A Misguided Quest Has Led Us Astray

Why so many "quality" initiatives in health care are doomed to fail, and how physicians are willing participants.

THE NAIVETE AND INSULARITY OF MOST physicians, combined with a basic intent to be of help, has not served physicians or the public well. Compounding the problem is the basic tendency of any person or group to be self-serving and defensive. Making the situation even more complex is the small, but vocal and visible, segment of physicians who are frankly arrogant, greedy and dishonest.

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Throughout history physicians and other healers largely operated independently. While there were some external regulations and proscriptions, by and large physicians (and other healers) did what they wanted. Their contract was with the individual patient. Each patient was diagnosed and treated individually.

Because physicians (and other healers) have the same basic needs as every other human (indeed every other living creature), some provision had to be made for assuring that there would be enough to eat, a place to sleep and sufficient clothing to be decent and warm. Further, most humans appear to have a need for some types of creature comforts. As a result, there had to be some way to assure some type of compensation for the provision of services, though the exact form and amount of recompense varied widely. For some, such as monks or medicine men, it could be food, lodging and fellowship. For physicians it usually came in the form of some type of fee for the service provided: a chicken; a valuable shell; a sinecure or money. While many physicians possessed special skills, by and large they were similar to the other more educated members of their communities, both in their social status and role in the community. It is interesting to recall that a significant number of the signers of the Declaration of Independence of the United States were physicians.

Focus Narrows, Isolation Increases

Until the latter part of the 19th century, almost all physicians were individual practitioners working with individual patients. They practiced their craft with almost no outside interference and lived lives similar to other similarly educated individuals in the mid to upper socio-economic sector. During the past 150 years, however, this has changed dramatically. Physicians' education and lives became increasingly specialized as they spent more and more of their time learning about the manifestations of disease and methods of treating disease. They became decreasingly involved in their communities. Fewer read or wrote great plays or great music, and fewer became involved in the educational, political and cultural lives of their communities. As the field of medicine grew larger and more complex, fragmentation within the field of medicine occurred. For example, ophthalmologists became relatively isolated from the rest of medicine, and as a group became increasingly narrow and naïve. The successes and the excesses of capitalism during the 20th century led to the development of enormous opportunities and wealth on one hand and increasing regulations on the other.

Physicians, eager to be participants in the former, became willing sacrificial lambs for the latter. While industry and the other professions vigorously and effectively resisted being bought out and controlled by others, physicians actually wel-

comed what they considered unimportant changes, which many considered opportunities to assure themselves of a better income, and of a way to become better doctors, concentrating on patient care. How lovely a thought, not to have to concern themselves with asking patients to pay: nice for the physicians and nice for the patients. While greed certainly was a part of the attraction to the whole new system of appearing to be paid by somebody other than the patient, probably the major reasons most physicians started "accepting insurance" were the hopes that it would be easier for the patient, that the system would take care of those situations in which patients did not have funds to cover major expenses, that they (the physicians) would be more assured of being paid for their services, and, finally, the fear that if they placed individual charges to their individual patients, the patients would leave them to seek care from physicians who "accepted insurance." Also, as the majority of patients became insured, there was a reluctance to charge patients for a service that the patient expected to be able to obtain without apparent charge, because the patient was already paying a company that assured them they would have such services.

It is an extraordinary comment on the ingenuousness of the leadership, as well as the rank and file, of the medical profession that they never paid attention to what everybody else in every other vocation knows, specifically, that "he who pays the piper calls the tune," that "he who controls the purse strings controls what happens."

The Quality Fallacy

As costs increased because of an increased amount for services, increase in technology, increase in complexity of services, increase in effective treatments and also what seemed to be an increasingly large number of dishonest physicians, the obvious reaction was increasing regulation. Amazingly, and to be explained only by their unawareness of the way the world has always worked, physicians actually welcomed the regulations, adding some of their own. They participated actively in quality assurance committees, despite the fact that should have been obvious to everybody—that good, honest physicians did not need to be monitored by quality assurance committees, and that dishonest and frequently incompetent physicians would quickly learn how to keep from being controlled by them; the good honest physicians would describe their surgical complications and be penalized, whereas the nefarious physicians would lie. The clerks reviewing the charts were, of course, unable to distinguish whether something on the chart was a correct observation or a fabrication.

