing was about payment. And Tom, you testified to the commission. And there was a direct question to you. What is the future of fee for service? What did you say?

Thomas Lee: How 'bout those Red Sox? (LAUGHTER) No, I think— it's gotta change. And we all know it. And the question is how can it change without causing tremendous disruption to the providers, and to the patients they take care of?

Arthur Miller: Now, are— are you feeding us a euphemism when you say, "It's gotta change"? Do you really mean it's gotta go away?

Thomas Lee: I think that over the next several years, it will not be viable for folks who are just taking fee for service, without any kind of incentive for things other than, you know, volume.

Arthur Miller: Now, Charles, what would you have testified?

Charles Baker: I think what I would've said is that fee for service is probably not going to go away. Because we muddle in the healthcare space when it comes to reimbursement, because we don't know what else to do. I actually hope that what Harry says is that primary care needs to be treated with a lot more respect by the payer community, generally, and by Medicare in particular, because Medicare is, for all intents and purposes, the payer who sets the rules of the game for everybody else.
And Medicare is procedure-driven. It's technology-driven. And it doesn't pay for time. It pays for transactions.

Arthur Miller: Arnie, what would you have said?

Arnold Epstein: You know, I would've said we're gonna learn the lessons from the early '90s. And if there was a lesson from the failed Clinton health reform, there were a couple, it was, "Let's not try to radically force a completely new system down America's mouth, 'cause they will not take it." We had alliances, and we had HIPCs, and we had a 1300 pages of change that we were gonna put forth. And it was almost dead on arrival.

Arthur Miller: All right. Let me give you some texture about Harry Oldman. He practices with two other physicians. It's a— three-physician, family practice. He's got the typical cluttered— facility. Lots of file cabinets. Karen, you tell me. What is the optimum compensation scheme?

Karen Davis: Well, for—

Arthur Miller: For Harry.

Karen Davis: —Harry, I think what we need to move to is give him the option of being a patient-centered medical home. What do I mean by that?
That practice should be rewarded for taking accountability. For making sure those patients are getting appropriate counseling. They're up to date with their preventive care. If they're overdue for a diabetes checkup, that they've been told to come in— "The doctor wants to see you." And that means, in addition to fee for service, a monthly panel fee for being a medical home. So, it's moving to what I think of as a blended system of payment, which has worked very well in Denmark, and where people have well-established relationships with primary care, and where compensation for primary care is on a par, or even higher than, compensation for specialty care.

Arthur Miller: Tom, now, you tell me. Is he ready to be a home, a center?

Thomas Lee: No, I think Harry, I think Harry needs help taking care of those folks. And I don't think Harry can do it by (COUGHING) himself, no matter how hard he tries. And— I think Har— you know, the theme is team care, these days. And it's not— you know, we obviously need teams for like the really sick people. But for the not-sick people. The people who need help with their weight and their blood pressure and smoking cessation, it shouldn't be Harry who's sort of following up to see if they stop smoking.
And Harry's whole practice has to get paid in a way that— it can support a team around them. So, I think this medical home concept is critical. 'Cause you know, we need physicians to trust non-physicians to do things, that they don't have to see every single thing.

Arthur Miller: But Harry's not set up to be a team.

Thomas Lee: Harry— Harry's practice needs help evolving in that way.

Arthur Miller: Well—

Ruben J. King-Shaw, Jr.: I think what I would do for Harry's practice, in particular, is I would add a fee for consultation and advice. I think there's absolutely an opportunity for us to pay physicians for their cognitive advice and counsel to their patients, which would be different from, I think your healthier patients, to your sicker ones. So, that's one thing. And Medicare can do that. Insurance could do that if it, if it wanted to. Second thing that I would do is absolutely not go the road of a primary case management system. Medicaid programs have tried that for years. And it doesn't effectively change their clinical outcomes, or their physician engagement. If, on the other hand, you were to give the physician a budget that the physician, he or she, can use to direct to outside supportive agencies, whether that's social work or counseling or dieticians, et cetera, now you have the physicians with a pool of resources to assemble a team, a team of individuals who can support patient care.
But I think that the— the— the crux of making the difference here is not to destroy the fee-for-service system, but to add to it to make it a valuable use of a physician's time to have a conversation, an intimate, relevant, purposeful, directed conversation with his or her patients on a regular basis.

