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The Evolving Role of Physicians in a Reformed American Health Care System

Gov. Howard Dean

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*Gov. Howard Dean**

Thank you for your kind introduction. I am going to make one factual correction which should be of interest to everybody. Technically I am the longest serving governor in history of the State of Vermont.[1] The reason I am the second longest serving governor in Vermont's history is because Vermont was an independent republic from 1777–1791.[2] The only person who served longer than I did was a governor named Thomas Chittenden, who served eight one-year terms as governor of the Republic of Vermont and nine one-year terms as governor of the State of Vermont.[3] I thought I would share a little arcane Vermont history before I started this off.

But this is a real honor and I thank you for the opportunity. I am so excited (a) that you have a new medical school, and (b) that you have a practicing internist as the dean of the new medical school, for those of us who are not academic physicians—and I was not an academic physician. I had a practice in Shelburne, Vermont about nine miles south of Burlington. I think this conference is incredibly important and auspiciously timed for the crisis that we face in terms of what is happening now in American medicine. I was asked to talk about the role of physicians in health care reform, and to do that I am going to try to confine my remarks to thirty minutes. For those of you who want to eat, feel free to do it. I was once at a political dinner in Essex County, New Jersey and I am used to people making a lot of noise and no matter how much you clank your forks you could not possibly make as much noise as the guys who were slapping each other on the back and drinking

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1. Vt. State Archives & Records Admin., *Governors, Terms of Service*, http://vermont-archives.org/govhistory/officers/pdf/governor.pdf.

2. State v. Elliott, 616 A.2d 210, 216-17 (Vt. 1992).

3. *See* Vt. State Archives & Records Admin., *supra* note 1.

while I was speaking at the Essex County New Jersey Democratic Club. So feel free to eat, enjoy desert, and by all means clank your glasses as much as you want—it will not bother me at all. And if I cannot confine my remarks to thirty minutes, which I may not quite be able to do, we will have lots of time for comments, questions, and rude remarks as necessary.

Let us look at the situation today. It used to be that physicians had a lot to say about how the health care system ran. Today they do not have much. There are some drivers in how we practice and many of the drivers conflict with each other, leaving us stuck in the middle. My wife is still a practicing internist and has the practice that she and I shared with a couple of other doctors before I became governor. She spends roughly five hours a week on the weekend days filling out insurance forms and fighting with insurance companies about what they are going to cover and what they are not going to cover. And some of them—with the true tact that any physician will use—are idiotic.

So let us talk about the drivers: fee-for-service medicine. What does fee-for-service medicine do? It drives up costs more than anything else.[4] People who believe that somehow free markets are going to deal with the problems in medicine, and all we have to do is let the free market run the medical system and everything will work fine,[5] have never practiced medicine or do not know that much about the practice of medicine. If they have, they must be practicing on some planet that we have not discovered yet. When you are paid via fee-for-service medicine, basically you are paid to do everything you possibly can for the patient whether it is necessary or not. Let us make the assumption that ninety percent of all physicians are ethical people just like ninety percent of every other occupation. But incentives work! So if you pay me to do something, you are going to get it. And the way it happens among ethical people who do not run up the charges just to make money, is straightforward. If it is a judgment call and you are worried, and you have done two MRIs and maybe the patient can benefit from a CAT scan, and you know somebody else is going to pay for it, and it is also going to help the hospital—and by the way you only got paid forty dollars for the Medicare physical you did, so maybe you can make it up

4. *See* Susan D. Doughton, *Response to Professor Mark Hall*, 28 CUMB. L. REV. 329, 330 (1998).

5. *See generally* Marianne Jennings, *Restoring Medicine to the Free Market: Views of an Economist, Lawyer, Mother, and Patient*, 8 J. AM. PHYSICIANS & SURGEONS 121 (2003) (arguing that free market forces may resolve the medical and insurance problems associated with the American health care system).

this way—you are going to do the test. That happens hundreds of thousands of times every single day in the United States.

So we are not in control of our own decision making, first of all, because of the way we get paid. We do not necessarily make the best decisions for the patient because of the way we get paid—fee-for-service medicine. It is a significant problem.