There was, of course, absolutely no improvement in the quality of care because of the introduction of quality care committees. There was, however, an enormous increase in the cost of caring for patients. Misguided academics published articles on how patients who were in a health maintenance organization actually seemed to get better outcomes than patients not in such health-care systems, forgetting that the quality of the data that they were using to come up with the conclusions was flawed, inevitably being skewed in favor of a regulated system, because of the way that the data was accumulated. Eventually quality assurance committees disappeared in a way similar to why the arms race between the United States and the Soviet Union stopped, not because the obscene absurdity of the arms race was recognized, but rather because people ran out of money to continue it. The injustice, ineffectiveness and decrease in quality of care that was the result of "quality assurance committees" have simply gone unexpressed.

Physicians bridle when their fees are reduced by some regulating organization. But what else would any regulating organization do except reduce fees? It is beyond understanding why the response of the medical profession—leaders and followers alike—is to recommend massive mobilization of physicians to contact "their legislators" so that physicians will be more appropriately compensated and can spend their time being physicians and not clerks. The problem, of course, is the system itself.

What a paradox that one of the great jewels of the 20th century, the massive improvement of health that is the consequence of improvement in health care, has been associated with the increasing enslavement of those responsible for providing the care. The entire system is based on fallacious assumptions. These include: 1) the incorrect belief that a disease can be appropriately categorized by a code, as if all patients with "pneumonia" have the same disease, need the same diagnostic procedures and the same therapeutic approaches; 2) the incorrect assumption that two different patients with the same diagnostic entity should be considered in the same way, as if there was no difference between the diagnosis, treatment and significance for the patient and society of a healthy 2-year-old child losing vision from a cataract and a severely demented terminally ill 80-year-old person losing vision from a cataract; 3) a totally wrong belief that the consequences of a disease with a particular code are the same in different individuals, as if the significance of becoming unable to use one's hands because of carpal tunnel syndrome was of equal importance to a professional singer or to a professional violinist; 4) the incredible belief that somehow all "health providers" provide the same quality of service and, therefore, should be reimbursed at the same levels. (Consider the absurdity of all players on the Dallas Cowboys, or all CEOs of all companies, receiving the same salary); 5) the

demeaning idea that individuals have no responsibility for their own health, so that if they want to drive motorcycles without wearing helmets, have promiscuous sex without precautions, or destroy their liver by massively excessive alcohol intake, they are still entitled to exactly the same services for exactly the same costs as individuals who hold themselves accountable for their own health and consequently did not act in such ways.

What a tragic irony that in every other walk of life the most conspicuous recognition of a contribution is based on the perceived value of the contribution, whether that be an oil painting, a new computer chip, hitting more home runs than anybody else, designing the most fashionable clothes, or discovering a process that allows farmers to increase their crop yield.

Standards Don't Serve Individuals

Only a population of astoundingly naïve individuals could welcome a new regulatory plan, "pay-for-performance." No other group of people in any vocation would willingly let an external body over which they have no control determine what they would be reimbursed, especially when the criteria for deciding on the quality of performance which will be essentially unable to be defined and unable to be verified, and will be decided by those making the definitions, as hazy as they are.

The possible explanations for physician behavior during the past 50 years include naivete, apathy, lunacy or all three. However, probably the best explanation is that physicians have simply removed themselves from the realities of daily life as a result of a specialized education in college (in which they ignore history, economics, political science and psychology), a medical education in which they are first taught by people who are isolated in laboratories or clinics (who, for example, seriously believe that knowing the difference between a gram-negative and a gram-positive bacterium is more important than knowing how to become a powerful person), and, later, are taught by those who get up early, work hard all day without a thought about the world outside their offices, and get home late at night.