Arthur Caplan: In fact, speaking for Harry, I have to say, I don't care all that much about how I get paid. I'm very interested in getting paid. I want to get paid. But I want back my time which you keep taking away from me. Not you but this system. I don't have time. I spend it doing everything but medical care. It comes out of what I can do with my patients. I want my professionalism back. And I want some relief from constantly being tortured by third parties like lawyers.

Bill Frist: And also, Harry— (LAUGHTER) Harry is telling his— Harry is telling his 25-year-old daughter, don't go to medical school. Don't be a doctor. And the why, what is Harry thinking, is exactly that. It's more red tape. It's more paper work. And all I want to do is heal.

Robert Galvin: But we have a cost problem that we better get to.

Bill Frist: (OVERTALK) But— but the cost problem, let— let's get to it then real quick. Because what happened in the elections last year, we're in 2009, was that the uninsured, which is a huge issue. 47 million people uncovered. They die sooner. They get care later. It is a terrible problem. If the cost is too high, it drives up the ranks of the uninsured. And then you get back to the causes of cost, and that's where we're at this hearing today with fee for service. Because I do believe that if you're incentivizing the system by the number of procedures done, heart transplants, heart surgery, numbers of patients, and that's the way you're paying, so therefore you have to see 25 patients instead of 15 a day, and you can't talk to them about their smoking, we've got a problem. So, the incentive system today for physicians is to do more cases, more procedures. Fee for service, however, you don't have to blow it up. Because I agree, it's part of our American system. But you do have to change what the service is. Right now, we pay on volumes. And what we need to be doing is paying on value, outcomes. How good a job and rewarding that outcome.

Chapter 3: Electronic Health Information

Arthur Miller: Okay. One thing is clear. Harry's got to change. I mean, you raise an interesting point, Art he sits there with his paper records filling out the forms. What are we gonna do about that, Tom?

Thomas Lee: It's a big problem. And I don't think Harry can fix that. I think that it would help if the insurance companies could get together on this simplification thing. But for them to do it, they need the businesses to get behind it. It's a collective problem, reducing— reducing the bureaucracy.

Arthur Miller: There's one thing I don't understand. As I wander around I see people with computers. When I go to my doctor, he's constantly shuffling paper. What is that?

Ruben J. King-Shaw, Jr.: There are— there are so many health care technology options out there. And the reality is, any physician from a sole practitioner to a large medical group can outsource all of that paperwork to any one of a number of companies who will take care of that for them.

Arthur Miller: Why doesn't my doctor do it?

Ruben J. King-Shaw, Jr.: I'll start— I'm sure that the doctors in the room could give you credible answers. But one reason is that it has changed. And they would rather not deal with it. One reason, that it's not affordable. One reason is that you can outsource all these things and still have all this left-over paper. And I think part of it is that, you know, there— there's a— there's a I believe a focus on the medical professional on practicing medicine, not technology and business. And so, if you ask a physician, where am I gonna spend my time, researching how to outsource all my technology or reading a journal that's gonna help me practice better medicine? Or touching a patient? I would rather do one of the other two than figure out what company to hire to manage my office.

Bill Frist: Information technology, this is why I'm optimistic generally about the transformation of health care. If we use information technology right, which health care has not invested in as a sector ever, compared to every other industry out there, we have doctors who transform medicine today. Evidence-based medicine, transparency. Smart consumers where they can shop and know how good a doctor is or how good a hospital is or a plan is, none of which you can do today. But information technology if appropriately applied will allow that. What is the bottleneck? It's not the private sector. It goes back to the physician. And it goes back to these 20 patients the physician is seeing at four to five minutes just to— just to get compensated adequately today. And you put that computer in their office. And instead of seeing 20 patients a day, because your productivity falls for at least six months, that computer is slowing you down. It is hurting you. It benefits society, it benefits the health care system. But it hurts the— the key hole through which all this has to flow and that's the physician there.
And (OVERTALK) let me just say, before I close. We can incentivize it by basically, tie in a little bit of reimbursement. So your productivity may fall, but you'll get paid a little bit more if you use health information technology or this electronic health record. And that will change it.

Karen Davis: I agree that we've got to—

Arthur Miller: Charles, the Senator describes this as a short term, long term, almost cultural phenomenon again. What's hanging the doctors up?

