

Insights From Organized Crime for Disorganized Health Care

John H. Wasson, MD

Abstract: During college and medical school, the author's summer employment acquainted him with members of organized crime families. After a full career as a primary care clinician and geriatrician with research on improving health care delivery, the author opines that several insights from organized crime should be of interest to health care professionals: (1) don't damage the host; (2) protect the brand; and (3) lead necessary adaptation. From these insights, the author presents symptoms of failure evidenced by the US health care system, followed by several adaptations that would reduce the system's costs, improve its image, and address future challenges.

Key words: *chronic disease management, ethics, health care cost, health care fraud, health care improvement, howyourhealth.org, Medicare fraud, patient-centered care, professionalism, what matters index*

GUIDELINES FOR SUCCESS FROM ORGANIZED CRIME

Don't damage the host

A noteworthy paragon of organized crime, Tony was an international union leader, an

Author Affiliation: *Medicine and Community and Family Medicine, Dartmouth-Geisel School of Medicine, Lebanon, New Hampshire.*

This study was adapted from a presentation to the MacLean Center for Clinical Medical Ethics and the Center for Health and Social Sciences at the University of Chicago; December 5, 2018.

Conflicts of Interest and Source of Funding: *The author declares no conflicts of interest. The author under license with the Trustees of Dartmouth College develops HowsYourHealth.org and related websites and distributes them without compensation. HowsYourHealth.org is the source for the patient-reported data in this report.*

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Correspondence: *John H. Wasson, MD, Medicine and Community and Family Medicine, Dartmouth-Geisel School of Medicine, Lebanon, NH 03766 (John.H.Wasson@Dartmouth.EDU).*

DOI: 10.1097/JAC.0000000000000273

invited speaker at an Ivy League university, and a candidate for a US Cabinet position. Although Tony's impressive career was devoted to maximizing financial gain, Tony's ambition did not extend to a level of greed that would inflict excessive damage on his host or attract too much attention.

Protect the brand

To protect his brand, Tony cultivated and maintained friends in highly influential positions. Although Tony was eventually found guilty of extortion, bribery, and tax evasion, his friends, apparently unaware of organized crime's rough brand protection methods, submitted supportive requests for leniency to the authorities. Tony served only 3 years of his 20-year sentence.

Adapt aggressively

Tony's indictment signaled the need for new methods and personnel. Following the oft-quoted adage of the bank robber Willie Sutton, "Go where the money is," the simple, cash-based money laundering and bribery of Tony's day evolved into the large-scale, untraceable currency transactions of today.

SYMPTOMS OF FAILURE IN DISORGANIZED US HEALTH CARE

At the time this author met Tony, US health care was considered a cottage industry, with health care functions broadly distributed among local providers. However, after the enactment of Medicare and continuing into this century, experts have argued that consolidation would increase health care’s cost-effectiveness and reduce undesirable variations in care delivery (Swensen et al., 2010). Unfortunately, those predicted improvements have failed to materialize, as evidenced by the following symptoms.

Damaging the host: Unsustainable costs and failure to deliver basic care

In the decades since the consolidation of US health care, per capita health care costs in inflation-adjusted dollars have escalated by more than 600%, and the number of health care administrators has exploded by over 3000% (Cantlupe, 2017; Kamal & Cox, 2018). Conglomerated US health care is now extracting almost 20% of the nation’s gross domestic product, of which more than 30% is estimated to be waste and of this 30%, as much as a third may be corruption (O’Neill & Scheinker, 2018; The Economist, 2014). Conglomerated US health care accounts for a major proportion of excessive global profit, and on a per capita basis, US health care’s waste is greater than the entire amount devoted to health care in 90% of the countries in the world (The Economist, 2018; Wikipedia, 2018a). Despite the expense, huge quality gaps and undesirable variation in US health care delivery remain, even with the enactment of increasingly onerous measures and regulations (Fisher et al., 2003a, 2003b; National Academies Institute of Medicine, 2018; Sinsky et al., 2016; Trustees of Dartmouth College, 2018).

