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Interview with Stuart H. Altman, Ph.D., HFACHE, Dean and Professor, The Heller School, Brandeis University

Stuart H. Altman, Ph.D., HFACHE, is dean and Sol C. Chaikin Professor of National Health Policy at The Heller School for Social Policy and Management at Brandeis University, Waltham, Massachusetts. An economist whose research primarily covers federal and state health policy, Dr. Altman has served in numerous positions. From 2000 to 2002, he was cochair of the Governor/Legislative Health Care Task Force for the Commonwealth of Massachusetts. In 1997, he was appointed by President Clinton to the National Bipartisan Commission on the Future of Medicare. For 12 years, he served as the chairman of the Prospective Payment Assessment Commission. From 1971 through 1976, Dr. Altman was deputy assistant secretary of planning and evaluation/health at the U.S. Department of Health, Education, and Welfare.

From 1977 through 1993, Dr. Altman was dean of The Florence G. Heller Graduate School at Brandeis University, and from 1990 through 1991, he was the interim president of Brandeis University. He is the chair of the Council on Health Care Economics and Policy, a member of The Institute of Medicine, a member of the board of overseers of the Beth Israel Deaconess Medical Center, cochair of the Advisory Board to the Schneider Institutes for Health Policy at The Heller School, and Honorary Fellow of the American College of Healthcare Executives.

Dr. Grazier: *You have been a university president, a dean, a professor, head of a national payment commission, and author of national health insurance proposals, but you didn't start in healthcare. How did your early career influence what you do today?*

Dr. Altman: I was trained as a classical economist, focusing on human resources—labor economics as they used to call it. I wrote my dissertation on unemployed married women in the labor force. This was in the early 1960s, when there was a lot of debate over the unemployment rate. I realized that the labor-force participation of women was here to stay and that women were going to be more and more of a force. The '60s were a very interesting time, particularly for a young economist, because the government was very action oriented. I worked with Bill Gorham, assistant secretary in the Pentagon, who was asked to become assistant secretary for planning and evaluation at HEW [The U.S. Department of Health, Education, and Welfare]. Instead of joining Bill at HEW, I went to teach at Brown University, where as soon as I arrived, I was told: "you know all about women in the labor force; we have a problem with nurses." It was through writing a book on the supply of registered nurses that I got involved in healthcare. In the '70s, I was appointed as the deputy assistant secretary for health planning and evaluation in the Nixon administration.

The early 1970s was a really exciting period for healthcare in America, and it was during that era that the federal government attempted to directly control healthcare costs through a variety of regulatory systems. President Nixon imposed wage and price controls in 1971, and I was appointed deputy director of the unit responsible for controlling the health sector. I also retained my position at HEW, and in 1973 my office helped develop the Nixon administration's national health insurance plan—the State Children's Health Insurance Program; a version of that plan almost passed in 1974. In addition, I was very involved in the creation of the health planning law, which established health planning and certificate-of-need programs throughout the country. We also helped draft the HMO Act of 1973. Needless to say, I received an education under fire in healthcare. Once I learned about healthcare, I never wanted to leave it.

I left government and became dean at Brandeis University in 1977, where we established one of the largest health policy research centers in the country. In 1983, the Congress appointed me the first chair of the Prospective Payment Assessment Commission to help implement the Medicare DRG hospital payment system. I continued in that position until 1994. I also served on President Clinton's transition team and later was a member of the National Bipartisan Commission on the Future of Medicare.

I have a fair amount of energy and a little craziness. My success has been a combination of having good training, being at the right place at the right time, and doing a decent enough job that I was able to gain the respect of people who were in the position to make decisions.

Dr. Grazier: *You needed to go to Washington, DC, to accomplish a lot.*

Dr. Altman: I was willing to take risks. I took a fellowship from The Federal Reserve Board in Washington to complete my dissertation, and my faculty advisors told me not to do it, saying, "You'll never finish!" I had not been to Washington, so I wanted to see what it was like. This was in the early '60s, and Washington and I have been close friends ever since.

