The Great Shell Game

When it Comes to Health Care More is Not Always Better Quality But it Invariably is More Costly — and Therein Lies the Rub

By Joseph A. Califano, Jr.

In America, quality health care is like motherhood—as well it should be. So it’s not surprising that since World War II, our national energy has concentrated on improving health care and making it universally available.

Government programs like Medicare and Medicaid, union bargaining, and progressive corporate management have all been focused on more health care benefits for our people. In the past, we let costs rise, even when there was little or no correlation between higher costs and better quality health care.

For far too long, we assumed that more was better without even thinking about it. Today in America we take more tests, use more drugs, give more X-rays, perform more surgery and spend more time in hospitals for minor medical procedures than anywhere else in the world.

We’ve lost sight of the fact that more is always costlier—even though more is not always better quality care. And the cost of health care has become one of our nation’s most serious economic and social problems.

I want to discuss these costs-and how they are crippling American business — weighing down the American taxpayer-and threatening the
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elderly, who need health care most, with government rationing of life-essential medical procedures. And I want to talk about some early hints of change and the opportunity for American business to act, especially in the imminent General Motors-Ford-United Auto Workers contract negotiations.

True reductions in costs will come only with fundamental changes in the way we deliver and pay for health care. Those changes, in turn, will require concerted action by all the players—employers and unions, the Administration and the Congress, federal, state and local government, lawyers and judges, doctors, hospitals, laboratories, drug companies and other suppliers—and patients.

Unfortunately, we are not getting such concerted action. Instead, government payers are concentrating more on cutting their own costs without regard for the impact on the system as a whole. The structure of the health care industry is such that caps on payments by one purchaser produce largely illusory savings. The suppliers simply shift costs to other purchasers or to other parts of the system.

Controlling health care costs has become the Great Health Care Shell Game. The Congress puts a cap on Medicare payments to hospitals, and the hospitals just pass the costs off to the states. The states put their own caps on Medicaid hospital payments, and the hospitals just move the pea to the private insurers and the Blues. The Congress establishes caps on medical procedures in hospitals and the doctors move the pea outside the hospital to their offices or clinics.

It’s time to end the shell game and establish a comprehensive national policy to deal with health care costs. That’s why Chrysler has urged the Congress to establish a commission on health care reform.

The statistics regarding health care costs are shocking.
• This year, for the first time in our history, Americans began spending
more than $1 billion a day on health care.

• Health care costs rose from $41.7 billion in 1965 to $355 billion in 1983—an increase of 751 percent.
• Hospital costs jumped from $13.9 billion in 1965 to $150 billion in 1983—an increase of 979 percent.
• Physicians’ fees increased from $8.5 billion in 1965 to $68.1 billion—an increase of 700 percent.
• Over that period, the Consumer Price Index rose—but only by 216 percent.

Health care is still the most inflationary sector of the economy. In 1983, the cost of medical care rose at a ten percent rate, more than triple the 3.2 percent increase in the overall Consumer Price Index. The daily cost of a hospital room rose 12.2 percent, to an average of almost $400 per day. The 1983 bill of $355 billion was a levy of almost $1,500 on every man, woman and child in America.

There are some signs in the first part of this year that actions by government and business are slowing the rise in costs. Nevertheless, this year health care continues its inflationary assault on the American economy.

**How We Created a Frankenstein System**

There is no longer much disagreement about the structural causes of inflation in the health care industry. Everyone working in the system is acting in response to economic incentives they face.

First, hospitals have generally been reimbursed on a cost or, in the case of for-profit hospitals, a cost-plus basis. Doctors are paid on a fee-for-service basis. Thus, the more hospitals have spent, the more money they have received; the more services doctors perform, the more money they make.

The new Medicare prospective payment system—setting payments for 467 health diagnoses from appendectomies to gall bladder operations—is a step in the right direction. But even this Diagnostic Related Group (DRG) system is part of the Great Health Care Shell Game: it lets the hospitals shift the pea to the states and private insurers, and it lets the doctors shift the pea out of the hospital and into their offices where there are no cost containment caps. It also continues to fund capital expenditures and physician training on a cost basis.

