VIEWPOINT

Salve Lucrum: The Existential Threat of Greed in US Health Care

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In the mosaic floor of the opulent atrium of a house excavated at Pompeii is a slogan ironic for being buried under 16 feet of volcanic ash: *Salve Lucrum,* it reads, "Hail, Profit." That mosaic would be a fitting decoration today in many of health care's atria.

The grip of financial self-interest in US health care is becoming a stranglehold, with dangerous and pervasive consequences. No sector of US health care is immune from the immoderate pursuit of profit, neither drug companies, nor insurers, nor hospitals, nor investors, nor physician practices.

Rapidly increasing pharmaceutical costs are now familiar to the public. Pharmaceutical companies have used monopoly ownership of medications to raise prices to stratospheric levels, and not just for new drugs. Flaws in US patent laws leave loopholes allowing profiteering drug companies to gain control of some simple and long-known medications and to raise prices without constraint. Eye-popping prices for new, essential biological and biosimilar drugs, enabled by the failure of any serious drug price regulation, have yielded enormous profits for drug companies even though much of the basic biological research funding has come from governmental sources.

Particularly costly has been profiteering among insurance companies participating in the Medicare Advantage (MA) program. Originally intended to give Medicare beneficiaries the choice of access to well-managed care at lower cost, MA has mushroomed into a massive program, now about to cover more than 50% of all Medicare beneficiaries and costing far more per beneficiary than traditional Medicare ever has.[1] By gaming Medicare risk codes and the ways in which comparative "benchmarks" are set for expected costs, MA plans have become by far the most profitable branches of large insurance companies. According to some health services research, MA will cost Medicare over $600 billion more in the next 8 years than would have been the case if the same enrollees had remained in traditional Medicare.[2] Opinions differ about whether MA enrollees experience better care and outcomes than those in traditional Medicare, but the weight of evidence is that they do not.

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Hospital pricing games are also widespread. Hospitals claim large operating losses, especially in the COVID pandemic period, but large systems sit on balance sheets with tens of billions of dollars in the bank or invested. Hospital prices for the top 37 infused cancer drugs averaged 86.2% higher per unit than in physician offices.[3] A patient was billed $73 800 at the University of Chicago for 2 injections of Lupron depot, a treatment for prostate cancer, a drug available in the UK for $260 a dose.[4] To drive up their own revenues, many hospitals serving wealthy populations take advantage of a federal subsidy program originally intended to reduce drug costs for people with low income.[5]

Recent *New York Times* investigations have reported on nonprofit hospitals' reducing and closing services in poor areas while opening new ones in wealthy suburbs and on their use of collection agencies for pursuing payment from patients with low income.[6] The Massachusetts Health Policy Commission reported in 2022 that hospital prices and revenues increased during a decade at almost 4 times the rate of inflation.[7]

Windfall profits also appear in salaries and benefits for many health care executives. Of the 10 highest paid among all corporate executives in the US in 2020, 3 were from Oak Street Health, and salary and benefits included, reportedly, $568 million for the chief executive officer (CEO). Executives in large hospital systems commonly have salaries and benefits of several million dollars a year.[8] Some academic medical centers' boards allow their CEO to serve for 6-figure stipends and multimillion-dollar stock options on outside company boards, including ones that supply products and services to the medical center.

Avarice is manifest in mergers leading to market concentration, which, despite pleas of "economies of scale," almost always raise costs. That is what is happening as hospital consolidations proceed largely unchecked in many urban markets[9] and as physician practices are purchased by for-profit firms. Mergers, acquisitions, and public offerings have been occurring throughout health care, often at valuations that defy logic. Oak Street Health, an innovative primary care company that employs physicians and plays heavily in MA, had a $15 billion initial public offering in 2022, equivalent to $196 000 per patient in their panel.

Profit may have its place in motivating innovation and higher quality in health care, as in any industry. But kleptocapitalist behaviors that raise prices, salaries, market power, and government payment to extreme levels hurt patients and families, vulnerable institutions, governmental programs, small and large businesses, and workforce morale. Those behaviors, mostly legal but nonetheless wrong, have now accumulated to a level that poses an existential threat to a sustainable, equitable, and compassionate health care system.

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For individuals, the costs can be extremely painful.

A total of 41% of US adults, 100 million people, bear medical debts. One of every 8 individuals owes more than $10 000. In Massachusetts, 46% of adults say they skip needed care because of costs. As of 2021, 58% of all debt collections in the US are for medical bills.[10] Health insurance premiums in Massachusetts have gone up more than 200% in 2 decades and now cost more annually per family than a car. People of lower income must choose high-deductible plans; they cannot afford more complete coverage. In no other developed nation on earth is deep medical debt as present a threat as in the US.

Greed harms the cultures of compassion and professionalism that are bedrock to healing care. Health care executives and board members who know better nonetheless feel compelled to play the games of pricing, acquisition, and revenue maximization that others do. Professionals find themselves trapped in record keeping, coding behaviors, and productivity imperatives that belie the reasons many went into health care in the first place. "Moral injury" is the harvest, with demoralization and disengagement to follow.

US health care costs nearly twice as much as care in any other developed nation, whereas US health status, equity, and longevity lag far behind. Unchecked greed is not the only driver of that failure, but it is a major one. Few, if any, other developed nations tolerate the levels of avarice, manipulation, and profiteering in health care that the US does. *Salve lucrum* is the wrong answer.

What to do about greed? No answer is easy, not least because of the political lobbying might of individuals and organizations that are thriving under the current laxity. The cycle is vicious: unchecked greed concentrates wealth, wealth concentrates political power, and political power blocks constraints on greed.

Perhaps the demoralization of professionals, the conflicted consciences of many executives, and the anger of the public represent potential political energy that, with proper leadership, can become kinetic.

First, health care professionals in all disciplines need to become noisier about the conflict between unchecked greed and the duty to heal. Extortionate drug prices, exploitation of market consolidation, coding games, excessive executive compensation, and promulgation of unnecessary care ought not to be met with silence. Silence is assent.

Second, health care professionals should insist that their guilds and trade organizations demote the pursuit of higher payment among their priorities. They should insist that resources flow to the neediest in our society. The protection of patients—all patients—is the first and highest calling, and that includes protection against onerous medical debt and bankruptcy.

Third, health care leaders and professionals should lobby Congress to pass legislation to rein in greed. Reforming patent laws, changing coding and billing rules, strengthening antitrust enforcement, expanding price transparency, and accelerating global budgets for the care of populations are agendas that have languished without strong action in Congress for years because the money of incumbents drowns out the greater public interest.

Fourth, health care professionals should insist that their organizations invest actively in improving the true social influences on health. America's hospitals should bring a fair share of their resources to mitigating the actual causes of illness, injury, and disability.

The glorification of profit, *salve lucrum,* is harming both care and health. Health care should not be an engine for excessive private gain.

ARTICLE INFORMATION

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