# Would Reform Bills Control Costs? A Response To Atul Gawande

December 22nd, 2009

by Alain Enthoven

Atul Gawande, MD, is one of the best medical writers of our time. I subscribed to the *New Yorker* just so I could read him. I reached eagerly for my Dec. 14, 2009 *New Yorker* when I heard he had an article there. I was deeply disappointed. What worries me is that his article will be used to support a political campaign to gloss over the failure of proposed legislation to significantly moderate health expenditure growth.

Gawande acknowledges that the cost of health care "…will essentially devour all our future wage increases and economic growth. The cost problem, people have come to realize, threatens not just our prosperity but our solvency." "So what does the reform package do about it? …Does it institute nationwide structural changes that curb costs and raise quality? It does not. Instead what it offers is … pilot programs."

Gawande goes on the recount the history of how the Agricultural Extension service did research, developed pilots to test the results, persuaded farmers to try the pilots, and sparked the agricultural revolution that so benefited the US economy in the first half of the 20th century. And he goes on to suggest that the many pilot programs for health care improvement proposed in the Senate bill could lead to a similar result and transform American health care.

His analysis is deeply flawed.

**The Farmers Were Willing Partners; The Medical Industrial Complex Is Not**

First, the agriculture analogy is inapt. In the case of early 20th century agriculture in the United States, the Agricultural Extension Service was working with the winds of market incentives at its back, helping it to move forward. That is, the Extension Service was helping farmers to do exactly what farmers wanted to do—if only they had the necessary information about what works—that is, innovate to improve quality, productivity and profits. The Department of Agriculture's goals and the farmers' incentives were aligned.

That is not the case in medicine today. Physicians complain that doing the right thing costs them money The incentives in today's dominant payment model are oriented to doing more, spending more, using more complex methods when simpler methods would do just as well for the patient. I recall the chancellor of a famous academic medical center complaining: "We introduced innovations that saved thousands of dollars in patient care and the result was that we lost the dollars in revenue."

Virginia Mason Clinic in Seattle offered a well-publicized example. Stopping the wasteful practice of doing an MRI on every lower back patient cost them a lot of revenue and drove the diagnosis and treatment of back pain from very profitable to being a loser. I doubt they'll ever want to do that again.

Second, Gawande got it wrong about pilots. In agriculture, the farmers wanted better crops and generally welcomed or tolerated pilots to show the better ways. The Medical Industrial Complex does

not want such pilots and often strangles them in the crib. For example, nothing lasting and significant came of the pilot to reward people for getting their heart bypass surgery at regional centers of excellence. I don't remember the details of how it died, but I believe it was tried and went nowhere. No doubt every hospital thought it was a center of excellence and wanted to be so rewarded.

Another more recent example is durable medical equipment. David Leonhardt had an excellent article in the *New York Times* on June 25, 2008 called "High Medicare Costs Courtesy of Congress." Someone had sold the good idea that prices of durable medical equipment should be determined by competition, and there was a provision in law for pilots to test competition. The industry lobbied hard to stop it and promulgated scare stories. "Grandma won't get her oxygen." Leonhardt recounts how Democratic and Republican leaders got together and postponed the pilot— and, I suspect, postponed it forever. There were proposals to test health plan competition, fought off by the industry of course. So this is not a fertile political environment for pilots. In fact, one of the most important lessons that has come out of the current "reform" process is the enormous power of the medical industrial complex and their large financial contributions and armies of lobbyists to block any significant cost containment.

Moreover, we do have some excellent and outstanding prototypes of better care at less cost. Gawande and the President name them: the Mayo Clinic, Kaiser Permanente, Intermountain Healthcare, Geisinger, Scott and White, etc. So if they are so great, why haven't they proliferated and taken over America? —a question I have been hearing and answering for at least 30 years.

I wrote a paper called "Curing Fragmentation with Integrated Delivery Systems" for a June 2008 Harvard Law School conference, soon to appear in a book by Oxford Press. Briefly, in the first half of the 20th Century, the medical profession went all out to strangle these group practices with many reprehensible anti-competitive tactics. The Supreme Court found that organized medicine had violated the Sherman act when trying to destroy the Group Health Association. When Russell V. Lee founded the Palo Alto Clinic, the Santa Clara County Medical Society expelled him, and his expulsion had significant negative consequences for his malpractice insurance and hospital privileges. Organized medicine got laws passed to outlaw "the corporate practice of medicine".

