Q&A: Addressing high costs and greed in health care

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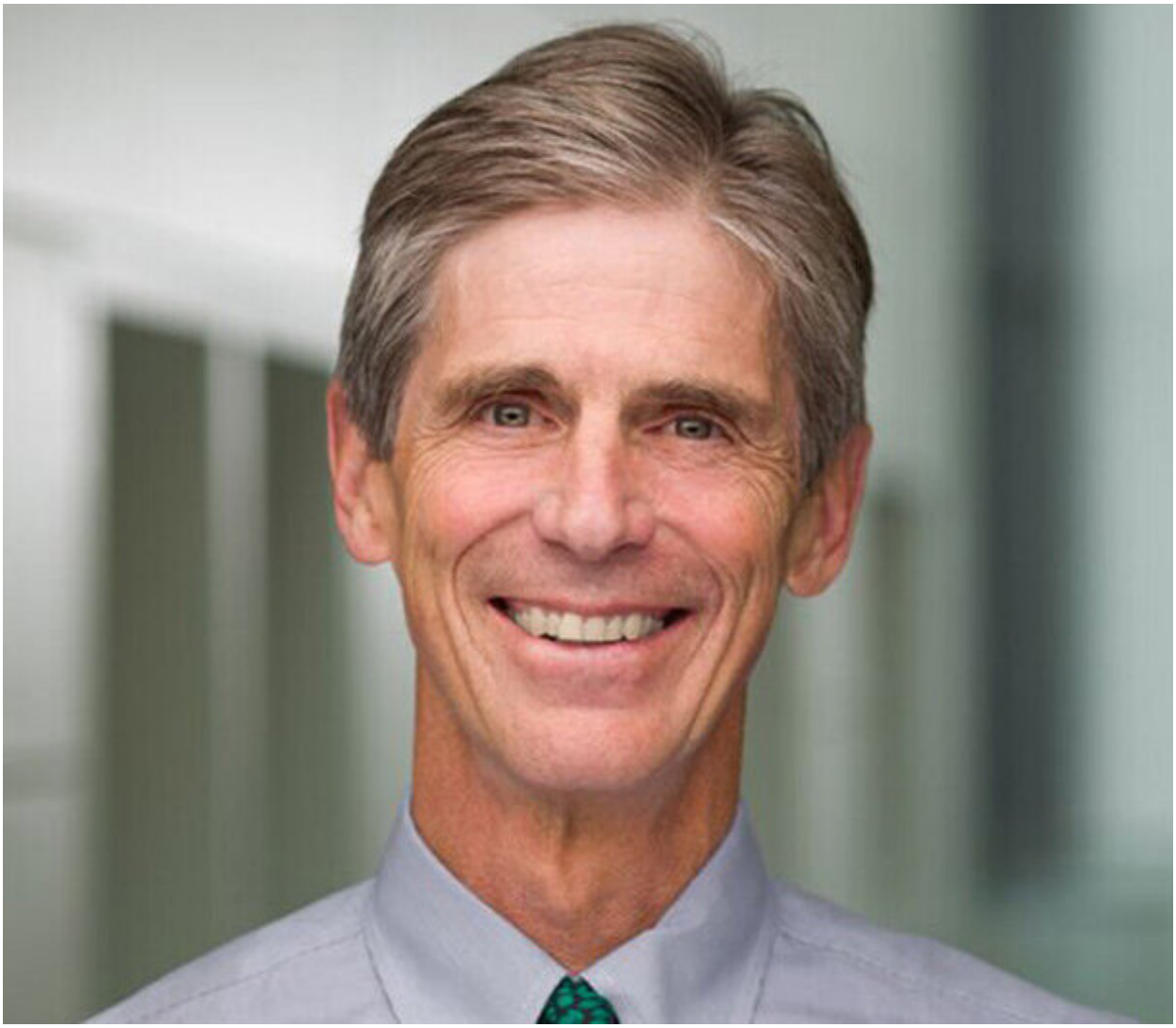

Elliott Fisher, MD, MPH. Credit: The Geisel School of Medicine at Dartmouth

At the core of the U.S. health care system there is a paradox, says Elliott Fisher, MD, MPH, a professor of health policy, medicine, and community and family medicine at The Dartmouth Institute for Health Policy and Clinical Practice.