Second—and of critical importance as we think of the potential for a competitive economy in health care—the prevailing third party payment system eliminates any relationship between the buyer and the seller. When an American buys an automobile, he or she picks a dealer, negotiates about model, price, terms of payment, optional equipment, color, trim. Then the buyer picks the car he or she wants, and pays for it.

But no one enters a hospital and says, “I would like a coronary bypass today,” or “I would like a hysterectomy tomorrow.” Where hospitalization is involved, the patient doesn’t
even pick the surgeon or specialist; the family physician does. That specialist prescribes the medical procedures and picks the hospital at which they will be performed. Knowing he is not likely to be sued for conducting an extra test—and since he’s not paying the bill—the doctor has every incentive to run lots of tests. And so does the hospital, since its charges for tests help pay for the expensive equipment used to conduct them.

Ninety-four percent of the hospital bills in America are paid by government programs, private insurers and the Blues. Americans simply aren’t aware of the cost of their own health care. Have you ever seen contestants on “The Price Is Right” trying to guess the price of an appendectomy to the nearest dollar?

And, since someone else is picking up the tab—there’s no incentive to comparison shop. When was the last time you called around to compare prices on getting some blood tests or X-rays? Or dickered with a doctor or a hospital over a price?

These structural characteristics create a Frankenstein health care payment system, with Gargantuan growth on the supply side as we train more physicians, build more hospital beds and invent more expensive medical technologies, all with far too little resistance on the demand side.

The creation of this health care cost monster did not spring from the brain of some demented doctor. We all contributed mightily to the effort.

American businesses, experiencing high growth in the post-World War II period, had little concern as they expanded health care benefits. After all, health care seemed a lot less expensive to give employees than a higher per hour wage.

Unions demanded more health care coverage for their members, especially since health insurance premiums were tax-free fringe benefits to workers. With each round of bargaining, managers who fought with other suppliers over the price of each nail or screw, and union leaders who negotiated for each half-cent an hour, kept adding health benefits to contracts without realizing that they were becoming hostage to costs beyond their control—costs that over the long run endangered jobs and hobbled profits.
The government also made its contribution. When the Medicare and Medicaid programs were instituted in the 1960’s, the government was preoccupied with improving access to health care for the elderly and the poor. So we paid the political price by simply superimposing those programs on the existing cost-based, fee-for-service system.

The doctors and hospitals initially resisted these government programs, but once the Congress legislated the fee-for-service, cost and cost-plus reimbursement system into them, the doctors and hospital administrators cheerfully joined in the creation of this swollen health care cost monster.

Lawyers, judges and juries fed this Frankenstein with malpractice litigation that established unpredictable and unrealistic standards of negligence and whopping judgments against doctors and hospitals who failed to run one test or another.

And the patient wanted the best—to hell with the cost—for himself, his parents, his spouse—and most of all, his children.

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**How We’re Penalizing Ourselves**

For the past two years, I have been serving as head of a special commit-

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tee on health care of the Chrysler Board of Directors created by Chairman Lee Iacocca. This is the only committee of its kind in American business.

At Chrysler, as we fought for survival, we had to address the cost of health care.

It has not been an easy task. In 1984 Chrysler’s health care costs will exceed $400 million, making the Blues Chrysler’s single largest supplier. That’s more than $1.1 million each day. This year Chrysler’s total health care bill (which includes Chrysler’s Medicare payroll tax and a portion of the health insurance premiums of its suppliers) will exceed $550 for each car we sell. That’s down somewhat from $600 a car last year—not because inflation in health care costs has abated, but because we are selling more cars. This year Chrysler must sell about 70,000 vehicles just to pay for its health care bills.