Charles Baker: I think the technology companies, no offense meant, have overcommitted and over promised with regard to how easy and seamless the pursuit of an electronic office will actually be. And most of them, not one or two of them, but most of them didn't pan out. I mean, I spent a day following one of the docs in our network around his office. They were going through the process of implementing an electronic medical records system. And the complexity associated with having your scheduling in one system, your billing in another system, your referral activity in another system and your electronic medical record in another system is real. And meanwhile, the whole time he's worrying about all that, the phone's ringing. And it's his patients calling. Saying, you know, what about this? What about that, you know. So and so's on the phone. I need some help. And I came away thinking the technology companies have not done a good job of walking around in the doc's shoes and understanding what the true issues associated with trying to make this transaction are.

Arthur Miller: Karen, is this important?

Karen Davis: Well, it's absolutely important. And physician practices all around the world have hit many of the problems that Charlie's talking about. But we are way behind. One fourth of American primary care physicians have electronic systems. In all these other countries, they are already there. The Netherlands, New Zealand, Denmark, UK. Ninety percent of physicians have totally electronic offices. And they have all of those problems you're talking about. What's different in those countries? The government was willing to set standards on what is an acceptable system. They have many software vendors out there. But they know if they buy one, it's gonna meet the standards. And that this information can be pooled together in the health information exchange that the government has set up. In other places, they've helped pay for these systems. So, I think we need to either build it into payment or assess insurers, Charlie, including yours. But in Denmark, they found once they got this up, and yes, there was up-front productivity loss. But once they got it running, they were saving 50 minutes a day. Because it was so much easier to get the information they needed, to order a prescription or authorize a refill of a prescription. It really pays off. And not— and not that long. But it needs leadership. National leadership.

Arthur Miller: Karen, as a patient, I can understand it is easier to bill and to do a lot of sort of semi mundane tasks. Is there a real value to this?

Karen Davis: Absolutely. The first thing that happens when I go in to see my doctor is, the receptionist hands me a form that said fill out your medical history. So that's the first opportunity for a medical error. That I don't remember all the medications I'm on. That I don't remember, when was the last time I had that test. Why doesn't my doctor's office have that? Sometimes, my internist sends me to a GI guy. And when I go back to her, she said, what did they tell you? And— and so I tell her the advice I got. But does she have an integrated electronic medical record that not only has her information, tracking my cholesterol over time, but has the medications that my ophthalmologist has me on, has the medications that other doctors might have me on? No. We've got a siloed fragmented health system. And until we really get with it on comprehensive information we're gonna have lots of medical errors, lots of duplication, lots of waste.

Arthur Miller: You look very troubled.

Reed Tuckson: I want to ground this in a little bit of— of reality. These challenges are clear there. They've let— they've set down the rhythm tract of the problems. Let's look, though, that we've got a relationship with 550,000 physicians. The number of them that are connected with a company like ours doing interactive work electronically is on the rise. It is fairly, very significant. Secondly, we know now that there is an organization that is actually

creating the national standards, so that there will be interoperability. And lastly, from your point of view as a patient, know that, for example, with our company, 20 million people have personal health records.
Those are personal health records assessable through a swipe card every time they go to their doctor's office. Very, very easy to get. So the important things that Karen mentions are available today in real time. We're not moving fast enough, but we are moving.

Stephen Schroeder: I think there is an elephant in the living room that we're not talking about. All these comments presume the persistence of a vibrant primary care system. But if Harry is telling his sons and his daughters and his nephews not to go into medicine, those that go into medicine know for sure they don't want to go into primary care. And they want to go on what they call now the road to happiness. So this means they want to go into radiology, ophthalmology, anesthesia, dermatology, or emergency medicine. It's an old-fashioned road. And why do they want to do that? They want to do that because they're coming out with huge debts. Because unless we fix the payment system, they're not gonna get the kind of income that they'd like. That they're more attracted to shift work, so they don't have to worry about patients after they leave. They want that eight-to-five job. And then finally, they don't like all the hassles that we've been hearing about. That— that— that Art has just talked about.
So the electronic medical record by itself isn't gonna fix that. And unless we do more fundamental surgery on making primary care a more compelling field, I think we're gonna worry about, and maybe this isn't bad, that medicine in— in the future in primary care will be practiced by others than doctors.

Arthur Miller: You got a quick fix?

Stephen Schroeder: Fix the reimbursement system. Increase the prestige within medicine and within the medical schools. And try to get some technologic help to the practices.

Arthur Miller: That is— (APPLAUSE) quick.