Due to runaway costs, our system whose purpose is to improve well-being increasingly prioritizes financial interests over the public good—causing much suffering.

In their recent paper, published in *Health Affairs Forefront*, Fisher and colleague George Isham, MD, MS, senior fellow at the HealthPartners Institute, address the problem of greed in health care and outline the actions that each of us could take to address the inequities in our current system and improve both care and costs for everyone.

In the following Q & A, Fisher talks about some of the key factors driving this paradox and what can be done about it.

What compelled you to write this paper?

Frustration and anger. I have been working to improve U.S. health care and slow cost growth for years, having led the research that helped establish Accountable Care Organizations as a new payment model under Medicare and many private payers (I also came up with the name).

Yet health care costs continued to rise. I wrote a piece in 2020 for *New England Journal Catalyst* (*The Single System Solution*), explaining why I thought progress was so slow and what we should do. I shared that with George Isham, an old friend who was for many years the CMO of HealthPartners in Minnesota, an organization founded in the 1930s. And he said, "Elliott, you missed the underlying problem: it's greed." We were off to the races.

What is the fundamental problem you are addressing?

While health care is supposed to help people—and often it does—we must recognize that the high and rising costs in U.S. health care cause harm. More than half of U.S. adults report direct financial harm from health care every year, whether this is difficulty paying bills, fear about being able to pay for care, or delaying or skipping care because of costs. These harms fall largely on the poor. But the indirect harms hurt us all—rising insurance premiums, deductibles and copayments, reduced wages, and less government spending on other social needs.

Why is this happening?

We know a lot about the superficial reasons that health care costs 50 percent more per person in the U.S. than in other countries: monopoly pricing, a focus on profitable services rather than better care, huge administrative waste, a fragmented system, incentives across the board that encourage cost growth, and the inability of government to intervene.

But Dr. Isham and I wanted to draw attention to a deeper cause: the individual and collective choices that drive avoidable spending increases. Choosing to use monopoly power to increase prices, choosing to order unnecessary tests and procedures, choosing to ignore the terrible burden imposed on the poor by egregious billing practices, choosing to ignore the structural changes that could make things better, or worse, lobbying against these changes to maintain current profits.

The underlying problem is the degree to which the health care system as a whole has prioritized financial interests over the public good and the good of patients. We try to be careful not to accuse individuals of greed—most have great intentions. But we need to stand up and work

together to put patients and the public first.

Many would say that greed is what makes capitalism work. Why should health care be different?

Everyone has a legitimate interest in receiving an adequate income. The profit motive drives innovation and is fundamental to achieving benefits that markets bring. But health care is different in two ways.

First, lack of information on the value of most treatment forces patients to rely on the expert guidance of health professionals—who therefore have an ethical and legal obligation to put the needs of their patients first. The public impression that health care is increasingly about making money is undermining the trust upon which we depend.

Second, unlike the market for many goods and services (cars, computers), market failure is pervasive in health care: monopoly power, barriers to entry, and costs that make insurance essential but difficult to implement in an unfettered market. This is why every other developed country ensures universal access and much more effective regulation of both insurance and providers—with both better outcomes and lower costs.

What can be done?

Policy change is certainly important—and we outline some key ideas in the paper that deserve more serious consideration at both the state and federal levels.

But we can do more than lobby our legislatures and hope for change. The major contribution of the paper is to lay out numerous specific ways that individuals and organizations can act to turn the tide.

We can learn how to organize for change. We can use those skills to persuade the hospitals and health systems where we work to adopt fair billing practices and to focus on improving efficiency rather than raising prices. And, as individuals or leaders of our organizations, we can join with others to work as stewards of the health and well-being of our communities.

And our last question: after all these years working in health care, does this paper reflect a change in perspective for you? And if so, how?

Much of my earlier work focused on designing health policies to try to make our health care system better. I have come to realize, however, that good ideas will not change the system. Dr. Isham and I both believe that we must organize ourselves to push for change, hold each other accountable to the extent we can, and act differently in our day-to-day work.

There are many ways that individuals and organizations can make a difference. This paper was an attempt to advance the conversation about the actions that each of us could take to address the inequities in our current system and improve both care and costs for everyone.

More information: Addressing Greed In Health Care: If Not Us, Who? And How?, *Health Affairs Forefront* (2023). DOI: 10.1377/forefront.20230414.474060

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