Let us talk about malpractice. We do not practice medicine the way we would like to because of the fear of being sued.[6] It is a problem. It is not as big a problem as Republicans say it is, but it is a bigger problem than Democrats will admit. Now look, I am the former chairman for the Democratic National Committee[7] so a lot of people I like a lot are trial lawyers. The fact of the matter is that people deserve compensation when they can prove injuries or negligence on the part of physicians, hospitals, and other providers. But the truth is that we have jury verdicts that are sometimes out of proportion in terms of the damage that was caused.[8] We have nuisance lawsuits that are a problem.[9]

So we are not in control, we do lots of things that are calculated to satisfy a mythical jury. We imagine ourselves, at least I used to, thinking about what you were going to do when you were in the courtroom and the lawyer was saying "and doctor, why didn't you do X, Y, and Z tests?" Of course, it is always easier in any profession to second guess people once you have all of the evidence. One of the things I tell a lot of people in both medicine and politics is that the two have one commonality that I know of for sure, and that is that the favorite instrument in both politics and medicine is called the "retrospectoscope."[10] And it is one hundred percent correct at all times.[11] It is easy in court to use a "retrospectoscope," but not so easy when you are there with a patient in the middle of the night.

So we do not practice the way we like to because of the reimbursement, and we do not practice the way we would like to

6. Lisa L. Dahm, *Healthcare Systems and Quality of Care: Do International Measurement Standards Exist?*, 20 TEMP. INT'L & COMP. L.J. 395, 438 (2006).

7. Richard Keil, *Howard Dean Becomes Chairman of Democratic National Committee*, BLOOMBERG (Feb. 12, 2005, 11:13 EST), http://www.bloomberg.com/apps/news?pid=newsarchive&sid=aK.B_m7wKrs8&refer=top_world_news.

8. *See* Chris A. Messerly & Genevieve M. Warwick, *Nowhere to Turn: A Glance at the Facts Behind the Supposed Need for Tort "Reform,"* 28 HAMLINE L. REV. 489, 500, 510 (2005).

9. *See id.* at 501.

10. *See* Jun Wu, Note, *Rewinding Time: Advances in Mitigating Hindsight Bias in Patent Obviousness Analysis*, 97 KY. L.J. 565, 567 (2009) (discussing the effects of examining a defendant's level of care through a "retrospectoscope").

11. J. Allan Hobson, *Psychiatry as Scientific Humanism: A Program Inspired By Roberto Unger's* Passion, 81 NW. U. L. REV. 791, 806 (1987) ("The psychoanalytic 'retrospectoscope' works so well as to be suspect.").

because of the problems of the malpractice system. We do not practice the way we would like to because of insurance companies.[12] Because insurance companies are not very smart. They basically attack physicians where they can; they always attack the weakest ones first—which are primary care physicians—because it is harder for them to attack the hospitals. The hospitals can get together and say, "well, ok, if you do not give us 'X' rate, then we are not taking your insurance." Then the insurance company cannot sell their insurance in a particular region because people are not going to drive sixty-five miles to a different hospital center. My wife is now undergoing a review of all of her charts, because the particular insurance company that she works with in this particular area, which is very large and very evil, is going to retrospectively inspect her charts to see if the letters "BMI" are on the chart. They do not care what you said to the patient. They do not care that there is a discussion about body mass index and weight for the last five or ten years with this particular patient. If the letters "BMI" are not in the chart, you are going to get under-reimbursed. So she is now going through her charts, looking at her notes, and every place there is a discussion of weight and blood pressure and whatever else, they just add "BMI!" This is medicine? This is doctors doing what is best for their patients? It is important to discuss obesity and weight with patients. Mindless bureaucracies, which oversee these matters, are not helpful and contribute to the burnout rate for physicians who are already burned out.

And let me just say, by way of discussing burnout rate, one of the great things which I hope Hofstra will begin to change in American medicine is that nine percent of all of the graduates of medical school in 2008 in the United States went into family practice.[13] Nine percent. Today, already in this country, about thirty percent of physicians are in primary care, seventy percent are in specialties.[14] Most people think the reverse ratio is the right one. So this is basically another area in which primary care input is being gradually excluded from making decisions about how the medical system works for each patient. When specialists are in charge of care without primary care coordination, care is much more expensive, and there is more unnecessary care.[15]

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12. *See* Lauren Numeroff, Note, *Playing Doctor: The Dangerous "Medi-Spa" Game Without Rules*, 27 J.L. & POL'Y 653, 693-94 (2009).