Dr. Grazier: *Would you recommend this trajectory to your students today?*

Dr. Altman: Absolutely, so that they can get involved in policy at the right level. Going to Washington is a wonderful policy training program. Life is very different today than in the '60s and '70s. Back then, there were no health economics training and no health policy schools. Most of the research institutes that exist today started in the mid-1970s, so healthcare policy was created by a small number of people and backed by very little analysis.

Dr. Grazier: *Do you think the growth in the number of health analysts has contributed to the cost of healthcare?*

Dr. Altman: Sure it has. The growth in analysis is a necessary outcome of the fact that healthcare has grown from 7 percent of the gross domestic product to 16.5 percent and from $75 billion to $2.2 trillion. Every unit and every group in the health system want to protect themselves, so they fund a lot of research that

generates a lot of activity. This growth in health research and analysis is positive, but it's not all positive; a lot of it is about defense then offense then defense.

Dr. Grazier: *You just served on an Institute of Medicine study group on emergency departments. Please tell us where you stand on this topic.*

Dr. Altman: Emergency departments were set up to be just that—for emergencies. They handle problems that the regular healthcare delivery system can't handle because of timing. Over time, emergency departments took on a role that has nothing to do with emergency care.

The emergency department (ED) has become the primary delivery system for two groups: the uninsured and several subpopulations of Medicaid recipients. In addition, many insured patients now use the ED for convenience or to speed up the process of receiving diagnostic work-ups. For populations that are not well served, the emergency department is not only the best place but also the only place to get care. I give tremendous credit to hospitals and their emergency departments because they have become the country's safety-net system. They do what the government should do: provide decent care for our underserved populations.

The issue, however, is that ED care can be much more expensive and, because it is episodic, can be very fragmented. Some argue, however, that getting ED care is not more expensive because the emergency department is already geared up for patients, so the fixed costs have already been incurred; therefore, the marginal cost of having another person come in is really minimal. There is truth to that in the short run; but, over the long run, fixed costs become variable.

In the 1990s another trend began, where well-insured people started using the emergency department, either for their convenience or their doctors' convenience, to get care that could be given in an ambulatory setting. Just as this new wave of demand hit, economic pressures were forcing hospitals, and therefore emergency rooms, to close. That led to a number of problems, including shortages and diversions, that emergency departments face today.

The question is, in an ideal delivery system, do we accept this reality and just build emergency department capacity to deal with these three levels of need? Or do we try to expand, improve, and change the financing and delivery systems such that nonemergency care can be delivered in more appropriate settings? In other words, people who can get care outside of the emergency department should do so; this group includes those who abuse the emergency department and those who use it as their primary care system. They should be able to find an alternative, which is a better way to get primary care. Emergency departments are not designed for primary care, do not offer continuity, and are often staffed with physicians who are not geared to give primary care.

People come to the emergency department because healthcare systems do not give them a justifiable and satisfactory alternative to getting care, but that doesn't mean we should accept this status quo. We should work hard to reduce the demand for emergency care and return the emergency department to its original purpose.

Dr. Grazier: *That is a very complex situation; it seems to me you would have to attack it from so many dimensions. From the insurance standpoint, it is probably cheaper to go to the emergency room and pay the $50 copay.*

Dr. Altman: It is complex. The managed care world got blasted in the 1990s for being draconian in their payment or nonpayment of emergency care claims. They basically said, "If we find that you didn't need to be there, we won't pay for it." I can understand the backlash, because that policy may have been too strong. On the other hand, emergency departments charge the insurance companies significantly more money for providing the same care that is given in a primary care setting. They do more services—perform extra tests and procedures and provide linkages to a primary care physician—because they have had no experience with the person.

Unless the emergency care links back to a primary care or secondary care system, it is very episodic. The experience itself is not pleasant, often involving very long waits and repetition of tests that the person may just have recently undergone. Many emergency departments channel people who have insurance to some form of semi-emergency care. That is the right thing to do.