Then came World War II with the well known story of how exemption of health benefits from Wage and Price controls and income taxes put health insurance into employers' hands. And, for various reasons, most employers don't offer choices of health insurers, blocking competitive market entry by the health plans affiliated with medical groups. Or, if they do offer choices, employers like the state of Massachusetts pay 80-100% of the premium for the plan of the employee's choice, thus depriving efficient plans the opportunity to market their superior cost-effectiveness. On the other hand, a few employers like the University of California, Stanford — and, I believe, Harvard– as well as the states of Wisconson and California offer choices and a fixed dollar contribution so that efficient systems can reach the market and sell their superior cost-effectiveness. In these employment groups, large majorities usually choose efficient integrated delivery systems. That experience ought to be replicated across America.

As I listened to the President and read Gawande's citation of the iconic delivery systems, I thought "I wish they would ask themselves what it is about this health insurance market that prevents the Hondas and Toyotas of medical care from winning out." There is an answer. If America wants 1,000 pilot projects to blossom and grow into significant improvements in health care delivery, it must reform its system based on the principles of competition and wide, responsible, informed, individual consumer choice of health plans. Experience shows that people will join if they get to keep the savings.

**No Time To Wait**

This is Insurance and funding, not Health Care. The assumption is that Health Care can be bought like Dry Goods.

The third major flaw in Gawande's analysis is that we do not have time to wait for the decades it took for the agricultural revolution to happen. In 2009, health care is draining the federal budget some $1.15 trillion, which accounts for most of the federal deficit of $1.4 trillion. (This includes the revenue loss from the exclusion of employer contributions from taxable incomes.) Worse yet, that amount is keyed to the growth in National Health Expenditures, growing some 2.7% per year faster than non-health care GDP. The track we are on is feeding soaring deficits. So President Obama and Budget Director Peter Orzag have been right in saying that we must reform health care to get expenditures under control.

The tragedy is that the two laws working their way through Congress do practically nothing to slow health expenditures, except for the excise tax on high cost plans (a good and important idea) and pilots. The excise tax would be a lot more effective if it were accompanied by a system to assure people choices so that they could respond to the incentive in the tax.

Assumes they have a job and have the disposable income to buy a CHOICE (Insurance, not the CARE). Having a choice that you can't ay for is sophistry.

Health care expenditures are now doing great damage to our society's future, crowding out education, infrastructure, criminal justice and research, all of which are important for health in the long run. This will make it much harder to pay for projects intended to mitigate greenhouse gasses and climate change, as well as to pay for the military forces needed to deny Al Qaeda safe havens from which to plan attacks.

This is a nation founded on a tax revolt, and Americans' tolerance for taxes is low. The case for more taxes is not helped by the obvious and generally acknowledged wastefulness in the health care system (which government now pays most of) or by the obvious failure of public schools to do their job. And of course, health care's contribution to the national debt is burdening future generations and risking our fiscal future. Was about the tax breaks given to others, not ones own taxes.

The American people are being deceived. We are being told that health expenditure must be curbed, therefore "reform is necessary." But the bills in Congress, as Gawande acknowledges, do little or nothing to curb the expenditures. When the American people come to understand that "reform" was not followed by improvement, they are likely to be disappointed. Our anguish is only intensified by the fact that the Republicans are no better at fiscal responsibility, probably worse as they demagogue reasonable attempts to limit expenditures.

Congress is sending the world an unmistakable signal that it is unable or unwilling to control health expenditures and the fiscal deficit. That is not going to make it easier to sell Treasury bonds on international markets. I fear this will lead to higher interest rates.

**The Way Forward**

What should be done? I explained it in my "Consumer Choice Health Plan" articles in the 1978 *New England Journal of Medicine*. The idea is also in a recent report by the Committee for Economic Development (CED). The general idea is for government to pay everyone's way into the purchase of an efficient or low-cost health plan, meeting standards in their state or region but no more; if people want something that costs more, they must pay the difference with their own net after-tax dollars. Additionally, the creation of exchanges that broker multiple choices of health plans would drive the delivery system to produce better value through consumer choice and competition.