13. NAT'L RESIDENT MATCHING PROGRAM, RESULTS AND DATA: 2009 MAIN RESIDENCY MATCH 20 (2009).

14. *See* Ashley Halsey III, *Primary-Care Doctor Shortage May Undermine Reform Efforts*, WASH. POST, June 20, 2009, at A1 ("Today, almost 70 percent of doctors work in higher-paid specialties.").

15. Kristine Marietti Byrnes, Note, *Is There a Primary Care Doctor in the House? The Legislation Needed to Address a National Shortage*, 25 RUTGERS L.J. 799, 806-07 (1994).

Pharmaceutical incentives push costs up and reduce the influence of good physician judgment.[16] Now this is under a lot of fire and a lot of states are trying to outlaw this.[17] I do some work with pharmaceutical companies—I think pharmaceutical companies are badly misunderstood in this country. The truth about pharmaceutical companies is that a lot of people are mad at them because Pharma, their trade association, was an arm of the Republican party for sixteen years, they charge a lot for their stuff, and they have ads that people do not like. The truth is pharmaceutical companies save America money, a lot of money. When I was an intern, if you had a heart attack—for those of you who are not physicians we will try not to use medical terminology here—if you had a heart attack you were in the hospital probably for ten to fourteen days, depending on the severity. Today, you can be out in three or even two. The main reason for the change is that pharmaceutical advances have allowed us to get patients out of the hospital, in many instances, much faster than was possible thirty years ago. Pharmaceuticals are eleven percent of all the money that we spend on health care in this country.[18] If you doubled how much pharmaceuticals companies charged or cut it in half, you would not have an appreciable effect on how much money we spend. But there is the idea that pharmaceutical companies go out and seduce doctors with vacations and lunches, which also alters practices. I often tell companies I advise that it would be better from a PR point of view *not* to do all those advertisements. Unfortunately these ads do expand market share, and there are a few instances where they have actually increased public awareness around issues of sexuality, which doctors have not historically been very good at.[19] So I think I am right about these ads being a net negative, but so far I have lost the argument.

One of the things many providers are very afraid of is comparative effectiveness review—I think comparative effectiveness review is absolutely essential.[20] We have got to know what works. Of course corporations and providers may be selling products that do not measure

16. *See* John Dudley Miller, *Study Affirms Pharma's Influence on Physicians*, 99 J. NAT'L CANCER INST. 1148, 1149 (2007).

17. *Id.* at 1150.

18. Jennifer S. Haas et al., *Potential Savings from Substituting Generic Drugs for Brand-Name Drugs: Medical Expenditure Panel Survey, 1997–2000*, 142 ANNALS INTERNAL MED. 891, 891 (2005).

19. *See* Peter Conrad, *The Shifting Engines of Medicalization*, 46 J. HEALTH & SOC. BEHAV. 3, 6 (2005).

20. *See generally* Alvin I. Mushlin & Hassan M.K. Ghomrawi, *Comparative Effectiveness Research: A Cornerstone of Heathcare Reform?*, 121 TRANSACTIONS AM. CLINICAL & CLIMATOLOGICAL ASS'N 141 (2010) (advocating that the medical community embrace the concept of comparative effectiveness research ("CER"), and noting the potential value that CER has to offer the American health care system in light of recent health care legislation).

up, which is where the real opposition to comparative effectiveness review comes from. The fact is that America pays for a lot of health care that does not work, and that we do not need, and we will never control costs without knowing what works and refusing to continue to pay for treatments that do not work, or that barely work.

This approach can be tricky. We save a lot of money using generic drugs,[21] for example. But no drug, whether it is generic or proprietary, works for everybody.[22] And if a generic drug works for seventy percent of the people that is great. But there are thirty percent of the people who cannot use it and you have got to have a reasonable formulary procedure that allows you to be both pressed towards using generic drugs to save money where possible, but also allows the freedom without too much bureaucracy to prescribe a proprietary drug if it may work better for a particular patient.

The last thing I will mention in this regard is hospitals. Hospitals impinge on the way we practice medicine. This is not just so that they can make money, it is also in response to outside interferences. And some of the interferences may be a good thing, but they have unintended consequences. One of the biggest problems that we have in this country—this ties directly into malpractice and particularly in end of life care—is that the tendency in hospitals has been for the last fifteen to twenty years to have pulmonologists or anesthesiologists in charge of Intensive Care Units ("ICUs").[23] There is not a question in my mind that pulmonologists in general know a lot more about running ICUs than internists. The problem is end of life care.