Dr. Grazier: *Do hospitals have solutions?*

Dr. Altman: Yes and no. Yes in that hospitals can develop alternatives to emergency departments that can handle these types of patients, are less expensive, and offer a more humane setting and continuity of care. No in that hospitals are reasonably well paid for part of the emergency care they provide, so they are reluctant to lose the patient who has insurance. They want to keep these patients within their system, but out of their emergency departments. By providing an alternative, this situation could be a win-win: The hospital can keep the patient, but it does so in a different and more appropriate care setting.

Dr. Grazier: *Do you look back to your experience in the 1960s and 1970s, when there were mandated health systems planning and certificate-of-need regulations, and say, "that system wasn't such a bad idea after all"?*

Dr. Altman: It wasn't such a bad idea, but it had negative aspects. It was bureaucratic and hostile, and it made a lot of money for consultants and lawyers. There is also the question of whether it was really effective in controlling spending in the long run. Often, the decisions of the planners were overruled by the political system. Healthcare generates lots of jobs; it is much harder for powerful interests to fight against the market. It is true that markets have their limits, and they can generate situations that are not good for society as a whole—for example, closing a hospital in a poor neighborhood where the ED is the sole source of care. Unfortunately, in many instances today, we have neither well-functioning markets nor systemwide planning.

Dr. Grazier: *Is the current healthcare system sustainable?*

Dr. Altman: People ask me this question a lot, and my answers are pretty equivocal. When I started in this business, I was told that if we spent 8 percent of the gross domestic product (GDP) on healthcare, the system would have to be

curtailed. Healthcare spending is now up to 16.5 percent of the GDP, but the lights have not gone out. We have problems now that are similar to those we had in the 1980s: Too many people are uninsured, and raising money to fund our needs is difficult. The United States is very rich, so I don't know at what level of spending that we would "hit the wall" and force a real cut in spending.

I see no major signs that we have reached that level however, so at least for now our system is still sustainable. On the other hand, 16.5 percent of the GDP or $2.2 trillion is a lot of money, and current studies on spending growth suggest that the healthcare system could have a "brown out." The system is not going to go bankrupt, but if the number of people covered by private insurance continues to fall, and we are unwilling to expand coverage under Medicaid and Medicare, then healthcare providers are going to face a larger and larger amount of uncompensated care. As providers try to pass these extra expenses on to private insurance, the negative cycle will continue. Private insurers will not stop paying, but they will try to pass more of the costs to their insured. Therefore, to break this cycle, it is in all of our best interest to find ways for the healthcare system to work more efficiently, to provide needed care, and to eliminate unnecessary care.

Dr. Grazier: *Some researchers are addressing these questions, and some practitioners are trying to deal with the realities of implementing these research findings. How can we bring together these two groups and their respective work in such a way that the healthcare system can become more sustainable?*

Dr. Altman: One thing the government needs to do is develop mechanisms for doing cost-effectiveness studies—comparative analysis of what works and what does not. Right now, piecemeal work is out there, which often does not directly tie into reimbursement. One question is whether the government will play a bigger role in research beyond what it does through its small and vulnerable agency, the Agency for Healthcare Research and Quality.

Dr. Grazier: *For hospitals, are the researchers asking the right questions?*

Dr. Altman: I think so. The study done on catheterization and angioplasty was really incredible, but too few of such studies are being conducted and many are not funded adequately. For every $1 we spend on research, we spend $100 on new techniques and new drugs. This is a 100 to 1 difference; a little more balance would help.

Dr. Grazier: *The key to sustainability may be a matter of getting to that balance.*

Dr. Altman: I am not in favor of a radical change in our healthcare delivery and financing systems; I don't think Americans would tolerate it. We have some good in our healthcare system, but we can't be complacent that what we are doing is the right thing to do. We need the government to be a bigger player in the system, but not to dominate. Most Americans are nervous about the government getting too involved, but it must get more involved—both in providing coverage to those who cannot pay for healthcare and in funding the generation of knowledge that will help make our system work better. The alternative is not acceptable to anybody.