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Eisenhower's Nightmare:
A Massive and Malignant Healthcare Industrial Complex®

Market Corner Commentary
September 27, 2022

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After leading the Allies to victory in World War II and serving eight years as president, Dwight D. Eisenhower delivered his last speech to the American people as a public servant on January 17, 1961. To emphasize its importance, Eisenhower spoke to a nationally televised audience from the White House Broadcast Room. Delivered three days before John F. Kennedy's inauguration. Eisenhower's "Farewell Address" is among the most influential presidential speeches in American history. In it, America's legendary general warned the nation about a new and pervasive threat to their liberties.

He named it the "Military-Industrial Complex."

Sixty-plus years later, Americans confront another industrial complex that threatens our pocketbooks, diminishes our health and compromises our well-being. Like the Military-Industrial Complex does for national defense, the Healthcare Industrial Complex® contorts and distorts the financing and delivery of healthcare services. Here's a sobering thought. As industrial complexes go, healthcare's is orders of magnitude greater and more destructive than the military's.

THE RISE OF THE HEALTHCARE INDUSTRIAL COMPLEX

Drawing on his deep military and political experience, Eisenhower used apocalyptic language to describe the threat posed by the emerging Military-Industrial Complex.

> ***This conjunction of an immense military establishment and a large arms industry is new in the American experience. The total influence — economic, political, even spiritual — is felt in every city, every state house, every office of the Federal government. We recognize the imperative need for this development. Yet we must not fail to comprehend its grave implications. Our toil, resources and livelihood are all involved; so is the very structure of our society.***

Eisenhower counseled that Americans should "guard against the acquisition of unwarranted influence, whether sought or unsought, by the Military-Industrial Complex. The potential for the disastrous rise of misplaced power exists and will persist."

Since this "Farewell Address," industrial complexes have proliferated across American society. From education to energy to prisons to tech to financial services, industrial complexes occur when companies, government agencies, and elected officials collude for their parochial benefit rather than work together for the nation's benefit. Industrial complexes arise through unrestrained market concentration, skewed legislation, pro-business regulations, lackluster monitoring and toothless enforcement. Industrial complexes use their financial and political muscle to obstruct legislation and dilute regulations that would limit their profiteering.

As Eisenhower first prophesized, these industrial complexes have become a cancer on American democracy. The Healthcare Industrial Complex, however, is exceptional because of its size and reach into every community and household. It is causing irreparable harm to our political, social and economic systems at all levels.

In 1961, when Eisenhower delivered his Farewell Address, military expenditures constituted 9% of GDP. Today, the military consumes 3% of GDP. Then, healthcare spending was 5% of GDP; today it is 20% — over twice the level at which Eisenhower agonized over the Military-Industrial Complex's "unwarranted influence." Given its unrivaled economic scale, the Healthcare Industrial Complex has positioned itself to maximize its influence by spreading its malignant business practices.

FEE-FOR-SERVICE MALPRACTICE

This massive Healthcare Industrial Complex fragments the delivery of healthcare services, making the U.S. healthcare system both more expensive and less effective than health systems in other advanced economies. It uses its misbegotten power for its own benefit at the expense of greater American society. This is why the U.S. spends one of every five dollars on healthcare, yet consistently fails to meet people's basic healthcare needs. Strikingly, as healthcare spending continues its upward climb, national life expectancy peaked at 78.9 years in 2014 and has since declined to 76.1 years (2021 CDC estimate).

Probably the most important root cause of U.S. healthcare's dysfunction is its dependence on fee-for-service (FFS) payment schemes that reward over-pricing and over-treatment. In FFS Medicine, physicians, hospitals, and other providers receive payment for each service performed, not for a desired health outcome. In this way, FFS medicine incentivizes providers not only to provide more care, but to do more of what pays higher rates on the fee schedule but also to deliver fewer vital care services (e.g. preventive care) that pay less or aren't reimbursed.

There is no correlation between higher FFS payment and better health outcomes. Instead, higher FFS payments align with surgical procedures and high-technology interventions regardless of their health impact. Hence, U.S. healthcare does an abundance of MRIs, hip replacements, and cataract surgeries. Moreover, physicians and hospitals receive payment for procedural complications, so there's greater tolerance for medical errors and less emphasis on quality outcomes.

Thus, it is no surprise that the U.S. healthcare system deprioritizes preventive care, mental healthcare, chronic-disease management, social-care interventions and other primary-care services that improve health. Overall, the U.S. spends only 8% of its total healthcare expenditures for primary-care services. This is half the primary-care expenditure levels of other industrialized nations. These countries spend more on primary-care services but far less per-capita on overall health expenditures. On a relative basis, failure to provide adequate primary-care services diminishes U.S. health status.