We will digress here and talk about the "death panels" and all that kind of nonsense. You know, of course, the death panels never really existed, but the language that was written that led to the death panel stuff was actually written by a Republican, Senator Charles Grassley in the 2003 revamping of Medicare.[24] And what Grassley, who was chairman of the Finance Committee at the time,[25] permitted was then copied by

21. *See* Haas et al., *supra* note 18, at 891, 894-96; Rishi Gupta, *TRIPS Compliance: Dealing with the Consequences of Drug Patents in India*, 26 HOUS. J. INT'L L. 599, 622 n.95 (2004).

22. Gupta, *supra* note 21, at 622 n.95 ("As we continue to understand more and more about the genetic basis of disease, we are learning that while a particular drug may be effective for some people, it is not likely to be effective for everyone.").

23. *See* C. William Hanson III et al., *The Anesthesiologist in Critical Care Medicine*, 95 ANESTHESIOLOGY 781, 781, 785 (2001).

24. *See* Amy Sullivan, *Oh,* Those *Death Panels*, TIME.COM (Aug. 13, 2009, 10:14 PM), http://swampland.blogs.time.com/2009/08/13/oh-those-death-panels/; Conrad F. Meier, *Senator Defends Medicare Reform Measure*, HEALTH CARE NEWS (Aug. 1, 2003), http://www.heartland.org/healthpolicy-news.org/article/12568/Senator_Defends_Medicare_Reform_Measure.html.

25. Robert Pear, *Bill on Medicare Drug Benefit Is Stalled By House-Senate Republican Antagonism*, N.Y. TIMES, Aug. 27, 2003, at A15.

the Democrats when they did their version of health care in the House, was something that was very sensible. That is to allow primary care physician visits to also be paid, in addition to the daily regular pulmonologist visit, for seeing a patient in the ICU.[26] Why is that important? I understand you do not want to pay two doctors for seeing a patient in the ICU. But the reason we should is this: when I practiced, even though I was an internist, I would see five-year olds whose parents did not want to drive eighteen miles roundtrip to the pediatrician in town, for an ear ache or something. I would see, of course, the adults, and I had a geriatric practice with their parents. You would often see three generations of a family. If somebody who was eighty-five or ninety and not in terribly good health ended up in the ICU and I went to the family and said, "you know, I think we have done everything we can here, oh we can do this machine and that machine, but I do not think it is going to have a good outcome," ninety-five percent of the time the family who knows me and trusts me because I treat them and their kids too would say, "Oh alright, let us get the rest of the family from around the country and we will figure out what to do about it." And they would take the recommendations and let go. Maybe five percent of the times they would say, "Mom was always the fighter her whole life and she would want everything done."

Today that does not happen, because you cannot go into an ICU and have some doctor you have never seen before say, "you know, I do not think this is going to work and I think we have done everything we can." Because the doctor does not want to say that to somebody they do not know, partly because of malpractice and partly because it is an incredibly emotional, difficult time and the patient does not want to hear it. And for those of you who are in medicine and do this kind of stuff, you know very well that the biggest problem is not the wishes of the patient (if they are of sound mind), because seniors fear one thing more than dying. What they fear is that we are going to stick them with tubes every place and keep them alive against their will. The real problem with situations like this is the family, some of whom have been in California for fourteen years and have not come east once to see their family member and now all of a sudden they have to deal with the interfamilial dynamics of guilt and so forth and so on.

It would make so much more sense from the hospital, the medical system, and the insurance companies' points of view if they were paid a hundred dollars or whatever it is, probably more in New York than what

26. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, H.R. 1, 108th Cong. § 405(b)(1)(B) (codified as amended at 42 U.S.C. § 1395m(g)(5) (2006)).

it is in Vermont, for an extra hospital visit because an extra day in the ICU—whether you are on the way out the door and just using the bed space or whether you are curable—is well worth the one hundred dollar fee you get for the hospital visit. And the likelihood of being sued goes down dramatically, as everybody knows, when the physician has a long-standing personal relationship with a patient and family.[27]

So the bottom line is doctors do not have a lot of say in how the health care system works right now. It does not help the patient, and it makes care, in the long term, a lot more expensive. Going through charts typing in "BMI" when it does not appear so that you do not get dinged by the insurance company is not a productive use of the physician's time. Even though it may not immediately hurt the insurance company, ultimately it does. The doctor gets burned out faster and goes and does something else, or finds a different way to get around it.

