LAST JUNE, PRESIDENT Obama presented his case for radical overhaul of the U.S. health-care system to the annual meeting of the American Medical Association, a powerful physician assembly famous for resisting government influence on the practice of medicine.

The doctors reportedly were heartened by the president’s call for incentives to encourage more physicians to become primary care providers and by his promises to help reduce the need for “defensive medicine,” provided mainly to avoid malpractice suits. The boos came later, when Obama said he opposed capping malpractice awards.

The health-care dilemma remains the most important issue facing the United States. This year we will spend about $2.5 trillion on health care; next year we will spend more. This year the country has nearly fifty million people without health insurance; next year there will be more. Obama’s plan is just one of several that will attempt to make their way through Congress.

To help sort things out, Bostonia spoke with Stephen Davidson, a School of Management professor of business, policy, and law and former director of the school’s graduate program in health-care management. Davidson’s book In Urgent Need of Reform: Saving the U.S. Healthcare System will be published by Stanford University Press early next year.
BOSTONIA: A widely praised New Yorker article by Atul Gawande suggests a big problem with American medical care is that too many doctors, like those that Gawande saw in McAllen, Texas, see their practice as a business first and as a human service second, ordering many revenue-producing tests and procedures that have not been shown to improve or extend patients’ lives. Do you agree?

DAVIDSON: It is an old story. In a fee-for-service system, doctors can adjust the volume of services to compensate for what they believe are inadequate fees. Gawande describes particularly dramatic examples to illustrate the point and carry it to its logical conclusion. In writing about the excesses in McAllen, Texas, he points out that most places are more like El Paso, where costs are much lower. Nonetheless, it is true that doctors do sometimes choose services that do not reliably produce the desired outcomes. My view is that doctors think they are doing what their patients need even when they act in this manner.

Provider income is under pressure. Inflation-adjusted physician income actually declined by about 7 percent between 1995 and 2003. One of the things I worry about is that as physicians find themselves under more financial pressure, their professional ethic — that service to the patient comes first — will erode further. If that happens, more places will look like McAllen than El Paso, because entrepreneurs (some of them physicians) will move in and offer financial rewards for behaving like McAllen providers. This scenario occurs only in a fee-for-service system, in which doctors and other providers are paid separately for each service provided.

What about the malpractice lawsuit component? Is that a red herring?

Malpractice is very important to physicians. Insurance is expensive and being sued can be a devastating experience. But as a part of the health-care reform picture, it’s tangential. The justification for such lawsuits is that they help keep doctors conscientious. As a quality-promoting strategy, however, they are a blunt instrument and probably have little positive impact on quality. Doctors fear that overlooking a service for treating a condition is a sure way to be sued. That is probably not the case, but providing a service as a defense against a potential malpractice suit has the side effect of resulting in another fee. So, while they try to protect themselves against a lawsuit, they also increase their income. That said, research shows that the best way to avoid malpractice suits is for doctors to build relationships with patients and let them see that they are trying hard to solve a clinical problem. That requires spending time with patients, but insurers — invoking the economics of the situation — discourage longer visits.

Can you give us a simple explanation of Obama’s proposed changes?

His primary goals are to limit health-care spending and increase the numbers of Americans with insurance, using the competitive private insurance market. Among other things, that allows people who like their present coverage to keep it. To reduce the uninsured, there would also need to be new regulations, as well as subsidies for low-income people. In addition, the president would invest public funds to spread the use of health information systems, including electronic medical records (EMRs), to improve care and reduce unnecessary services. It is probably most useful to see these as a set of principles rather than detailed proposals.

How will Obama’s plan reduce costs?

The goal is not really to reduce current spending, but rather, to reduce future increases. The United States currently spends about 16 percent of its gross domestic product on health care, about five points higher than the second most expensive country. So if the increase in spending can be kept lower than economic growth, gradually the share of GDP spent on health care will decline.

One way to achieve that goal is to increase the number of Americans with good insurance coverage. That would reduce use of hospital emergency departments for routine complaints and even for serious illnesses that can be treated in a doctor’s office. An emergency department is much more expensive than an office visit, as well as more likely to lead to inpatient hospitalization.

“The United States currently spends about 16 percent of its gross domestic product on health care, about five points higher than the second most expensive country.”

WEB EXTRA
Through October, Stephen Davidson will take your questions about health-care reform at www.bu.edu/bostonia.