The tragic impact of FFS Medicine is well documented in "The Hospital: Life, Death and Dollars in a Small American Town," which describes the experiences of Americans like Keith Swihart, in rural Williams County, Ohio. He has Type-2 diabetes, a dying wife, and a special-needs son. To care for his son after his wife's death, he left a well-paying factory job with a long commute.

Working long shifts at the local Menards for $12 per hour, Keith struggles to afford insulin and ward off collectors for $35,000 in unpaid medical bills. Shortly after starting at Menards, he goes to the emergency room with a swollen big toe on his right foot. To stop the infection from spreading, a surgeon amputates the toe.

During the next year, diabetes costs Keith more of his right foot and much of his eyesight. At 39, he hobbles to medical appointments and has numerous surgeries. After diabetes ravaged Keith's body, FFS medicine kicked in to pay for his acute treatments. There's abundant funding for amputation but little to none for diabetes prevention and management.

The mismatch between the lack of preventive services and affordable insulin Keith needed to manage his diabetes and the acute services necessary once the diabetes took hold is breathtaking and cruel. The transactional nature of FFS medicine drives this maldistribution of healthcare resources. Rather than paying for a visiting nurse, nutrition consults and healthy food to prevent or manage Keith's diabetes, American society absorbs Keith's enormous treatment and disability costs as he spirals downward.

The tragedy of U.S. healthcare is that there are countless Keith Swiharts in America. They often live in lower-income communities and struggle against crippling chronic diseases without access to basic and vital primary-care services. They suffer in silence and isolation while agonizing over unpaid medical bills. Medical debt accounts for 58% of all debt collections and is the leading cause of personal bankruptcies.

With nowhere else to turn, many patients appeal for public philanthropy. GoFundMe sponsors over 250,000 medical campaigns each year that raise in excess of $650 million. While Americans' philanthropic generosity is noble, the amounts raised are nowhere near enough to fund vital and necessary medical care of those making the requests. It is remarkably cruel that our wealthy nation forces so many of its citizens to forgo privacy and seek charity as they fight debilitating disease and injury.

PROFITEERING AND POLITICAL POWER

FFS medicine leads to profiteering. Through their "Health System Tracker," the Peterson Center on Healthcare and the Kaiser Family Foundation document U.S. healthcare's inflated prices. For example, the average 2014 appendectomy price in the U.S. is $15,930 compared to $3,814 in Australia. This extreme pricing variation exists not just between the U.S. and other countries, but also within the U.S. Providers in many regional markets have monopoly pricing power. For instance, hip replacement surgery in New York City averaged $56,739 and $25,044 in Baltimore during 2018. Americans also suffer from the world's highest drug prices. The average 2015 price for a 28-day supply of Humira to treat rheumatoid arthritis in 2015 was over three times more, $2,669 vs. $822, in the U.S. than in Switzerland.

The Healthcare Industrial Complex's economic and political power is vast. Its tentacles touch every American community. Entrenched incumbents relentlessly escalate prices to unsustainable levels while using their political influence to undermine reforms that would limit their profiteering.

Hospitals provide lifesaving care, but also heartlessly pursue patients to collect bills. Hospitals are bedrock local institutions and often communities' largest employers. This makes it easy for politicians to praise hospitals and receive their financial support, but difficult to criticize their anticompetitive practices.

Beyond hospitals, health insurers apply time-consuming and frustrating procedures to deny services and reduce payments to clinicians and hospitals, even as they raise premiums to self-insured employers. Pharmaceutical companies often charge astronomical prices for drugs with marginal benefit. Even more pernicious is Big Pharma's instrumental role in unleashing the opioid plague on an unsuspecting American public. The cumulative cost in lives lost, community devastation, family trauma, related treatments and ongoing addiction has been catastrophic, and unique to the U.S. among advanced economies.

Anticompetitive behaviors enable the healthcare industry to engage in profiteering and resist market demands for value-based care provision. Rather than lowering prices through economies of scale or improving quality, consolidation creates monopoly pricing power within regional healthcare markets. As a consequence, healthcare's already high prices rise at artificially high inflation rates. Multiple studies have found that provider consolidation increases post-merger prices.

Merged provider organizations use their expanded leverage to negotiate higher prices with commercial health insurers and their revenue-cycle sophistication to charge hospital-based facility fees for procedures in ambulatory centers and physician offices. The damage goes beyond higher prices. Multiple studies also have found that care quality and patient satisfaction decrease after mergers.