So what is to be done about this? We are going to talk about the health care bill in Washington I am sure in the Q&A period, but if you could do anything that you wanted to do, it would not be the bill that is in Washington right now. Because it is only an extension of the existing system. My favorite thing to say about this bill is that it makes everybody mad on both sides of the aisle, but the God's honest truth is that the bill that you see before you is almost exactly the same bill that Mitt Romney passed.[28] The Obama Bill is the Romney Bill. It extends the current system to cover everybody. But the current system is broken, and it is particularly broken in terms of physicians' role in the system.

Now the advantage of the Romney system is that it does have some good infrastructure. The exchange mechanism is good. Having universal health insurance is terrific. Massachusetts deserves credit; it is not all bad. Ninety-seven percent of the people in Massachusetts now have health insurance.[29] That is an extraordinary achievement—of course they have no idea what to do about the cost—but they are now debating, because of this terrible problem, the elimination of fee-for-service medicine.[30]

Now, specialists do not like the idea of the elimination of fee-for-service medicine; internists and primary care people love it. Today, the average primary care physician in the United States makes less money than a salaried physician working for the National Health Service in

27. *See* Philip J. Moore et al., *Medical Malpractice: The Effect of Doctor-Patient Relations on Medical Patient Perceptions and Malpractice Intentions*, 173 W. J. MED. 244, 248 (2000).

28. Kevin Sack, *Romney on Health Care: A Particular Spin*, N.Y. TIMES, Apr. 10, 2010, at A12.

29. Kevin Sack, *Massachusetts Panel on Health Costs Seeks End to 'Fee for Service' Care*, N.Y. TIMES, July 17, 2009, at A10.

30. *Id.*

Great Britain, which spends half of what we spend on health care.[31] The average American primary care physician makes less money than a primary care physician paid for entirely by salary working for one of the most socialized systems in the world, which is the National Health Service in Great Britain. We would love to be on salary. We would love to not have to deal with all this fee-for-service stuff and the internal conflicts that go on knowing whether we are going to leave the office with adequate staff, but not because we are being so grossly under-reimbursed in one area where we have to make it up someplace else. We would love not to have to see patients every six minutes because of somebody's productivity analysis. We would love not having to mindlessly go back and scan for "BMI" on charts on weekends. It would be a whole different way of practicing medicine. We would not be making decisions based on our income, we would not be making decisions based on whether the insurance company would pay us or not. It would be a big improvement and a big step in the right direction.

Secondly, the biggest failing in the American medical system, in terms of cost control, actually has nothing to do with the government or even the insurance companies. It has to with bad business practices. And the reason they are bad business practices is because we do not run ourselves like a business. Anybody who thinks that the free market can work in the current medical system must be smoking something. They either have no idea how capitalism works or no idea how the medical system works. Let me explain to you why. I was in San Diego not long ago and I ran into a very smart cardiologist who invented an invention, and there maybe others like it, which is essentially an electronic Band-Aid that you can put on your upper chest and monitor two of the seven chronic conditions which we spend most of our money on.[32] These two conditions are congestive heart failure and diabetes.[33] And they would in real time, over Wi-Fi, conduct to the physician's office electrolyte, sugar, and hemoglobin A1C information on a daily basis. So that you could tell, and for those of you who do not practice medicine, when you start going down the tubes, the patient is not aware of it for a week or so—and if it is a male they do not see the doctor for another three weeks and by the time they get to see the doctor they are in real trouble. So in this case, you can tell when somebody's parameters are going south on

31. *See* KAREN DAVIS ET AL., MIRROR, MIRROR ON THE WALL: HOW THE PERFORMANCE OF THE U.S. HEALTH CARE SYSTEM COMPARES INTERNATIONALLY: 2010 UPDATE, at v ex. ES-1, 2 ex. 1 (2010).

32. *See* CTR. FOR HEALTHCARE RESEARCH & TRANSFORMATION, HEALTH CARE COST DRIVERS: CHRONIC DISEASE, COMORBIDITY, AND HEALTH RISK FACTORS IN THE U.S. AND MICHIGAN 2 & fig.IB4:1 (2010) (listing seven chronic conditions).