Ruben J. King-Shaw, Jr.: If I could just jump in and talk about Robert for a second. Robert's the patient. And Robert's pretty pissed off, pardon my French. You know, he makes an average of what, may— maybe, maybe he makes forty grand. And all he's hearing is that doctors want to make more money. It's important to keep on this table here that you do have a large consuming public that doesn't much care how doctors get paid. But they clearly want physicians to get paid adequately. And they want the physician to be there when they need them. And they want the hospital to be there. But the more they hear about how little they make and how much more we have to pay doctors and hospitals, the angrier they get. And we can't write Robert out of this conversation. And so far, I'm afraid we have.

Susan Dentzer: Nor can we write out Robert's distant relative, Mabel, down in Appalachia, obese, hypertensive, uninsured, unemployed, disabled. And nothing that anybody has talked about for the last ten minutes, electronic medical records, physicians fulfilling their life's dreams of being wealthy, is gonna matter one iota to her.

Bill Frist: I— I just— totally disagree. I think it's worth tying it back together. But to me, the conversation is— is very much apart. We started in— in these campaigns talking about the uninsured. That's the big problem that's out there but it very quickly gets translated down to cost. The cost that Robert sees— the average plan today is $14,500 for a family of four. So poor Robert, "Why is the cost so high?"
Then you gotta go back to the health care system, which is $2.2 trillion system out there. And how do you lower that cost curve over time? And you do it by technology; you do it by information technology and electronic health records; you do it by having physicians which are incented on service, on outcomes, and not just on volumes themselves. So they do tie together. We're not forgetting about Robert when we go back and address the cost in our health care system.

Chapter 4: Drug Costs And Rationing

Arthur Miller: Okay, Art has been sitting here listening to this conversation. I think you've been listening.

Arthur Caplan: I have.

Arthur Miller: Good. (LAUGHTER) Actually, he— he had a recent occurrence related to cost. A physician friend, an oncologist, reported that a patient of his had colon cancer. You wanna tell the rest of the story?

Arthur Caplan: Well, my oncologist friend said, "You know, there's a new drug out. And this guy's got disseminated colon cancer, so it's bad. But I think this new drug would help this guy probably prolong his life two months, maybe 30 percent chance."

Arthur Miller: Of two months?

Arthur Caplan: Two months. “Not sure he’s comin’ out of the hospital. Still may not feel well. It’s gonna cost about $200,000. And my question to you, Art, knowing that you are a thoughtful advisor on ethics is whether it’s worth it? And should I offer this, bring it up and should I even bring up the cost with him?”

Arthur Miller: And your answer, oh Great One, was? (LAUGHTER)

Arthur Caplan: I said I’d consult with a panel. (LAUGHTER) I said, “Look. At two months, $200,000, I’m not going to forego presenting things to people. They have a right to know their options. But you better be ready to come in there with a recommendation about what you think he oughta do relative to this drug.” Because when I see doctors talking about new technologies, new drugs, new devices— even new vaccines, that might be very expensive. They tend to come in and say, “You know, it’s— it’s a very expensive thing. I’m not sure how much is covered. But I’ll tell you what— Mrs. X, if you wanna kill your husband, don’t use it.” (LAUGHTER)

Sara Rosenbaum: I think that kind of dilemma is eclipsed by the much bigger dilemmas that in fact physicians have to confront every day. When you have patients with very garden variety conditions that require certain kinds of garden variety interventions. And the patients can’t afford them. That the dilemma for a physician is, do I even start to counsel patients on the kinds of treatments that I would recommend, the kinds of treatment options I would recommend, because this patient really doesn’t have any of these choices.

Arthur Miller: But that was going to be my third possibility.

Sara Rosenbaum: That I think is the more common dilemma.

Arthur Miller: But now your patient mortgaged the house, take available liquid assets, can cover the $200,000. It’s not insured. Does that color what you say to the patient?

Arthur Caplan: It would. And I think a lot of doctors, may not yet but soon will be, confronted with increasingly expensive, targeted drugs for individuals that are gonna cost a lot more money. And I have to start to say to them at the bedside, cost is gonna factor into our decision about where we’re goin’ here.

Arthur Miller: This particular situation is simply a microcosm of this world we live in. New drugs, new devices, new diagnostics. Americans who believe we should expend everything we can, even at end of life.

Arthur Caplan: And the right thing to do is to do all you can for your loved one.

Arthur Miller: Right. Now, Tom do we just accept this as America— this is the way Americans think?