In a commentary over 40 years ago, the *New England Journal* retiring editor, Dr. Arnold Relman, bemoaned the "huge new industry that supplies healthcare services for profit." Relman had the wrong villain. Nonprofit hospitals and health systems dominate the provider landscape and usually are a region's highest-priced service providers.

Lenox Hill Hospital, a nonprofit medical center owned by Northwell Health, repeatedly billed patients more than $3,000 for routine COVID-19 nasal swab tests, 30 times the test's typical cost. According to an analysis by Massachusetts' Center for Health Information and Analysis, nonprofit Mass General Brigham (formerly Partners HealthCare) operated the state's two most expensive hospitals, with prices about twice the state average.

High healthcare prices have a cost, not just to patients. As we and others have shown, this overpayment for healthcare services plunders the U.S. investment in education, infrastructure, and other useful goods, and reduces individual freedom as overburdened Americans scramble to manage their health within an uncaring system.

High Medicaid costs, for example, have caused states to decrease spending on higher education and increase tuition. From 1990 to 2014 as reported in a JAMA article, Medicaid's share of state budgets more than doubled from 9.5% to 19.1% as higher education's share fell, from 14.6% to 9.4%. As the article's authors note, state colleges and universities "have made up the difference with tuition increases and cuts to educational or other services" making college "less affordable and accessible" for students.

Industry leaders get higher returns walking the halls of Congress and state houses, fortifying their monopolistic market positions, than they ever could in a competitive marketplace. This is why the drug industry, hospitals, health insurers, nursing homes, and medical professionals spend almost four times more on federal lobbyists than the next highest-spending industry. Indeed, a recent study found that the pharmaceutical industry contributed to the campaigns of more than 70 senators, 300 members of the House of Representatives and 2,400 state legislators across both parties in the 2020 election cycle.

This is the antithesis of the "human betterment" that Eisenhower believed gives purpose to "America's experiment in free government." In Eisenhower's opinion, government must work "to foster progress in human achievement and to enhance liberty, dignity and integrity among people and nations." Instead, the Healthcare Industrial Complex "captures" local, state and federal legislators and regulators to enact favorable legislation, weaken regulatory oversight and dilute enforcement actions.

The Healthcare Industrial Complex uses its lobbying muscle to block reasonable system reforms. For example, private-equity funds with lucrative investments in air ambulances, emergency-room physicians, and anesthesiologists spent enormous sums lobbying and advertising against surprise medical billing. As a result, the final surprise-billing legislation shields industry incumbents from full accountability for their misdeeds, imposing an arbitration process instead of capping prices.

The legislation protects consumers from surprise bills but raises overall prices. This is well demonstrated in New York and other states that use arbitration to resolve surprise billing disputes. Higher procedural prices translate into higher insurance premiums for consumers without punishing price-gouging providers that generate the surprise medical bills. Half measures like this constitute "reform" when the Healthcare Industrial Complex flexes its political muscle.

REAL MARKET-DRIVEN REFORM

So, what can we do about it? The good news is that America's Healthcare Industrial Complex is not invincible. It achieves its victories in the shadows through influence peddling, obfuscation, and opaque disclosure. New federal laws governing political contributions, lobbying and conflicts of interest could reduce the industry's political and regulatory influence. While constructive campaign-financing reform is desirable, the following three market-based reforms working together can truly propel industry transformation.

- Better healthcare purchasing by governments, businesses and individuals
- Liberated healthcare data and applied analytics
- Pro-market (as opposed to pro-industry) regulatory reforms

The compounding effects of these market forces have the power to reshape healthcare's supply-demand dynamics in ways that deliver more appropriate care and greater value to American consumers. To be effective in reducing the Healthcare Industrial Complex's unwarranted influence, reform must advance all three forces simultaneously.

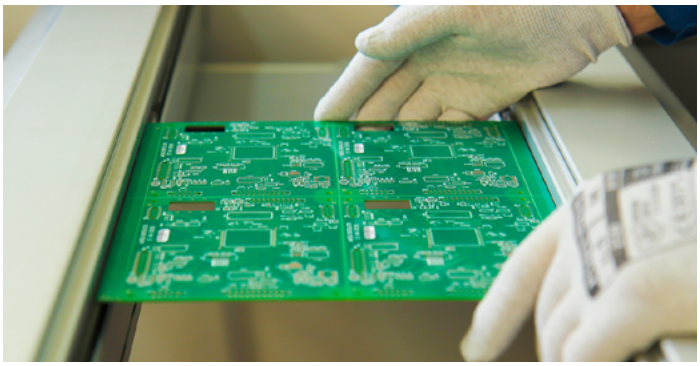
Better Purchasing

As capitalism makes clear, if the U.S. wants to change the way the healthcare system delivers care, we need to change how the system pays for care. We need more value-based purchasing that delivers better outcomes at lower costs.