33. *Id.*

them long before they even know it. What does that mean for a seventy-five year old with diabetes and congestive heart failure? It probably means at least one ICU visit per year that is avoided. I do not know what an ICU visit costs around here, but it is got to be a fifteen hundred to two thousand dollars per day minimum before you even get to the procedures.[34]

Sounds like a great idea. I do not know what this costs, let us say it costs three thousand dollars if you have all of the infrastructure. The problem is that nobody is going to buy it. I would not buy it as an internist. Because I do not get reimbursed for it—it is three thousand dollars out of my pocket. But the hospital is a separate entity. They do not see this as a savings to them; they are not going to pay for it. They see the sixty thousand dollar ICU visit as a loss of revenue because they need to fill that ICU bed with somebody to pay for it. The only people set up to do things like this right are places like Kaiser, where they are the insurance company, the hospital, the tertiary care provider, and the primary care provider all at once.[35] That is the way a normal American business in a capitalist system works. That is, a business like that will make the same kind of decisions that a major corporation would make. If you invest on the front end, you will get paid back a lot on the back end—either by making smart decisions early on, or by making savings or even investing in inexpensive things that later on have huge payback. That is a successful business model in almost anything you do.

This is the place where the American dream is. Somebody came over many generations ago and they started—my wife's grandfather started—a little pharmacy in East New York. They could bring in an improvement, right? They would figure they would bring in a new cash register. They did a lot more things and kept the accounting. That is how you do it. You invest in something upfront that saves you bookkeeping expenses at the end, and over time you are more profitable and more efficient. We do not do that in medicine. Until we have a totally integrated system we cannot do that.

One of the things that I do in my in my life is I talk to people about things like this and try to figure out how to integrate them. It occurred to me as I was speaking to the founding dean that it would be interesting after we get our feet under us and hopefully the Liaison Committee on Medical Education gives us the accreditation and all that kind of stuff, is that we open up some talks. I do some consulting work for corporations

34. Louise Harmon, *Fragments on the Deathwatch*, 77 MINN. L. REV. 1, 59 n.117 (1992) ("A good estimate of the basic cost in an ICU is $2,000 to $3,000 per day.").

35. Janet Rae-Dupree, *Disruptive Innovation, Applied to Health Care*, N.Y. TIMES, Feb. 1, 2009, at BU3.

on health care costs. I am really interested in how big corporations, which are self-insured, or particularly those that are insured with insurance companies (of course they have to take a big chunk off the top for the equity investors), could directly contract the providers.

Which brings me to the last point I am going to make. If you are fully integrated, you can take risks. Now there are rules of course that you have to comply with because you are essentially an insurance company and you have to have capital. But if you can take risks, you can use actuarial standards to figure out what the capitated payments are. I used to love practicing medicine; I practiced for ten years. I was there when HMOs were not-for-profit, traded on the New York Stock Exchange.[36] I loved it. Practicing for HMOs got a bad name because once they began to have to deliver increased quarterly profits every year, they kind of focused more on the quarterly profits than they did on the people in the system, either the patients or the physicians.[37] But I worked for a non-profit based in Albany that had extensive numbers of patients in Vermont. I loved it. We did not make as much money per patient, but the dollars would come in, whatever it was every month. We did not have to worry if somebody could pay the bill or not, the insurance company sent us the check. We did not have to worry about treating people over the phone, which you can do reasonably well. But after you have done it a while you think, "Gee, if I do not bring these people in, how am I going to pay the nurse?" You just actually got to practice medicine. If you restore capitated care, that is the way that doctors are going to be back in charge of the system. That sounds counter-intuitive for those of you who have had to live the last twenty years under for-profit capitated care, but when it is not-for-profit, you essentially end up with what is a global budget—and guess who makes the decisions in the global budget? Partly hospital administrators, but mostly the people who take care of patients.

Global budgeting and/or capitated care only works in a fully-integrated system. It does not have to be one hundred percent fully-integrated, there is no way—for example, a community hospital in rural America is not going to be doing heart transplants and liver transplants, nor should they. So you are going to have a reinsurance policy for stuff like that, that is not hard to figure out. And it is not even that expensive, it is expensive medicine, but the insurance policy spread across the whole country is not expensive. But for most capitated care, the range of procedures that are done for the average American, we are not talking

36. *See* James C. Robinson, *The Curious Conversion of Empire Blue Cross*, 22 HEALTH AFF. 100, 101 (2003), *available at* http://content.healthaffairs.org/content/22/4/100.full.pdf.