Of course, this cannot be done in one stroke. Incremental steps are needed. One of the best legislative expressions of this was the Managed Competition Act (MCA) of 1992 and 1993 sponsored by Conservative Democratic congressmen Cooper, Andrews and Stenholm. Briefly, create exchanges (then called Health Plan Purchasing Cooperatives, the same idea) in every state, require all employment groups up to 100 employees to buy through the exchange (to continue to qualify for the tax exclusion), cap the tax exclusion at the price of the low-priced plan in the exchange, and use the savings to subsidize health insurance for low-income people. The Congressional Budget Office estimated that the number of uninsured below the poverty line would decline from 15 million to 4 million, and National Health Expenditures would be reduced below the baseline projection.

The Committee for Economic Development report starts out like the MCA and describes a smooth transition rolling out exchanges to successively larger employment groups until all employees have the benefits of choice and competition to serve them. The bi-partisan Wyden-Bennett "Healthy Americans Act" is built on the same principles. In the late 1990s, the bi-partisan Commission on the Future of Medicare proposed a similar idea to convert Medicare to defined contributions or "premium support" payments and offer multiple choices of competing alternative plans. Victor Fuchs and Ezekiel Emanuel proposed a similar concept. In all these cases, cost conscious individuals would limit expenditure growth by choosing plans offering the most value for money.



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## 6 Responses to "Would Reform Bills Control Costs? A Response To Atul Gawande"

### RobertMecklenburg Says:
January 6th, 2010 at 2:17 pm

Although we agree with Alain Enthoven's sense of urgency in controlling health care expenditures, he is incorrect in his statement regarding the financial consequences to Virginia Mason of improving the process of diagnosis and treatment for back pain. The reverse is true: the changes we made in the delivery of uncomplicated low back pain have improved margin for Virginia Mason and we are rapidly expanding the deployment of this model.

What may not be apparent to Dr. Enthoven is that while revenue attributed to lumbar MRI imaging decreased, this decrement was more than offset by financial gains related to improved efficiency in delivering care. Virginia Mason's cost to provide care for back pain decreased substantially by leveraging physician time with physical therapist providers. In addition, the ability to provide same-day access to evidence-based care attracted a several-fold increase in patient volume.

The net effect was improvement in margin for Virginia Mason, lower cost for purchasers, more rapid return to function for patients and high patient satisfaction. The success of this approach has led us to expand the model to headache, breast nodules, large joint pain and cardiac symptoms and to disseminate these standardized care methods across the VM enterprise. Reduction in unnecessary imaging is a component of each of these initiatives.

Cost + Profit vs Profit vs who gets it (less cost to facility, but less profit to Radiology, more profit to non-physicians. It is a balance sheet problem - what is an asset and what is a liability, and what allows for shifting that column.

We believe that aligning reimbursement with value by payers would be a powerful incentive and support for providers to produce only value-added healthcare. The contribution of providers is to produce that healthcare value and this work can proceed at once. The contribution of purchasers is to purchase wisely, for as long as purchasers continue to consume low value health care it will persist in the marketplace.

The path forward will require this type of marketplace collaboration in order to shift the current emphasis on the relentless pursuit of revenue, often related to non-value-added services, to a more enlightened emphasis on implementation of reliable systems that lower cost by improving access and quality.

Gary S. Kaplan, MD, Chairman and CEO
Virginia Mason Medical Center

Robert S. Mecklenburg, MD, Medical Director
Center for Healthcare Solutions at Virginia Mason

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### Susanne Madden **Says:**

January 3rd, 2010 at 5:17 pm

You make reasonable assertions based on solid information. The part you do not address is that government needs to break the stranglehold that insurers have on the system. Until something is done to address that, providers of healthcare services are not working in a free market economy and cannot compete as an industry on price or efficiency. The Mayos and Geisingers have proven that concerted efforts to control costs and improve outcomes is quite possible through integration, but only because they are big enough and high profile enough to command the cooperation of insurers in paying for that care. The rest of the profession is left to follow the rules of participation set by corporations interested only in managing profit, not care.

Insurers don't pay for care - they are a pass thru and for future coverage, and alternative economy - we are mixing up banking/finance/accounting with actual services and products.

The greatest disappointment in this reform is the apparent death of the 'public' option. If that option had made it through, insurers would – out of necessity – have had to begin to compete based on the delivery of value to physicians, who deliver value in the form of savings to them. That said, my belief is that those dollars should not be paid from insurers to physicians, but from insurers to a pool based on percentages of revenue that a third party then distributes to physicians based on outcomes and quality. In doing so, physician organization innovations producing value could be rewarded appropriately. Set the dollars aside for rewarding innovation and you have the potential to inspire real collaboration. As it stands now, the largest and most adversarial insurers will simply continue to run the show, and doctors will continue to have to dance to the tune of Wall St.