Thomas Lee: Well, you know, this— I think it is the way we think. And I think that this question you bring up, you know, you know the joke about three boxes on your desk: In, Out, Too Hard. This is— this is the too hard one. And we’re gonna have to face it but I think we should— we have to do everything we can to dodge the question by doing everything else we can to improve health and make care more efficient. Where we actually know what to do, you know, following guidelines where we actually have evidence. And there’s a lot we can do. I don’t really think it’s gonna help us completely dodge that question of— of the very high-cost drugs and the— and the other forms of progress. But we can do a lot to mitigate the need where we have to face it.

Arnold Epstein: This is a big problem. The numbers I’ve seen on this put it at something like $130 billion a year. And the quip is that the U.S. is the one country in the world where they think death is optional. And we act that way. And I think— as difficult as it is— I’d take it out of the “too hard” box and I’d start to force it on the— “we have to start to deal with this” box. And the time to deal with it is not at the bedside. It’s with a broader group trying to think about standards and trying to think about piecemeal efforts where we can put things— out of bounds, so to speak. And I don’t know if that means we say that people don’t get dialyzed when they’re 97— or bring it back to 95 or 92. Or that certain medications when the cost per life-year adjusted is $500,000 per year, we say that we’re really not gonna cover them. And we try and change the culture. But I think we have to do things like that.

Arthur Caplan: I— by the way, I have not seen one insurance company ready to take on the issue of what you’re gonna do at the end of life.

Reed Tuckson: Well, I would say to you that—

Arthur Caplan: Cost-wise.

Reed Tuckson: Well, no, no. I— I would say this, that first of all, it is— it would be ridiculous to think of any one sector trying to make these decisions. You joked about it but your joke was— actually had the— the glimmer of truth in it when you said, "I would consult the panel."
That you have got to have the physicians involved in this. Now, it is very clear that the variance in care at the end of life, even at our best scientific centers— when you compare them head-on. Is so extraordinarily— divergent and inconsistent as to be of major concern. And we are trying to get the profession to create guidance before you get to the bedside about what's important. The problem is failure of leadership right now and we gotta find ways of doing it.

Arthur Caplan: I gotta jump in with one other ethics thing and then I'll let my panel members help me through this dilemma. But if it's $200,000 for my mom versus your— lady who needs prenatal care or your diabetic, hypertensive in Appalachia. My choice— my moral choice— a lot of Americans are gonna say mom.

Reed Tuckson: Yeah.

Karen Davis: But what we've got— got the money.

Arthur Caplan: Now it's gonna take political leadership to move that.

Karen Davis: We spend twice what every other country spends. So my first question is what does this drug cost in France? And I bet you it costs 50 to 70 percent less in France than it costs here. So the first thing I want our physician leaders with their white coats marching down that Mall in Washington to do is to not just say, "We can't stand it that you're cutting our fees by ten percent." I want them to say, "We can't stand it that there are 47 million uninsured. We can't stand it that our patients can't afford medications."
And we, as a nation, need to do what every other nation has done— and that's not just universal coverage, its being willing to negotiate pharmaceutical prices to get better deals. The U.S. is subsidizing prescription drugs in other countries because we accept whatever pharmaceutical companies charge, rather than having a system of assessing the cost-effectiveness of those drugs, devices, and procedures, and negotiating on part of the entire population to get decent prices.

Arthur Miller: Maybe we should stop (APPLAUSE) inventing and discovering things. How does that strike you? That we're putting our research dollars in the wrong place.

Karen Davis: But that's just what I was saying—

Arthur Caplan: Well, for the ethics—

Karen Davis: —is the false dichotomy. I mean, you don't have to do that.

Arthur Caplan: From an ethics point of view, you can't shut that faucet off. The public doesn't want it, they want to see advances. So does— the medical profession. I think if you went to patients and said, "We can get a handle on cost. Just not gonna have much in the way of new stuff for the next couple of decades." It's not a trade-off they'll take.

Chapter 5: Universal Access: Why?

Arthur Miller: Okay. Now, let's get back to Sara. Sara's been worrying about access as we've gone through this discussion. We have, as the Senator said, 47 million uncovered. Is this an ethical issue in your mind?

Sara Rosenbaum: I think it's the most basic ethical issue of all. But it is a national decision on our part. It's not the federal decision; it's not the state decision; it is a national social decision. And we've been very bad about this.

Arthur Miller: Steve, do you think it's an ethical, a human rights issue?