In order to make absolutely clear that this polemic is not about how to increase physicians' incomes, the following needs to be said. I do not believe that the primary goal of practicing medicine is to make a profit. The reimbursement, in whatever form, should be an appropriate spin-off from providing a valued service. The amount of reimbursement should be in line with the value of the service to the individual to whom that service is being offered. Only the individual can make that determination. A heart transplant may be worth $100,000 to one individual, but not to another. One person may be willing to pay 1 percent of his $10,000 income, that is $100, for a cataract extraction, and another person may be willing to pay 1 percent of his $1,000,000 income, that is $10,000, for a cataract extraction. The value of being able to see well may be extremely great for an elderly, non-ambulatory college professor trying to finish up a major book, so that such an individual may be willing to spend a significant portion of her income to have a cataract extraction, whereas such surgery may be of little interest to a person who likes to spend her time chatting with the neighbors. The basic problem with the government's and insurance companies' approach to the value of care is that it tries to standardize the value, based on the assumption that there is a standardized person. There is no standardized person. The entire premise on which the economic basis of medical costs is computed is flawed.

Some may argue that there is an ethical necessity to provide care. In this regard, it is easy to get lost in academic arguments about whether people have a right to health care or do not have a right to health care. That argument is really a digression. What is certain, is that communities that are comprised of sick people do not do well. For a community to be successful, it needs healthy people. Nations have been eliminated by disease, such as happened to the Native Americans shortly after the Europeans arrived. Communities that do not pay attention to the health of all their citizenry will not flourish. Disraeli commented that the ultimate security of a country rested on the health of its citizenry. Communities work best when they comprise individuals who are healthy in body, mind and spirit. The enlightened community will make the health of its citizenry a high potential.

A wise community will do what it needs to do to assure that its people are healthy. One way they do that is to assure that there are good physicians available to take good care of the people. Of course, there need to be regulations on what physicians can do and cannot do, just as there are regulations on other occupations such as pilots, or teachers or football players. But the "health-care system" will never work unless based on a contract between the individual physician and the individual patient, and between physicians corporately and patients corporately. Patients must decide individually and corporately whom they wish to pay and how much they wish to pay. Standardized payments for a particular medical service do not work, just as standardized payments for other services such as those provided by lawyers or plumbers or investment bankers do not work. Medicine would flourish in the "free market" system that is the heart of America's greatness.

My suggestions:

1) Have the United States government provide bare-bones insurance, federally funded, for everybody, em-

ployed or unemployed, child or adult. (The wealthy or those who want more comprehensive care could opt out of the universal bare-bones insurance or supplement it as they saw fit. Once again, working this through employers does not make sense, because some employees value health much more than others and are willing to spend much more of their income on health care than others. They should have the right to spend their finances as they see fit.) Universal, federally funded, bare-bones insurance would assure that everybody got the necessary vaccinations, the necessary preventive health-care services that are essential to keep the country healthy, as well as individuals. To find those services is not easy. There will always be those who wish the service would be more comprehensive, and those who would err on the side of being less comprehensive. However, the nature of mankind is that many men and women do not know what they need to do to keep themselves healthy, and never will know that, and that many men and women will never "save for a rainy day." Such people need to be protected from their own limitations, and also society needs to be protected from the ill health that those individuals will bring to society without available health-care services. Consequently, it is in the best interest of all for all to be reasonably healthy. Therefore, the "bare bones" would provide a sturdy skeleton, not one in which the bones were so poorly nourished that they broke when mildly stressed.

2)Have physicians—all physicians—universally jettison all present "health insurance systems" and accept payments only on a fee-for-service basis, except where patients are unable to pay and, until universal, bare-bones health insurance is available, provide care without charge to the patient.

3) Have hospitals jettison all private insurance contracts and develop their own insurance programs which will compete against each other to provide services of different value related to the values that different patients want and need.

4) Have physicians and hospitals decide not to participate in plans such as "quality assurance committees" or "pay for performance" which cannot be effectively monitored and do not take into account the inevitable differences in what people need, want and value.

In summary, the naivete and insularity of most physicians, combined with their basic intent to be of help, has not served physicians or the public well. Physicians need to adopt the same mode of action that has characterized the rest of the United States. Were they to do that, they would live better lives. Much more importantly, patients would do much better than they do at present, and the country would have a healthier citizenry.

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