Destroying the brand: Corruption and the erosion of public trust and professional enthusiasm

Since the consolidation of US health care, the number of stories about its corruption reported in the *Wall Street Journal* and *New*

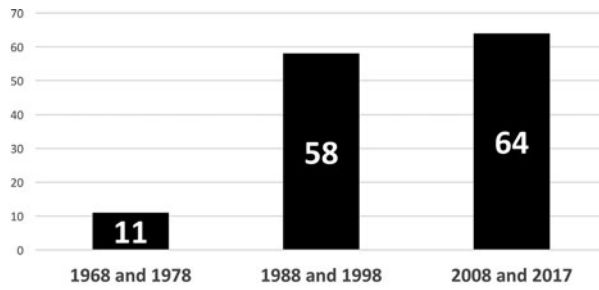
York Times has increased more than 5-fold, and the median dollar amount of each report has increased by a much greater amount, as shown in Figure 1.¹ The public has a very low opinion of the legal, business, and administrative personnel who increasingly rule conglomerated US health care (Gallup, 2018). Professionals are exhausted by the imposition of highly inefficient process reporting and reimbursement protocols; they are also disclosing moral injury from continuously being unable to provide high-quality care and healing (Dyrbye et al., 2017; Talbot & Dean, 2018).

Like many business enterprises and celebrities attempting to counter bad news, public grievances, and a loss of prestige, US health care conglomerates fall back on advertising and public relations. As examples, the author’s medical center now claims to be “stronger than medicine,” and the University of Chicago claims to be “at the forefront.” US health care conglomerates spend several billion dollars annually on public relations campaigns (Schwartz & Woloshin, 2019). Adding insult to injury, this extravagant puffery is often disguised by accountants as a community benefit so that health conglomerates can maintain their pretense toward nonprofit status.

Stagnant, not adaptive

Almost half of the adult population in the United States has at least 1 chronic condition, and chronic conditions generate most health care costs (National Health Council, 2014). Of patients with chronic conditions who are

¹The criteria for article selection were: medical AND fraud OR healthcare AND fraud OR doctor AND fraud OR nursing home AND fraud OR hospital AND fraud OR Medicaid fraud OR Medicare fraud OR medical insurance fraud OR billing fraud, excluding tobacco settlement and malpractice cases and repeated stories of the same allegations or crimes. Using established criteria, of these reports, 60% were related to fraud of medicines, devices, and/or services; 12% bribery and kickbacks; 12% improper marketing relations; 10% procurement corruption; and 6% misuse of position or conflict of interest. Multiple corruption categories could be identified in 23% of the stories (Sommersguter-Reichmann, Wild, Stepan, Reichmann, & Fried, 2018).



Review Period	# of Reports		MD Only		Median \$ Amount (Range), in millions	
	NYT	WSJ	NYT	WSJ	NYT	WSJ
Early (1968, 1978)	10	1	5	0	3 (0.15–4000)	Not reported
Middle (1988, 1998)	24	29	6	4		96 (1–688)
Late (2008, 2017)	35	29	5	4	89 (3.5–70,000)	97 (0.9–4,900)

Figure 1. *New York Times* (NYT) and *Wall Street Journal* (WSJ) reports of corruption with the consolidation of US health care in the years 1968 and 1978, 1988 and 1998, and 2008 and 2017, corresponding to the early, middle, and late stages of the consolidation of US health care, respectively. “MD Only” indicates that the only perpetrators were physicians. See Footnote #1 for search criteria.

unable to afford food, shelter, and clothing, only 20% report that they “receive the health care they want and need exactly when and how they want and need it,” and only 30% report “that they are confident they can manage most of their health problems”; the respective proportions of a financially secure patient population are 40% and 50%.² A whopping 50% of not-health-confident poor adult patients with chronic conditions report that their recent use of emergency or hospital care was possibly avoidable; the proportion for nonpoor adults is 25%. These data show that the current popular methods for managing chronic conditions are not working well.