Stephen Schroeder: I think that a country should be judged by how it treats its less fortunate. In that respect, I'm ashamed of our country. (APPLAUSE)

Ruben J. King-Shaw, Jr.: If— if I could just contribute to the discussion. I think the— the ethical issue is— I think it's a— it's a failure on the part of America to provide for the adequate health care for all of its citizens. Now that has become a debate over insurance. Insurance is one way to finance health care for a— for a population. It is not the only way. And so, all Americans, or all in America whether you are an American or not, should be able to access health care services. But I think that insurance is one model. Block granting is another model. Directly subsidizing the provider is another model. So I don't think the issue is insurance or not. It's whether we are financing adequate health care for our population or not.

Susan Dentzer: But that—

Arthur Miller: Okay, Jonathan. Let me ask you. We hear it's an ethical issue. We hear it's a human rights issue. Is that a winner if you take it to the public on that basis?

Jonathan Oberlander: No— I think if there's one lesson that we've learned about health reform in the last few decades it's that being right doesn't count for very much. We can come up with lots of stories to evoke moral outrage. And by the way, it's not just about the uninsured. There are many Americans with insurance who have inadequate protection and who file for bankruptcy every year because they're underinsured. But if we're gonna fight this battle for health reform on moral grounds, we're gonna lose.

Arthur Miller: There's one patient of good old Harry left. It's me. I'm Artie and I've heard this discussion about the 47 million. Fine. But look, I've got a job. It's a stable job. And I've got a health plan. If you tell me that these 47 million are gonna increase my taxes, or will increase my co-pays, which I'm frankly real sick of, I'm not with you. Unless you can tell me that there's something in it for me, I ain't there. Is there something in it?

Multiple Speakers: Sure— yes—

Arthur Miller: Whoa, whoa. (LAUGHTER) The dormant panel comes alive.

Reed Tuckson: We heard about the IOM study about the consequences of the uninsured. I was on that committee and what we documented, clearly, were that the consequences when you live in a community with people who are uninsured, you are being affected through the inadequacy of the public health system, the diversion of resources. You're being ac— compromised because of the effects on the hospitals and physicians in your community. At the end of the day, we could go through a laundry list of those things. But the consequences of uninsurance affect those who are uninsured and those who are insured who live in that community. All of us are in the boat together.

Susan Dentzer: And for the—

Bill Frist: I— I— I would also add on the cost issue real— real quick, just goin' back to talkin' to you, the patient. And I would— I would start off saying, yes it's a moral issue. And yes, it's gonna be expensive and yes, your taxes may go up a little bit. But I'd also say that recognize for these 47 million people, 12 million we already have a program for you: Either Medicaid or the Children's Health Care plan.
So that takes it down to, what? Forty-seven down to 35. Ten million are non-U.S. citizens; still have to deal with but whether it's community health centers or how we deal with it, we still have to deal with. But there are probably— and probably eight million make more than $50,000 a year. So the uninsured is not really the 47 million— it is, but in terms of what you, Art, have to worry about in terms of finances, is this hard-core probably 20, 25 million people.
Secondly, I would say you're paying it right now. You're paying a premium of $235 every month for your private health insurance. $70 of that goes directly to the uninsured, right now. And then, thirdly, I would say that you're already paying, the American tax payer, $50 billion for the uninsured. For those 47 million, $50 billion is already going to the uninsured.
Why? Because we have legislation that if uninsured comes to the emergency room, you're taken care of. So, I would begin that explanation because we're already paying for a lot of care for the uninsured in a very indirect, untransparent, inefficient way.

Karen Davis: And 45 billion of that cost, comes from the cost of— taking care of uninsured people or inadequately insured people who are working but their employer does not provide health insurance coverage or good health insurance coverage. So unless this is a shared responsibility where all employers either cover their workers or contribute to a fund— we're not gonna have the resources it takes to do this right.

Arthur Miller: Is this— is this a winning set of arguments? I didn't hear anybody say that my monthly payment, which he understated (LAUGH), will go down. Can we win with this?

Bill Frist: If you promise everybody coverage, we can put the plan together. But it goes back to where we started that it— every health insurance is still gonna go up three times as much as wages every year, as it's done on average the last 40 years, no. 'Cause we can make everybody feel good, but if the internal costs are still driven up three times faster than wages, it simply cannot be sustained. (APPLAUSE)

Arthur Miller: Great. John?