As an economist, you have it right when addressing the consequence of cost but maybe only from a 10,000 ft view. What we could use more of is the 100ft view – the one where we tie insurance company policy-making to providers ability to deliver low-cost, high-quality care. Rather than thinking of healthcare as a puzzle requiring a cost-reduction solution, we would do better to see it as the labyrinth that it is. There is no single solution, or series of solutions, that will bring about minimal costs. Even countries that have well-run healthcare delivery systems have substantial and increasing costs. The fallacy that is being created here is that there is some solution to cost, and we only need stumble upon the right series of events to make it all better. The reality is, healthcare is expensive and will continue to be so; the best we can hope for is to incentivize the right entities to create better value and improved outcomes. Note: that would be the little-guy physicians, NOT huge conglomerates whose sole purpose is to create wealth, not value.

In other words, tweaking what does work will not improve what does not. There are many levers that could be pulled to begin dislodging the pieces that simply do not work (e.g. the total control that for-profit insurance has on the physician market). In thinking about this, Malcolm Gladwell's distinction between puzzles and mysteries comes to mind. In one of his articles about Enron, he posits that puzzles are about having enough information. Gather the right bits together and viola! you have the solution. Mysteries, on the other hand, are not solely based on having information about a situation. To quote “Mysteries are a lot murkier: sometimes the information we’ve been given is inadequate, and sometimes we aren’t very smart about making sense of what we’ve been given, and sometimes the question itself cannot be answered. Puzzles come to satisfying conclusions. Mysteries often don’t.”

While I don't see healthcare as a mystery, it most certainly is not a puzzle. But reform hinges on making sense out of what exists. In a highly complex (mysterious even?) industry, much of what has been talked about in terms of reform is being treated as if it were a puzzle. That's where the pilot idea is being grown from. But as you accurately point out – in my view anyway – is that pilots cannot work if they cannot be adopted. And in this case, pilots that disadvantage one party while benefitting another simply cannot work. That is a zero-sum game.

There is a high cost for profit when it is simply for profits' sake. There is a reason why most countries in the world provide healthcare to their populations – it is a human service that does not improve from profitization.

In my view, controlling costs is about spending on the solutions that cost the least to support. Money spent on insurer profit is pure cost in the system. The incentives need to be focused on those that deliver care, and truly manage that care, not on those that add no value but profit from it none-the-less.

An additional problem is that Health Care has become a jobs program as well as an investment opportunity. It may be true that investment in companies in a free market setting can improve cost and delivery, but Health Care is not a commodity and the profits are made in increasing the Overhead activities, rather than the delivery. Insurance may be the commodity, but Medicine is more like a Utility?

**Dan Smith** **Says:**

December 30th, 2009 at 1:26 pm

A journey of a thousand miles begins with one step. Let's talk about the first step. This first step should address healthcare costs which are pushing us over the abyss. Why has the concept of state Medical Public Service Commissions (PSC's) not surfaced? History has shown that when essential services have been priced beyond the reach of the average citizen that PSC's can bring these high prices down to an affordable level. Let's turn the problem of healthcare costs over to state PSC's.

In so doing there are numerous hidden benefits that make this approach unique and worth much closer analysis by those truly interested in bending the healthcare cost curve. Those politicians who will dismiss this idea out of hand are not really interested in solving the medical inflation problem, but want only to give the appearance of concern while their inaction supports the status quo and the ill-gotten gain they derive from the current system. This is the only idea that has the potential to fix our system and correct its course without a full government take-over of healthcare. Let's look at how state Medical PSC's would work:

1. Starting with healthcare costs, the PSC's will have the resources to determine the basic cost of each Medical Charge Code used by providers to bill insurance. If the current medical charge code manual is not specific enough for some procedures, new medical charge codes can be added to help refine these costs. Annually these PSC derived costs will be adjusted for inflation until the next cost review cycle updates the underlying cost basis for the selected Medical Charge Codes. (Each year a sub-set of codes will be reviewed.) In addition, the PSC will calculate a mark-up percent for fair and reasonable provider profits for the coming year. The provider mark-up percentage will be determined by a new market 'check and balance' mechanism only available in a PSC environment. More on this later.