16% UNITED STATES
11% FRANCE
8.4% UNITED KINGDOM
5.9% MEXICO

SOURCE: ORGANISATION FOR ECONOMIC CO-OPERATION AND DEVELOPMENT 2007 DATA
admissions. So even if office visits grew because more people were covered, it is possible that spending would increase at a lower rate.

Another strategy is diffusing electronic medical records and other technology to physicians. EMRs, linked to up-to-date research-based recommendations, could save money in at least three ways: by increasing the chances that a doctor will choose the most appropriate, least expensive service in the first place, by reducing errors that need more services to correct, and by avoiding duplicate services because records are misplaced or a second doctor cannot access the original record.

A third method is competition among insurers — that rivalry will stimulate innovation, which will attract interest among potential buyers and allow insurers to keep premiums low.

The first two of these are more than plausible, but will require substantial investments. The third idea is more problematic. The theory reads well, but insurers’ past behavior provides little reason for optimism. Up to now, innovation has tended to mean new methods for segmenting the market to avoid enrolling high-risk people.

Is the argument that the Obama plan will limit choice a real concern?

This is not a simple yes-or-no question. To increase the numbers of Americans who purchase insurance, several things must happen. Private insurers must offer affordable policies. But health insurance is expensive; 16 or 17 percent of Americans don’t have it now, and most of those are employed, sometimes in more than one job. In other words, they have money, but cannot afford health insurance. Somehow the policies that insurers offer under the reform plan must cost less than the ones they offer now. How are they going to do that and make a profit that satisfies shareholders?

Public subsidies will help, but what will make the policies worth the money? Already, many insured people find that services they need are not covered or require such high out-of-pocket expenses that even with insurance they cannot afford the services. An insurance exchange like the one in Massachusetts has been proposed. For it to work, private insurers must be willing to offer policies under the rules set by the exchange. One way is by paying providers low fees, but that tactic may reduce the number of providers willing to treat patients.

Some argue that a public-sector insurance option is needed to ensure that private carriers offer good coverage at affordable prices — to “keep insurers honest.” The public insurer’s mission will be to make affordable coverage available, and it will not need to earn a profit to satisfy investors. So private insurers say that competing with a public plan would be unfair, and they’re pulling out all the stops to derail that idea.

Ironically, doctors, who complain mightily about dealing with today’s private insurers, are also opposed to a public option because they are afraid that the public-sector plan would pay them at Medicare rates, which are about 20 percent lower than rates paid by private insurers. The doctors are ignoring the fact that private firms often deny payment altogether and that they make it hard to get paid even when services are approved.

To many analysts, the most rational, least expensive plan would be a public insurance system run by the federal government. Medical services would still be private, but the payment function would be centralized. Since politically that is an unlikely outcome, and private insurers must be part of the solution, contentious issues like these arise.

There is also an argument that reform will negatively impact the quality of care. The assumption is that spending less must mean that patients get fewer services, and if people get fewer services, quality declines. As the Gawande article in The New Yorker shows so dramatically, that is not necessarily the case. The best care is often the least expensive. Nothing in Obama’s ideas or about health-care reform in general means lower quality care will result. And that is the case even if we succeed in increasing the numbers of insured and containing the increase in costs.

The Medium

COMPOSER RICHARD CORNELL TURNED A 32-WORD POEM INTO 141 BARS OF SYMPHONIC SOUND. HERE’S HOW. BY KIMBERLY CORNUELLE

ONE COOL FALL day in 2006, Richard Cornell, a composer with a penchant for computer-mediated music, was making his way around the Web in search of poems that might complement his recent readings of fourteenth-century Persian poet Hafiz and Dylan Thomas. Cornell, a College of Fine Arts associate professor of composition, found downloadable readings of poems about war and listened to a recording of Gary Snyder reading “Falling from a Height, Holding Hands.” What he heard would change his life for the next several months.

What was that? storms of flying glass & billowing flames a clear day to the far sky - better than burning, hold hands.

We will be two peregrines diving all the way down

“I heard it,” recalls Cornell, “and I thought, I’m going to have to deal with this.”

His way of dealing with the poem would involve five months of imagination, concentration, and labor. The composer says he was compelled to transform from one art form to another Snyder’s vision of two people choosing to jump to their death rather than be burned when the World