Jonathan Oberlander: I think that, first of all, let's be honest about the price tag for universal coverage. The price tag really is not that much. If you talk about adding the uninsured to the existing system, you're talking about

roughly $100 billion a year. We already spend over $2 trillion, so it's a mark-up but not much. When we cut taxes in 2001 and 2003, we found the money to do that. When we passed the Medicare Prescription Drug Benefit in 2003, we found the money to do that. When we went to war in Iraq, we found the money to do that. So this is a question of priorities. And the uninsured are not a political priority. And it's not that they're unaffordable, it's that we haven't chosen to pay that money. In terms of a— of a winning argument, I think the Senator was— was on to something there. Which is that — one of the untold stories is that health care costs are crowding the wages of American workers. If you look at American workers and the growth in wages since the 1970s, it's essentially eaten up by inflation. So where is that money going? Well, a lot of that money that should be going to higher wages and salaries is going to pay their health care bill. And so we've got to make that economic case that this is good for American workers. But we also— we need allies.

Chapter 6: Universal Access: How?

Arthur Miller: Okay. You've overpowered me, I'm convinced. Therefore through the magic of hypotheticals, whereas we've spent the day in 2009, we're going back to 2008. And I suppose now that I'm a convert, I am delighted that both political parties in this year of a presidential election are talking health care.
So on this beautiful spring day, I've taken my nephew, Sam, who's 25, he works at Mega Mart, which doesn't provide health care, and we've gone to Fenway Park. We're there to see the Sox play.

Reed Tuckson: To make Tom Lee happy. (LAUGHTER)

Arthur Miller: And we're talking about the fact that Sam doesn't have health care. And, I guess we're— as we're sitting there in a very slow pitcher's duel, we wanna review first the Republican platform. Senator, what is it?

Bill Frist: The Republican platform manifested by— by Senator McCain is, number one: No mandates, no employer mandate, no individual mandate; number two: It is a $5,000 tax— refundable tax credit, so it has meaning to people who are very low income, for a family of four. Or $2,500 refundable tax credit for the individual.
Thirdly, John McCain's plan eliminates the employer-sponsored deduction, which has really been the— the— the backbone, the real bolster of our employer-sponsored system which insures about 162 million people today. And the fourth, for the people who cannot get an insurance plan— it's out of their reach, he wants to give directly to the states grants through which they could get coverage.

Arthur Miller: So how is that—

Bill Frist: Those four.

Arthur Miller: —going to affect Sam? The 25-year old—

Bill Frist: Sam—

Arthur Miller: —without employer coverage?

Bill Frist: Sam basically gets a check, $2,500.

Arthur Miller: What's it gonna do for me, Artie, where I've got health coverage from my employer?

Bill Frist: You— first thing your employer may or may not do is, all of a sudden, your employer was putting it about $6,000 in to subsidize your health care plan— or say $3,000. And the federal gov— or the American people were subsidizing your health care plan because you get a tax deduction.

Arthur Miller: Uh-huh (AFFIRM). I loved it, I loved it.

Bill Frist: That's right. So your employer may say, "Well, the government's not helping me. The American tax payer no longer is subsidizing your plan, $3,000. Therefore, I'm going to stop offering health care and you figure it out." You get your $2,500 or $5,000 and go.

Arthur Miller: What the hell am I gonna buy with $2,500?

Bill Frist: Well, that's gonna be what our insurance friends here can offer. A plan today for a family of four costs $12— $11,500—

Arthur Miller: In front of Artie and Sam at Fenway, there are two other fans. There's Karen and there's Sara. So what do you say to Artie and Sam about this Republican platform?

Karen Davis: Well, I think you better look at that twice. As he said, many employers may— may drop us and leave us on our own, in charge, but trying to find health insurance in an insurance market that's going to be deregulated. And what that means is they may not take me if I've had any kind of health problem in the past.

Arthur Miller: Sara, what do you say about the Republican platform?

Sara Rosenbaum: Well, I've been listening to this and I just got finished telling my friend Karen that my daughter, who lives in New York City, who's about to be an independently employed theater director, went on-line last week to find an individual policy. And the best we could do for an individual, high-deductible plan in New York that gave her even remotely reasonable coverage was about $1,100 a month. And she's gonna be making probably in a good month, couple of thousand dollars as a young theater director. She's got 80 friends probably in the same boat. I just don't see that this is real.

Arthur Miller: Reed, do you— have any reaction to the Republican plan?