²HowsYourHealth.org, described in (Nelson, Eftimovska, Lind, Hager, Wasson, & Lindblad, 2015), was the source for the patient-reported data for this report. Responses were from 3000 US adult patients who had been recently hospitalized, 30,000 US adults who self-reported a diagnosis of hypertension, and 90,000 with chronic conditions.

As examples, targeting patients considered at risk for costly care using highly touted predictive analytics is inherently inaccurate and wasteful and targeting a single disease may also have serious unintended consequences (Fonarow, 2018; Garcia et al., 2018; Wasson, 2018). Instead, focusing on what matters to patients may be much more cost-effective (Wasson et al., 2017, 2018).

ADAPTATIONS TO SAVE US HEALTH CARE FROM “CRUISIN’ FOR A BRUISIN’”

The author has been affiliated with several of the many organizations that have struggled to help US health care make some necessary adjustments and improve its value. Nonetheless, considering the increasing gravity of the deserved condemnation, US health care’s response has been lackluster because in many ways, whether they know it or not, health care providers benefit from the system’s

faults, as frustrating and exhausting as those faults can be. Furthermore, US health care's current business model is bolstered by complex and shifting alliances of multiple "stakeholders"—professional guilds, hospitals, pharmaceutical interests, numerous political entities, investors—and the reimbursement expectations of its workforce and related enterprises. A logical conclusion is that conglomerated, disorganized US health care may not be bettering health care value but it has, both seemingly and in unseemly ways, become much better at extortion and violating the public trust. In this bleak environment, health care professionals who are enthusiastic about leading meaningful health care change are increasingly rare, whether from disappointment, guilt, fatigue, culpability, or indifference.

Perhaps guided by the slang of his youth, Tony and like-minded compatriots used their guidelines to reduce the risks of "cruisin' for a bruisin'." The demise of ostensibly invulnerable ways of doing business (such as Sears-Roebuck and the Chicago Taxi Medallions) should serve as a sobering reminder of the costs of delaying adaptation to new challenges. In this context, the author recommends feasible adaptations for US health care systems, hospitals, and practitioners that would immediately minimize the chances of a serious "bruisin'."

Stop damaging the host

- Eliminate the insane patchwork of multi-item process and regulatory measures used to define health care "value" in favor of simple, easily remediable, cost-effective measures (Wasson, 2017, 2019).
- Redirect public relations budgets into the education of medical students to reduce or eliminate the debt burden that pushes these students toward lucrative specialties and questionable billing practices. The amount wasted annually on public relation campaigns could more than offset the tuition of all medical students!
- Accept the reality that many of our educational and training practices are based on irrelevant traditions and restrictive guild

barriers. As an example, consider the actual skills required to perform Mohs surgery in contrast to the usual 12 years of after-high-school training required to become a Mohs-certified dermatologist:

- The job description and sole technical tasks are to use scalpel to remove a skin cancer and look through a microscope to determine that the skin cancer has been removed.
- Artificial intelligence is demonstrating its capacity to be as accurate as certified dermatologists and pathologists in interpreting skin cancers and specimens with a microscope (Kent, 2018; Kubota, 2017). The public is already adopting these techniques (SkinVision, 2018).
- A MEDEX program directed by the author required 18 months of education beyond high school and 1 to 2 years of field work for trainees to become certified dermatologic physician assistants. Is even this much training needed for such a repetitive technical task?

Protect the brand

- Report corruption. Most news stories about corruption suggest that health care professionals should have known about these brand-damaging activities. One recent example was so broadly disseminated (5 of New York state's largest hospitals) and long-standing (decades) that numerous people must have been aware of the problems (Goldberg, 2018). Another example involved a highly visible physician leader with many conflicts of interest unreported over many years (Thomas & Ornstein, 2018). Failure to report is ethically wrong and harmful to the profession. Resources for prudent whistleblowing are readily available on the Internet.
- Imagine hospitals and health systems adopting and disseminating as their public promise "We are Here to Help You Achieve Health Confidence" instead of offering to be "more powerful

than medicine” or “at the forefront.” Health confidence is easily measurable and should be the foundational principle for most interactions between health care professionals and patients.