37. *See id.*

about liver transplants and heart transplants and exotic procedures, we are talking about bread-and-butter medicine. The best way to let the doctors make the decisions about what is right medically is to give the institutions a global budget.

Now will doctors be told by hospital administrators, "Gee, we are kind of getting close to the end of our budget . . . ?" Yes, they will be told that. That is not a bad thing. The doctors should be required to have a responsibility to make choices that have to do with money because we do not live in an area of limitless resources. There is no such thing as limitless resources. People are always saying, "Well, if you pass Obama's plan, or this plan, or that plan, we are going to have rationing!" We have rationing right now. It is abysmal rationing. It is rationing if you do not have insurance, there is rationing if you do not have any money. There is rationing if you end up in a hospital that has exceeded its budget, et cetera.

The question is, are we going to have rational rationing? We spend almost forty-three percent more on health care in this country, as a percentage of GDP, than any other nation on the face of the Earth.[38] Forty-three percent more. Surely we can get down to twenty percent more without endangering the health care of any of our people while making rational, reasonable decisions. I will give you an interesting statistic, this is about ten years old so I do not know if it is still true but I suspect it is. We do three times more coronary artery bypass grafts and—for those of us who are not physicians, that is "open heart surgery"—we do that procedure three times as much per capita in the United States than we do in Canada, and the mortality adjusted for demographics is not different.[39] Now the morbidity is different: if you require a bypass graft in this country, you can be back on the golf course in eight weeks.[40] In Canada, it takes you five years because they are going to medically manage you as long as possible, and your quality of life is going to be different.[41] Let us not pretend that the Canadian

38. *Growing Health Spending Puts Pressure on Government Budgets, According to OECD Health Data 2010*, ORG. FOR ECON. CO-OPERATION & DEV., (June 29, 2010), http://www.oecd.org/document/11/0,3343,en_21571361_44315115_45549771_1_1_1_1,00.html [hereinafter *Growing Health Spending*].

39. Mark J. Eisenberg et al., *Outcomes and Cost of Coronary Artery Bypass Graft Surgery in the United States and Canada*, 165 ARCHIVES INTERNAL MED. 1506, 1506, 1509 (2005).

40. *See* Julian M. Aroesty, *Patient Information: Recovery After Coronary Artery Bypass Graft Surgery (CABG)*, UPTODATE, http://www.uptodate.com/patients/content/topic.do?topicKey=~6725/sid_trh3 (last updated Aug. 6, 2010).

41. *See* Brad I. Munt et al., *True Versus Reported Waiting Times for Valvular Aortic Stenosis Surgery*, 22 CAN. J. CARDIOLOGY 497, 498, 500 (2006). The median wait-time from primary care physician visit to surgery was 243 days for a population of British Columbia residents at least twenty-two years of age that had been placed on a waiting list for aortic valve surgery with the

system is perfect; it is not. But they have a deep sense of psychological well being—and many people have said, with some justification, that the Canadian system works fantastically well for the two-thirds of the people who are never going to need it. No Canadian is ever going to lose their house or going to die because they never could get medical attention. It is true that you have to wait a lot longer for a hip replacement or a coronary artery bypass. There is a trade off someplace. The one thing I know, and I think everybody in this room knows, is that we cannot go on the way we are. We cannot go on spending an increasingly large percent of our GDP, now up to 17.3%,[42] on health care when our nearest competitors are spending 10%.[43]

So, I am going to stop with this thought. If you give us a budget as a community, we will manage the budget and we will do it in a smart way. We will make the same kinds of decisions that you hope the private sector would make—that is to invest heavily in primary care to keep people out of the really expensive stuff later on. But you have got to let the people who actually know something about medicine and health care make these decisions because then you will have a kind of health care system that works for everybody. Thank you very much.

diagnosis of aortic stenosis between January 1, 1991 and December 31, 2000. *Id.*

42. Andrea M. Sisko et al., *National Health Spending Projections: The Estimated Impact of Reform Through 2019*, 29 HEALTH AFF. 1933, 1934 ex. 1 (2010), *available at* http://content.healthaffairs.org/content/29/10/1933.full.pdf.

43. *Growing Health Spending*, *supra* note 38.

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