Reed Tuckson: The— you'll think I'm avoiding the— the question. The issue is if you want to create the political equation— to actually get something done in Congress, what it's going to require are multiple different stakeholders who are all prepared to go for their second choice. What is frustrating is once you get beyond the moral outrage, what happens is at every sector; the— the— the private insurers, the manufacturers, small business— the advocates for— for individuals; everybody has got their own 18-point plan.
And what we have learned, over and over again, is that when people get wedded into those fundamentals: It can only be employer-mandate; it can only be individual-mandate; it can only be if you expand Medicaid and SGF; if it is only, if it is only. What happens is you never get to the calculus of actual legislation that can get passed. So what I am sort of saying to you, ultimately, is it is inappropriate for people to start laying down what camp they are in at this moment. What is in important is for people to make a public commitment to be part of the coalition to actually get something done and stop arguing about all these— ideological— must-haves.

Arthur Miller: Okay. So you've successfully evaded the question. (LAUGHTER) The ball game's over. In deference to Tom, Sox win 5-4. (LAUGHTER)
Now, Artie and Sam have left Fenway. They're right outside the stadium. They're having a bratwurst and beer. Now Susan, you were sitting in the row behind them. You wanna tell me about the Democratic plan?

Susan Dentzer: Yes, because at *Dismal Medical Economics* we actually did a side-by-side looking at the plans. And attempting to take what is real in those plans and what is fantasy. Our ratings show that all of these plans have a substantial element of unreality to them. Part of it is either Democratic or Republican holy writ that is being recycled from past debates. Part of it is fantasy based on a lack of understanding about how things really work now. And that's why we came out— our editorial page at *Dismal Medical Economics*, said much the same thing Reed just said, which is just that we will have to wait until after the election. See how things settle out between who has the presidency and who has the Congress. And then engage in a realistic discussion about how to pick up this together.

Arthur Miller: You're not helping Artie and Sam as they munch down their bratwurst. Because, in reality, they're trying to figure out who to vote for.

Susan Dentzer: Well, I'm telling Artie and Sam—

Robert Galvin: Don't get sick.

Arthur Caplan: Put down that bratwurst. (LAUGHTER)

Susan Dentzer: That this is gonna be a long process. And as important as it is who is the president, it's also gonna be important who's in the Congress. Who takes Senator Frist's place? What are people— what is the sentiment that people walk away with of feeling what the American public would really want here? And also, importantly, some kind of mechanism to get people closer together on the same page. Because as a nation, we're not there now.

Bill Frist: Can I just jump in? On the Democratic plan right now, universal is— is the goal. There are mandates— there's an employer mandate. The second big issue is the promise, a plan for the uninsured that equals that of United States congressmen or Medicare that that's promised to everybody.
And the third component— is the increased involvement of government. Expansion of Medicaid, expansion of SGF, just overall increase of government. And those sort of three components there are— are the gist of the plan that— that they have to be thinking about. And if I were them, what I'd be thinking about: The universal makes sense. But have— has that plan addressed what I mentioned earlier? That you promised everything but you still have cost going up three times wages which hits the— the consumer, the individual. Is there anything— in— in that plan that— that— that does that?

Arthur Miller: Bob, employer. Employer reaction?

Robert Galvin: I think business has— is as willing to get out of what it's doing now as it's been— that I remember. Even more so than probably the early '90s just simply because the costs continue to compound. And so, I think I might call it, well, *Let's Make a Deal*.
But the deal has to be what's on the other side? And that's why I think— I'm really, really in agreement with Senator Frist that unless the Congress can work together on access and cost at the same time, it's gonna be difficult to sway the business community into believing that what's on the other side of what isn't today is going to not be worse than today.
Now let me quickly stratify to say you gotta— when you talk about the business community, you gotta divide right away between those that offer coverage who are in a very different situation than those that don't offer coverage. And it's a really a large— middle-large versus a small employer. So I'm speaking really now on behalf of those that offer coverage.

Arthur Miller: Charles, reaction to these proposals?

Charles Baker: I think the— I think they're both political bromide from both parties. Put out there so that if somebody says, "Do you have a position on health care coverage?" The answer can be yes. I am completely in agreement with Reed that the whole (COUGH) debate about health care in the U.S. for the past 20 or 30 years, with the possible exception of the Medicare Modernization Act, where, you know, whether you like it or not, the President basically said, "I'm gonna stake my presidency on this and it will happen." And as a result, it did. That's what you need a president to do if you're gonna get the coverage question resolved.
And until that happens, it ain't gonna happen.