



SHATTUCK LECTURE

## Health of the Nation — Coverage for All Americans

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*On May 10, 2008, the Journal and the Massachusetts Medical Society brought together 13 panelists — physicians, academics, and business, insurance, and political leaders — for a seminar on U.S. health policy and health coverage. In a discussion moderated by Arthur R. Miller, J.D., of the New York University School of Law, the participants identified important challenges to the U.S. health care system and debated possible solutions.*

*The group addressed the dissatisfaction among physicians in general and primary care providers in particular and considered its relationship to a reimbursement system that rewards high-tech procedures rather than cognitive work and time spent with patients; various approaches to payment reform were proposed. The discussion also covered the growing need for major investments of time and money in information technology and the payoff that other countries have seen. Several participants expressed concern about the disproportionately high costs of new drugs and end-of-life care in the United States and broached the topics of negotiation of drug prices, cost-effectiveness analyses, and rationing.*

*After some consideration of the political, social, and economic obstacles to achieving universal access to care, the seminar concluded with remarks on the politics of health care reform and speculation about change under a new administration.*



**A video of the seminar is available at [www.nejm.org](http://www.nejm.org). What follows are excerpts from the discussion.**

*Arthur Caplan:* [The average physician's perspective is this:] I went to medical school. I'm loaded with debt. I've got an office full of people pushing paperwork every day. I don't have time to talk to anybody. No one in Washington seems to care what I think. I can't function this way. I don't get reimbursed enough.

*Charles Baker:* Primary care needs to be treated with a lot more respect by the payer community, generally, and by Medicare in particular, because Medicare sets the

And that means, in addition to fee for service, a monthly panel fee for being a medical home. It's a blended system of payment, which has worked very well in Denmark, where people have well-established relationships with primary care and compensation for primary care is on a par [with] or even higher than compensation for specialty care.

*Thomas Lee:* The theme is team care these days. We obviously need teams for the really sick people, but [also] for the not-sick people. The sick people who need help with their weight and their blood pressure and smoking cessation — it shouldn't be [the physician]

poseful, directed conversation with his or her patients on a regular basis.

*Steven Schroeder:* 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 [physicians are] telling [their] sons and daughters not to go into medicine, those that go into medicine know for sure they don't want to go into primary care. They want to go on what they call the "ROAD" to happiness — radiology, ophthalmology, anesthesia, dermatology, or emergency medicine. They want to do that because they're coming out with huge debts. Because unless we fix the payment system, they're not going to get the kind of income that they'd like. They're more attracted to shift work, so they don't have to worry about patients after they leave. And they don't like all the hassles. Unless we do more fundamental surgery on making primary care a more compelling field, I think in the future primary care will be practiced by others than doctors.



Reed Tuckson, Steven Schroeder, Karen Davis, Arnold Epstein.

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.

*Karen Davis:* We need to give [physicians] the option of being a patient-centered medical home. A practice should be rewarded for taking accountability, for making sure that patients are getting appropriate counseling, they're up to date with their preventive care.

who's following up to see if they stopped smoking. And [a physician's] whole practice has to get paid in a way that it can support a team around them. We need physicians to trust nonphysicians to do things.

*Ruben King-Shaw:* 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 an intimate, relevant, pur-

*Sara Rosenbaum:* When you have patients with very garden-variety conditions that require certain kinds of garden-variety interventions, and the patients can't afford them, the dilemma for a physician is: Do I even start to counsel patients on the kinds of treatment options I would recommend? Because this patient really doesn't have any of these choices.

*Arnold Epstein:* [Spending too much on care at the end of life]



Jonathan Oberlander, Charles Baker, Sara Rosenbaum, Bill Frist.

is a big problem. The numbers I've seen put it at something like \$130 billion a year. 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. I think we have to start to deal with that. And the time to deal with it is not at the bedside. It's with a broader group trying to think about standards and piecemeal efforts where we can put things out of bounds. 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 adjusted life-year is \$500,000, we say that we're really not going to cover them. And we try and change the culture.

*Karen Davis:* We spend twice what every other country spends. 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 the part of the entire population to get decent prices.

*Sara Rosenbaum:* [Access to care is] 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.

*Steven 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.

*Ruben King-Shaw:* It's a failure on the part of America to provide for adequate health care for all of its citizens. Now that has be-



Thomas Lee, Ruben King-Shaw, Susan Dentzer, Arthur Caplan.

come a debate over insurance. Insurance is one way to finance health care for a population. It is not the only way.

*Jonathan Oberlander:* 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 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 going to fight this battle for health reform on moral grounds, we're going to lose.

*Reed Tuckson:* 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 compromised because of the effects on the hospitals and physicians in your community. All of us are in the boat together.

*Bill Frist:* You're paying a premium of \$235 every month for your private health insurance — \$70 of

that goes directly to the uninsured, right now. The American taxpayer [is already paying] \$50 billion for the uninsured. Because we have legislation that if [you go] to the emergency room, you're taken care of. So we are already paying for a lot of care for the uninsured in a very indirect, un-transparent, inefficient way.

*Jonathan Oberlander:* The price tag for universal coverage 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.

*Reed Tuckson:* If you want 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 that every sector — the private insurers, the manufacturers, small business, the advocates for

individuals — everybody has got their own 18-point plan. And what we have learned, over and over again, when people get wedded to those fundamentals, is you never get to the calculus of actual legislation that can get passed.

*Susan Dentzer:* All [the presidential candidates' health] 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. We will have to wait till after the election — see how things settle out. And then engage in a realistic discussion about how to pick this up together.

*Robert Galvin:* I think business is as willing to get out of what it's doing now as it's been since I remember. Even more than the early '90s, simply because the costs continue to compound. So unless the Congress can work together on access and cost at the same time, it's going to be difficult to sway the business community into believing what's on the other side is not going to be worse than [what we have] today.

*Charles Baker:* [The presidential candidates' health plans are] political bromide — put out there so that if somebody says, "Do you have a position on health care

coverage?" the answer can be yes. [This applies to] the whole 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, whether you like it or not, the president basically said, "I'm going to 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 going to get the coverage question resolved.

Mr. Baker is president and chief executive officer of Harvard Pilgrim Health Care, Wellesley, MA. Dr. Caplan is a professor of bioethics at the University of Pennsylvania, Philadelphia. Dr. Davis is the president of the Commonwealth Fund, New York. Ms. Dentzer is the editor-in-chief of *Health Affairs*, Bethesda, MD. Dr. Epstein is chair of the Department of Health Policy and Management at the Harvard School of Public Health, Boston, and an associate editor of the *Journal*. Dr. Frist is a former U.S. senator (R-TN) and a visiting professor of international economic policy at Princeton University, Princeton, NJ. Dr. Galvin is the director of global health care at General Electric, Fairfield, CT. Mr. King-Shaw is chair and chief executive officer of Mansa Equity Partners, Tallahassee, FL, and Carlisle, MA. Dr. Lee is network president at Partners HealthCare System, Boston, and an associate editor of the *Journal*. Dr. Oberlander is an associate professor of social medicine and health policy and administration at the University of North Carolina, Chapel Hill. Ms. Rosenbaum is a professor of health law and policy at George Washington University, Washington, DC. Dr. Schroeder is a professor of health and health care at the University of California, San Francisco. Dr. Tuckson is executive vice president and chief of medical affairs at UnitedHealth Group, Minneapolis.

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