Excessive health care costs are eroding America’s ability to compete with foreign companies. Mitsubishi Motor Corporation, a Japanese car manufacturer in which Chrysler has an investment, spends only $815 a year for an employee’s health care costs while each employee pays approximately $374. Unlike Chrysler, Mitsubishi has no direct cost for retirees or their surviving spouses because of Japan’s national health coverage. Chrysler’s comparable cost per active employee is $5,700—four hundred percent higher.

That gap may well increase. The Japanese government is moving aggressively to control health care utilization by seeking a law to require a substantial co-payment for employees, beginning at 10 percent and rising to 20 percent.

What does Chrysler get for its health care dollar? A health care industry that is expensive, wasteful and inefficient. Let me share with you a few examples of what we are discovering as we analyze our own health care plan in depth.

• Among the nation’s Medicare recipients, a very common medical procedure is cataract surgery—lens extraction and implant. The procedure takes about 20 minutes, and rarely requires a general anesthetic.

The average ophthalmologist charge for this procedure in the Detroit area is about $2,000.

If a doctor performed three of these procedures a day, four days a week, 42 weeks a year, he would earn more than $1 million, for less than 200 hours of actual surgery, and have a 10 week vacation to boot. Compare this with the typical charge of $1,500 for serious abdominal surgery lasting four to five hours.

• We asked physicians at the Health Data Institute in Newton, Massachusetts to investigate eight Detroit area hospitals with extraordinarily high
percentages of non-surgical admissions for low-back problems.

This study showed that two-thirds of the hospitalizations—and 2,264 out of 2,677 of the total hospital days—approximately 85 percent—were inappropriate.

With respect to three of the hospitals audited, none of the admissions were found to be appropriate. In more than 60 percent of the cases, patients were subjected to electromyograms—an uncomfortable and expensive procedure that is rarely necessary for appropriate management of back patients. All the tests results were normal.

Had the inappropriate admissions not occurred, Chrysler would have saved approximately $1 million.

• Our physician experts also investigated the six Detroit area hospitals with the highest number of maternity admissions for our insured. In more than 80 percent of the 618 cases studied, one or more of the hospital days were found to be unnecessary—a total of over 1,000 inappropriate days, almost a quarter of the time spent in the hospital.

If these and other maternity-related inefficiencies and excesses were eliminated, Chrysler would have saved $1 million.

We have no reason to believe that Chrysler’s experience is unique. Similar waste and inefficiency exist in almost every health benefit program in this country. Chrysler’s preliminary investigation suggests that as much as 25 percent of its hospital costs may be due to waste and inefficiency. For Chrysler, elimination of those costs would save almost $50 million in 1984.

Other studies have also found substantial evidence of inappropriate or unnecessary hospitalization. The Department of Health and Human Services sponsored a study of the appropriateness of hospitalization of Medicare patients in 1980. The study sample included 25 hospitals, urban and rural, from different regions of the country. It found that 20 percent of the hospital admissions were either unnecessary or premature. Most important, the study concluded that 27 percent of hospital days were medically inappropriate. If we reduced the number of hospital days expected in 1984 by 25 percent, we would save more than $60 billion—without adversely affecting the quality of care.

How to Fight Back

Chrysler is not sitting still. In less than two years, we have acted to save nearly $10 million annually:
• We mandated second medical opinions before certain elective surgeries, which saves $1 million a year.
• We instituted programs to encourage outpatient surgery, which save $2 million a year.
• We have started a new program in Michigan to screen hospital admissions and control lengths of stay for Chrysler’s non-bargaining unit employees. We project a savings of $2 million in its first year. If we could extend this program to Chrysler’s United Auto Workers employees, which would require union agreement, we estimate we could save $9 million in the fast year.
• We have offered financial incentives to encourage our employees to enroll in Health Maintenance Organizations.
• We set up a screening program for
foot surgery, which cut utilization 60 percent and saves over $1 million a year.

- We began a program to promote generic drugs, which saves $250,000 a year.

These steps are only the beginning. We are currently exploring several preferred provider arrangements, including programs for outpatient psychiatric services, laboratory tests, and prescription drugs.