2. Because some Zip Codes have inherently higher costs than rural areas, the co-pays may vary by Zip Codes to offset these cost differentials so the Medical Charge Code cost basis can be leveled across the state. These office visit co-pays would be standard across all providers in a Zip Code and paid by the patient. These co-pays should not deter patients from seeing their doctor.

3. The PSC eliminates provider networks and provider service contracts. Thus, competition between providers is increased because insurance no longer delivers a pool of patients. Patients can go anywhere in the state and use their insurance because all insurers pay the same for identical services as set by the PSC.

Note: Since the PSC sets claim rates paid by private sector healthcare insurers, increased competition does not affect these rates, however, increased competition does affect the retail rate charged by providers to those without insurance and rates charged to all government plans resulting in some tax write-offs. Therefore, increasing competition to keep retail rates reasonable is still important.

4. Insurers now compete solely on the price of their policies because the doctors/hospitals are no longer tied to their networks. All insurance is accepted by the doctors/hospitals because they all pay the same PSC rates. This increased price competition forces the insurers to reduce premiums and focus on gaining state market share as the method to increase profits.

This eliminates the Providers rather than the Insurers! Insurerers compete solely on the cost of their product, not the cost of Medical Services! Competition among Insurers, not Providers which is the real goal! Insurance is Overhead, not Product.

commissioners may quickly increase insurer competition, if needed, by licensing new insurers to compete in

This completely severs the Goal from the Funding! Medicine is more of a Fiduciary with duty to the Savings Customer, not the Corporate shareholder. Corporations benefit the shareholder, not the Customer (Hillarycare 1993).

the state. There are no network or provider service contract requirements. Also insurers may be extricated from the state without affecting patient access and quality of care since patients are not tied to the insurer's network.

6. The PSC can greatly reduce the over prescribing of medical services by the way the provider mark-up (profit) percentage is determined. It can tie the profitability of the providers to the profitability of the insurers. If the profitability of the insurers decline because of the overuse of medical services, then the mark-up percentage for the providers is reduced on every Medical Charge Code. The providers will then think twice about how they prescribe healthcare because it now directly affects their profits. This one feature alone will cut healthcare costs significantly. Providers bear the pressure of Insurer Profits as well as their own.

7. Tying the provider mark-up to the net profit (percent of premiums retained after insurer costs are subtracted) that insurers keep creates a healthy 'check and balance ' mechanism. If provider costs go up, profits of both go down. If profits go up above what the average state business earns, the State Insurance Commissioner can intervene and license new state insurers to increase competition, if necessary. But both the insurers and providers have a right to earn a reasonable profit, so the elected State Insurance Commissioner will monitor insurer profits and take appropriate action if and when these profits noticeably exceed what other state businesses earn.

Note: If insurer profits surge due to the more efficient delivery of healthcare, then the insurer has the option to reduce gross profits with offsetting insurance policy premium reductions. This insurer action results in a two-fold benefit: 1) lowers projected net profit gain for the insurers which the PSC will use to determine the provider mark-up percentage for the coming year and 2) positions the participating insurer to increase state market share for the coming year. This allows the insurers and providers to earn fair and reasonable profits and policyholders to pay lower premiums.

The State Insurance Commissioner will post the annual profit margins for each state insurer and list prices for similar products. Policyholders can judge for themselves if their premium rates are fair. If not, some policyholders may react by dropping their insurer for a new one during the end-of-year sign-up period while retaining their same doctors/hospitals. Providers should make a profit, not insurers

8. The PSC does not make healthcare decisions and does not affect the doctor-patient relationship. The full time job of the state Medical PSC is determining the cost of Medical Charge Codes. The PSC will standardize these codes to make filing claims easier for doctors/hospitals.
Contradiction. By setting fees, PSC setermines what services offered. Doesn't guarantee anyone will do it. Indirect control.

9. The above discussion on computing the provider mark-up percentage eliminates the current adversarial relationship between providers and insurers and lets market forces determine the common profit. Another more simple but less ideal approach would be for the PSC to set the mark-up percentage based on some other criteria. The choice of method would be up to each state.

10. As you will note, the previous discussion portrays the Medical PSC as more a state Price Commission than a regulatory body. The role that this PSC plays in each state would be up to the state legislature and could evolve over time. The states will learn from each other.