Adapt aggressively: Go where the money is

Although only a few professionals will be developing and disseminating better methods for delivering health care services, almost every professional can test and promote them. Examples of new methods include the following:

- Single-item patient-reported measures that can assess primary care quality more cost-effectively than the multi-item Consumer Assessment of Health-care Providers and Systems measures (Ho et al., 2013).
- Devices such as an evolving X-Prize winner that diagnoses and monitors many clinical conditions independent of a health care professional or facility (Wikipedia, 2018b).
- More cost-effective common practices and educational processes such as the examples below for the treatment of high blood pressure and general chronic care management.

High blood pressure management

Consider, as an example of “going where the money is,” adapting treatment for the common chronic condition of high blood pressure, which afflicts about a third of the adult population (Fryar et al., 2017). Currently, only 15% of poor hypertensive patients and 30% of the nonpoor are health-confident and engage in regular self-monitoring of their blood pressure.

Merging the following observations into a health care service would have significant benefits for patients and payers:

- “Fixed-dose combination (polypill) therapy has become essential for hypertension treatment because it is an effective, scalable strategy that improves adherence, and thus [blood pressure] control. This therapy also can be ef-

ficiently incorporated into multilevel interventions through simpler supply chains, fewer pills, and ultimately fewer outpatient visits” (Huffman et al., 2018).

- “Physicians vary widely in their recommendations for office revisits. Patient factors accounted for only a small part of this variation” (Schwartz et al., 1999).
- “Substituting telephone care for selected clinic visits significantly reduces utilization of medical services. For more severely ill patients, the increased contact made possible by telephone care may also improve health status and reduce mortality” (Wasson et al., 1992).
- In October 2017, Apple was granted a patent for a system to approximate blood pressure using data that could be obtained with sensors, such as pulse transit time (Farr, 2018).

Adapting current blood pressure treatment methods would impose costs on certain players: the pharmaceutical interests who currently ply a confusing array of trade products, and the office-based clinicians who schedule more than 40 million visits each year for hypertension, would lose revenue. Winners would include patients, payers, and public-interest politicians (excluding those unduly beholden to the pharmaceutical industry or professional guilds).

Were polypills and self-monitoring generally available for all chronic cardiovascular conditions, savings and patient benefits might be much greater (Wald & Law, 2003). However, the availability of polypills and easy-to-use self-monitoring devices as substitutes for office visits are not sufficient to maximize blood pressure control. As shown in Figure 2, among nonpoor and poor adults in the United States, blood pressure control is most impressively influenced by patient confidence that they can manage their health problem(s) and engage in regular self-monitoring.

Expanding health confidence and understanding “what matters” to all patients

Across 11 industrialized nations, patients’ self-reported health confidence (that they