In short, Chrysler is trying to do everything it can to control health care costs by eliminating waste and inefficiency. But Chrysler and American business cannot control health care costs alone. We need help to restructure the financial incentives in America’s health care industry to eliminate its inefficiencies and, where possible, to instill some marketplace discipline and competition; where not, some controls.

In the long run, we need a national health policy. We need government to stop playing the health care shell game and start instituting some system-wide reforms.

But in the short run we need the active and wholehearted cooperation of the American labor movement. If the big unions will join with business, we can make major changes that will cut health care costs, make us more competitive and provide funds for rebuilding American industry and for higher wages for our workers.

**How We All Can Win**

Nowhere is the cooperation of big labor more critical than in the automobile industry. In the labor negotiations this summer, the United Auto Workers, General Motors and Ford can do more to change America’s health care delivery system than any other combination of big business and big labor in our nation.

The Big Three auto companies spent a total of $3.2 billion for health care last year. We estimate that that is more than 31 states collected in taxes and that it exceeds the total expenditures of 18 states. The Big Three—General Motors, Ford and Chrysler—can negotiate health care benefit plans with the United Auto Workers which are designed to spur competition in the delivery of health care.

This would lead to a win/win situation. Management saves money and at the same time the workers get quality health care. Eventually, the workers will see more actual take-home pay. Today, auto workers only see about two-thirds of their after-tax earnings in their pay checks. The rest goes towards fringes like health care.

We can design health care benefit packages that make doctors and hospitals compete for business on the basis of both quality and efficiency. As a result, those who perform unnecessary services or who create unreasonable costs will run the risk of not being included in the list of providers approved by company health plans and government agencies.

Implicit in this new kind of health care delivery system, of course, is the reclaiming by government, business and the individual of our long-ago surrendered right not to deal with certain health care sellers. As we exercise this right, we will see a dramatic improvement in the attitudes of hospitals and doctors. Gone forever will be the sellers’ markets—where the real buyer never sees the bill.

Here’s one Chrysler example of how Americans can get quality health care at far less cost. Chrysler recently introduced substantially more comprehensive optional dental benefit plans in Michigan and Indiana. The Michigan plans, for example, offer employees and retirees full coverage of all dental services through dental health maintenance organizations. There are no yearly maximums. There are no deductibles. These dental groups operate like a medical health maintenance organization. They agree to perform all dental services at a fixed, pre-negotiated cost to Chrysler.

Since these providers aren’t operating on the conventional fee-for-service basis, there are built-in economic incentives for them to operate efficiently.

Some 11,000 Chrysler employees and retirees have already joined these dental plans in the first few months.
They have saved themselves the copayments they would have paid under Chrysler’s regular dental plans and avoided the risk of having to pay amounts in excess of the limits under those plans. And they will save Chrysler about $2 million in the first year.

Here clearly the buyers—our retirees and employees—have become conscious of price and they made their own choice between two types of providers. That’s how competition and common sense can work in a restructured health care system.

Obviously, this has a significant impact on dentists. Dentists who still operate on a fee-for-service basis now have to compete to attract patients.

General Motors has also just introduced a dental HMO option in the Michigan area similar to Chrysler’s. When I was in Michigan, it was interesting to listen to the radio advertising from area dentists in traditional practice who are encouraging General Motors employees to stick with them. The Michigan Dental Association is taking out hysterical advertisements in Detroit newspapers attacking these plans. Clearly these fee-for-service dentists sense the scope of the change occurring in their business.

There is a sense of ferment and change in the delivery of health care. That’s what made the negotiations between General Motors and Ford and the United Auto Workers so critical. These three giants had the opportunity to break new ground for themselves and America by restructuring the old, seller-titled health plans. These plans were obsolete. They cost auto workers money. They cost General Motors and Ford too much money. Scores of millions of dollars would be wasted had the United Auto Workers negotiations not lead the way to quality health care for workers at far lower cost. The opportunity was too precious to pass up. The alternative was to continue to give foreign competitors, notably the Japanese, a cost advantage on a silver platter, while doctors and hospitals laugh all the way to the bank.