Ending fee-for-service payment mechanisms is the first priority. Alternative payment models that transfer financial risks to those delivering care reconfigure payment incentives for physicians and other providers. Alternative models like capitation and bundled payments pay physicians clear, predetermined, fixed prices for care services. Working for a fixed payment incentivizes physicians to strive for more effective preventive care and better health outcomes. They logically lead to more care delivery at convenient, lower-cost (non-hospital) facilities.

Under these types of payment arrangements, a surgeon who performs a hip replacement at a lower-cost ambulatory surgical center or orders rehabilitation services at home rather than in a rehabilitation facility, can actually earn more while reducing total healthcare spending. These types of risk-based payment models have the added benefit of reducing patient deductibles and copays.

By making physicians responsible for all care during the 90 days after performing procedures, bundled payments ensure the physicians focus on eliminating error to ensure timely recovery. If they don't, they bear the costs of additional treatments or high-cost "repair" services (e.g., a surgical-site infection). Everybody wins. There is precedent for this approach. Companies like Kaiser Permanente integrate insurance and care delivery to optimize care outcomes. Kaiser pays its doctors more when they keep patients healthier, and its insurance arm keeps premiums down since healthy people do not need as much treatment.



Data Liberation and Distribution

Liberating healthcare data is the second force that reformers must unleash on the Healthcare Industrial Complex. Healthcare's plutocrats like to control healthcare data to obscure their prices and performance outcomes. Like all data, healthcare data needs to flow freely to physicians, individuals, and places where it can have the greatest positive impact. Remarkable advances in data aggregation, analysis, and application create the potential to get the right information in the right format in real-time to support better resource allocation and medical decision-making. These advances are decentralizing care delivery, making it both more affordable and more accessible.

Like bundles, reference pricing is another tool that uses price transparency to drive more affordable, higher-value care delivery. The California Public Employees' Retirement System (CalPERS) discovered a five-fold variation in the cost of joint-replacement surgeries at different hospitals with no discernable quality or outcome differences. In response, CalPERS piloted "referenced-based" pricing for these surgeries at $30,000. Members could choose from a geographically disperse group of 46 in-network hospitals for that $30,000 price tag or pay the amount greater than $30,000 at the more expensive hospitals. During the two-year program, CalPERS saved $5.5 million. Demonstrating the potential of pricing transparency, 85% of the savings came from hospitals that cut their prices dramatically to avoid losing surgical volume.

Pro-Market Regulation

Pro-market regulations are the third force reformers have in their arsenal. Absent COVID, 2020's biggest healthcare stories would have been Medicare's new data-interoperability rules and the new requirement for hospitals and commercial insurance companies to disclose their negotiated procedure rates. These new rules are already accelerating development of new digital applications and making pricing discrepancies more apparent.

During the pandemic, America discovered that loosening state-licensure regulations and paying for telemedicine visits dramatically increased care accessibility and responsiveness. If we want these types of lower-cost but valuable provider-patient interactions to become routinely available, CMS and state regulatory agencies will need to make these types of pro-market regulatory reforms permanent. Antitrust regulators also must do more to create level-field competition in regional healthcare markets where health systems and/or insurance companies exercise near-monopoly pricing power.

HEALTHCARE FOR THE PEOPLE

Perhaps the greatest potential benefit of reining in the Healthcare Industrial Complex is eliminating the devastating inequities in healthcare service delivery that afflict disadvantaged populations in poor urban neighborhoods and low-income rural communities. Payment models that incentivize preventive care, healthcare literacy, integrated mental health services, and link healthcare to social services such as food stamps and housing, can lower costs, enhance well-being and revitalize livelihoods.

Like the Military-Industrial Complex that President Eisenhower warned against 60 years ago, healthcare's enemy is within. It is not possible to fix American healthcare without reducing the Healthcare Industrial Complex's total influence on policy, payment and oversight. Regulatory and market reforms must work in concert to protect consumers, level the competitive playing field, and promote better individual and community health for all Americans.

As America emerges from COVID-19 lockdown restrictions, it is imperative that the nation's healthcare system not revert to its pre-pandemic practices. Now is the time to advance reforms that drive better health outcomes, lower costs, increase access, and improve patient experience. Our nation's future prosperity, quality-of-life, and global standing depend upon it.

AUTHORS

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