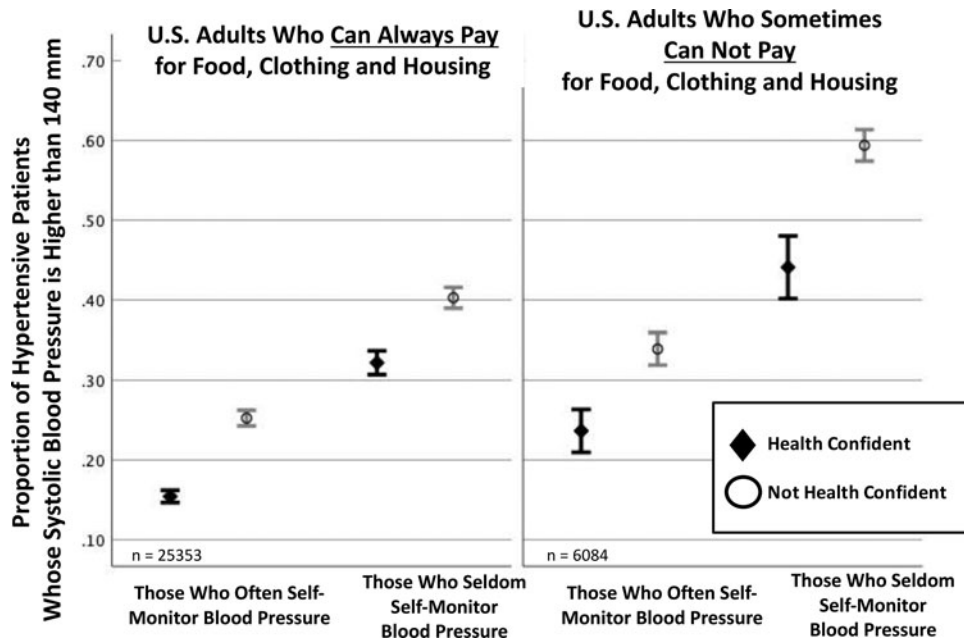


Figure 2. Lack of systolic blood pressure control (with 95% confidence intervals) is linked to poverty, health confidence, and the frequency of self-monitoring.

can manage and control chronic conditions) is strongly correlated with health care professionals' responsiveness to what matters, as demonstrated by allowing time to ask questions, encouraging patient involvement in decision-making, and explaining care in language that is easy to understand (Wasson, 2013). Not only is inadequate health confidence bad for health, as discussed above, it is also bad for society's health care budget: the majority of patients who lack health confidence use a great deal of avoidable and expensive care.

Several years ago, my colleagues and I began designing and testing a simple method for leveraging health confidence to assess patients' quality of life and overcome the limitations of current chronic care management methods, which rely on inscrutable and expensive computer-generated algorithms that fail to identify many patients at risk for costly care (Wasson, 2018; Wasson et al., 2017). For patients with chronic conditions, we determined that 5 patient-reported items are a suitable proxy for patients' quality of life and as accurate at risk stratification as

predictive analytics. These few measures also minimized clinicians' guesswork about what matters to their patients and reliably directed behaviorally sophisticated interventions. The 5 measures—low health confidence, bothersome pain, emotional problems, multiple medications, and the sense that the medications are causing illness—are called the What Matters Index (Wasson et al., 2017, 2018). Recently, the Physician-Focused Payment Model Technical Advisory Committee recommended to the Secretary of Health and Human Services that a patient-reported measurement approach using the What Matters Index and HowsYourHealth.org be tested within a capitated payment model (Ideal Medical Practices, 2018).

CAVEAT AND CONCLUSION

The waste and corruption of the US health care conglomeration, its appalling reputation with the public and its own professionals, and its inability—or unwillingness—to leverage social and technological advances to manage basic care and costly chronic conditions:

these are compelling evidence that this system will become only more insolvent unless it stops damaging its hosts, bolsters its brand with service (not slogans), and adapts aggressively. Amazon's coup-de-grace over Sears-Roebuck and Uber's over the Chicago taxis portend US health care's deservedly grim future. Ironically, "Medicare for All," derided by many as a socialist remedy for lopsided access to care, may be the current US health care system's best hope for preserving a sad semblance of the wasteful status quo.

Although this author's suggestions, based on insights from organized crime, may offer US health care a framework for radical change, they would have only a small direct impact on US health care's extravagant budget. Nevertheless, the suggestions are feasible and ethically sound, and in the aggregate, these adaptations could change expectations about health care value among health care professionals, policymakers, and patients. In turn, the parallel evolution of social expectations, technologies, and processes could magnify these initial steps toward an organized system that delivers the health care patients'

want and need exactly when and how they want and need it.

Of course, criminal insights cannot address the remaining ethical and political issues:

- What will happen to medical education and training, jobs in health care administration and measurement, and time-honored ways of delivering services and anticipating revenue?
- Will politicians support universal coverage at the expense of universal waste?
- Will new health care professionals deservedly be professional and receive fair payment for their expertise in a field that has earned the respect of those it serves?

For answers to these questions, may we look to a more profound and permanent source of inspiration:

Do not allow thirst for profit, ambition for renown and admiration, to interfere with my profession, for these are the enemies of truth and of love for mankind and they can lead astray in the great task of attending to the welfare of Thy creatures

Herz (1917 ; from *The Oath of Maimonides*).

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