My sense of this situation is that business is ready to move, particularly since the Business Roundtable survey revealed recently that business can reduce the rate of increase in its health care costs—even the behemoth General Motors is now rumbling. The question is whether American labor will end up the reactionary in this drama. It would be ironic had the United Auto Workers — perhaps America’s most progressive and far-sighted union, nourished and led by the imaginative genius of Reuther, Woodcock and Fraser—at this moment in our history impeded the restructuring of America’s health care system. Business and labor cannot do it all. But they cannot wait any longer to do their own thing.

How Will We Choose Who Gets Health Care?

This nation cannot afford further delay in addressing the health care cost
crisis. The graying of America is forcing the issue, with an ever growing population demanding more expensive high technology hospital care.

In 1940, roughly seven percent of our population was 65 or older. Today that proportion is about 12 percent. When the baby boom ripens into the senior boom in the first quarter of the next century, some 20 percent of our population—about 60 million Americans—will be 65 or older.

And the composition of our older citizens is changing. In 1940, less than 30 percent of our senior citizens were 75 or older. By the end of this century, almost 50 percent of those over 65 will be 75 or older.

It’s not just that life expectancy is now 72 for a man and 78 for a woman. Far more important is that those who live to be 65 now have a life expectancy of 82.

The effect of the aging of our population on health care costs is sobering. The congressional budget office now projects that Medicare’s hospital insurance trust fund will go bust by the early 1990’s.

Yet, the hospital fund crisis is only the tip of the iceberg. Many thoughtful Americans are deeply concerned about the frightening levels of unfunded pension liability in our country. The crisis in the Social Security system is the forerunner of far more serious financial crises as we face up to unfunded government and private-sector pension liabilities that many fear approach $1 trillion.

But few Americans have even begun to think about the unfunded health care liabilities of our nation. As our health care costs increase and our population ages, the present, unfunded post-employment health care cost liability of the Fortune 500 American companies alone—with about 15 million employees—approaches $2 trillion. The total assets of those companies were only $1.3 trillion in 1983.

That unfunded liability number alone should make us all realize that in health care costs, we face the greatest financial and social crisis in this nation’s history.

We must create an efficient health care delivery system. We can’t keep going the way we are. We simply don’t have the money.

That stark fact presages a terrifying triage for the American people, and a debate over euthanasia more searing than our debate over abortion. In The Painful Prescription, a book recently published by Henry Aaron and William Schwartz at Brookings, the authors argue persuasively that, like Great Britain, we will soon ration health care in our country.

We always have had rationing, of course, related to individual economic wealth. But, with Medicare, the government becomes the rater of health care for those who use and need the acute care system most. This role is reinforced by the fact that the federal government funds 90 percent of all the basic biomedical research in America, and, together with state and local governments, pays most hospital bills.

Bluntly put, Uncle Sam will soon be playing King Solomon with your father and mother and mine, and with you and me.

We face a frightening specter in our nation as medical technology and spiraling costs combine to blur the lines in hospital rooms among natural death, euthanasia, suicide and murder.

Without the most energetic pursuit of efficiencies, we will soon face a world in which there is no kidney dialysis for people over 55, no hip operations (or artificial hips) for those over 65, a world in which eligibility for expensive anti-cancer therapy will be based on statistical assessments of success, and key organ transplants will be severely limited to special cases of virtually certain recovery—all as defined in pages and pages of government regulations.

What kind of a vision for the future is that? It’s not a very pleasant one. But, in Great Britain, that future is now. That’s just what they do today.

We in America are fortunate because we still have time to avoid that fate. We can learn from Britain’s experience. We have a far more productive society. We can well afford to provide quality medical care to all. But we must have a coherent national health policy which will eliminate inefficiencies and reduce the cost of health care for our society as a whole.

These issues, which go to the very sanctity of human life, are what add a special dimension and solemn responsibility to the General Motors-Ford-United Auto Workers negotiations this summer, and to our congressional leaders’ work next year.