The state Medical PSC concept has amazing potential. Not only does it break the current dysfunctional bond between doctors/hospitals and insurance companies, but it offers a 'check and balance' system to mutually benefit all participants: providers, insurers and policyholders. Medical PSC's would eliminate any cost shifting from underpaying government plans to the state private sector plans. Without a doubt, this unique approach will position the American Healthcare system to control costs as healthcare is expanded by Washington. Congress does not know about this brilliant idea. Please write/call your state and federal representatives and tell them that we must have state Medical PSC's.

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### Linda Bergthold **Says:**

December 27th, 2009 at 4:49 pm

I think the first commenter misunderstands the nature of the "pilots" being proposed in the legislation. First of all, they are not necessarily going to be designed in academic settings. They will be real world experiments, designed and implemented by various health care organizations that actually deliver care. Secondly, the term "pilot" is an important one in terms of implementation. A pilot can be more rapidly disseminated

throughout the country, while a “demonstration” must go through a different process for implementation that is slower and requires more sign-offs. So making “payment bundling” a pilot, means that Medicare could review the results and very quickly put the projects in place on a national basis.
For that reason, I believe that the pilots in this legislation do have the ability to change the way we pay for care in a relatively short period of time. Prospective payment and DRGs reduced hospital lengths of stay substantially within a period of several years. Payment bundling in Medicare could have a very large spillover effect on the private sector as well. I am much more optimistic than Professor Enthoven on the ability of the system to react and change in response to this health reform legislation.

And bankrupted many hospitals.

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**acavale Says:**
December 22nd, 2009 at 10:27 pm

Prof. Enthowen: I applaud you for finally dissecting Dr. Gawande’s flawed analysis (not the first time it has occurred). While agreeing to your assertions that organized medicine may not want pilots like the framers did, I have to disagree with you about the motives for such behavior. While agricultural pilots were conducted in the sphere of activity of the farmers and were firectly relevant to their field of activity, most of the proposed pilots in health care are going to be conducted in the ivory towers of acedemia, which have very little relevance to community medical practice or medical care. Therefore, the outcomes of such pilots will be of little relevance to the average consumer or provider of health care. So why should they care about such pilots?

Second, the fundamental flaw in all the arguments for expanding the role of “insurance” as part of the “reform” proposal is the concept of insurance itself. The idea that a third party pays for my care, encourages me (as a consumer) to utilize the maximal amount of care that I can use, because I am not seeing the actual cost of the care I demand as a consumer. I would be far more selective if I had to pay a substantial share of the cost and would be a value-based customer. Besides, in a price-fixed third party payer system, which pays a physician the same irrespective of the quality of care, why would anybody embrace the idea of change?

In my own practice, we have been providing highly sophisticated chronic disease management via the phone, fax, email, secure website for years, thus saving our patients a trip to our office, not to mention co-pays and lost productivity for their employers. Yet, we have been the only losers in this bargain, because neither the government nor private payers have financially recognized the value of our service (sometimes up to 3-4 hours per day). Such services would have yielded us tens of thousands each year if we were accountants or lawyers. The absence of a free-market system to allow competition and efficiency is totally absent in the health care field, primarily because of third party payers. So blaming the provider alone is irresponsible and promotes the “entitlement mentality” that pervades the span of the nation.

The real valuable pilot would be to establish a direct financial and medical relationship between the consumer and provider of care. This is the only way to let people ration their own care based on what they feel provides the best value for their money. Unfortunately, this will never happen because neither the Congress nor the average public would dare take such a bold step. In lieu of this, the next best thing to pilot would be allowing (perhaps mandating) an even playing field amongst the consumer, the provider, the employer and third party payer. In such a pilot, all four parties could share the risk and costs of providing care to the public, keeping financial transactions fully transparent, and eliminating the cost of litigation (which would instantaneously eliminate 20% of cost of care) by agreeing to a quick, fair resolution of complaints without litigation. As a professor of business, it would be great if you could come up with such a model.

Finally, I beg to disagree with you that “integrated delivery systems” can offer higher quality care than networks of small community-based practices. While people may love to shop at Walmart for their consumer products, it is very unlikely that the public would want a Walmart of medical care. The reason why the Geisingers, Mayos, etc. have so little impact is because so few of us can actually access care at these institutions. When you are sick, you want a competent local physician that knows you and is aware of local circumstances, to heal you, not some ivory tower academic who knows the book of medicine inside-out and is worried about controlling costs more than curing the patient.

Integrated Medical Care vs Integrated Finance and Payment system.

Perhaps we deserve what we get because we entrust reform in the hands of our beloved politicians, rather