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Prologue: Over the past decade, America’s private corporate community has devoted increased attention and resources to efforts at modernizing the growth of its expenditures for the health insurance of its employees and retirees. In this issue of Health Affairs, a new survey of America’s corporate chieftains documents that these health-related subjects are very much on their minds, as are notions about pursuing major reform of the health system. One chief executive officer who has thought a lot about these issues is Paul O’Neill, a former high-ranking federal government official who assumed command of the Aluminum Company of America (Alcoa) in April 1987. In this interview, O’Neill expresses fear that the United States is headed inexorably down a road of developing a federally dominated national health insurance scheme, which he believes would result in a diminished system of care. Instead, O’Neill favors the imposition of a requirement on every citizen to purchase basic health insurance coverage, the cost of which would be treated as a tax credit, with public subsidies for people without the means to pay. O’Neill’s vision is similar to that proposed by Mark Pauly and his colleagues in this issue of Health Affairs. Other interesting views he expresses include a belief that private insurers should move back toward “societal rating systems or community rating systems,” and that American business is fooling itself when it concludes that private enterprise has the potential for doing a better job of controlling health and medical care cost inflation than does the federal government. O’Neill is a highly respected figure whose services President Bush sought for a Cabinet post. The timing was wrong for O’Neill, who at that point had only been Alcoa’s chief executive for a short period. Instead, he agreed to chair the President’s Education Policy Advisory Committee.
The Growth Of Social Legislation

Q: Mr. O'Neill, you departed government as a highly regarded executive in the president's Office of Management and Budget (OMB). During your tenure there, your responsibilities included the development and oversight of federal health and medical policy as seen through the eyes of, if you will, the nation's chief executive officer. Speak, if you would, to the philosophy that guided you in discharging your responsibility in this regard.

A: I joined what was then called the Bureau of the Budget in January 1967 and stayed for a decade through some very interesting, tumultuous times. When I left, I was deputy director, so my responsibilities encompassed most everything in the government in one way or another. I was hired to help in the development of “planning, programming, and budgeting” (PPB) in the domestic part of government. Lyndon Johnson had decided PPB had served him well in Robert McNamara's Defense Department, and he asked Charles Schultz, who was then budget director, to implement this management concept in the domestic agencies. My first assignment was to build a conceptual structure within which we could think about government activities in health, medical care, and other domestic realms. Before 1965, the government's principal involvement in health/medical care was in the direct delivery of services through the Veterans Administration (VA), the Defense Department, and the Public Health Service. The landslide legislation period of Lyndon Johnson's “Great Society” changed the federal role in health care in a dramatic way, shifting the emphasis from direct delivery of care to financing mechanisms—Medicare and Medicaid. Because the Medicare and Medicaid legislation emerged quickly and was supplemented with other new policy thrusts involving health manpower and a huge expansion of biomedical research funding, there wasn’t much of a conceptual structure for thinking about these things. So I was striving to create a framework within which we could make judgments about the role of the federal government in health care at the same time that that role was being expanded in a dramatic fashion.

Q: Were you then of the view that it made sense to leap into these new activities that took the federal government far beyond its previously limited role around direct delivery of care?

A: I don’t ever remember sitting down and thinking about the subject as clearly and crisply as your question suggests. It is important to remember that the federal leap into health and medical care was only a part of the federal leap into every aspect of our society. The names of the programs illustrate the point: Manpower Development and Training Act, Elementary and Secondary Education Act, Law Enforcement Assistance Act,
Model Cities, New Communities, Urban Renewal, Food Stamps, Legal Services, Economic Development Administration, Rural Development, Child Nutrition, Environmental Protection Agency, National Endowments for the Arts and Humanities, Small Business Administration—more than 1,000 programs in total by the mid-1970s.

As I studied what we were doing in health and medical care programs, it became clear to me that we lacked a systematic set of goals and objectives. In the absence of goals and objectives, it wasn’t possible to have a rational allocation of resources.

Q: During your tenure, you became closely identified with a number of controversial policies. Which do you recall most vividly? Please explain your reasoning.

A: During my tenure, there were major battles over proposals to (1) consolidate categorical programs into special revenue programs; (2) target food stamps, child nutrition programs, and school lunch benefits to low-income people; (3) replace the traditional welfare programs with the so-called Family Assistance Program; (4) reduce or eliminate the Legal Services Program, Model Cities, Urban Renewal, and subsidized housing under Sections 235 and 236; (5) close Public Health Service hospitals; (6) close the Office of Economic Opportunity; (7) eliminate veterans’ benefits for those who suffered no economic impairment; (8) create a new agency for consumer protection; (9) create funding support for health maintenance organizations (HMOs); (10) close down the Hill-Burton subsidy program for hospitals; (11) enact catastrophic health insurance; (12) challenge the traditional peer review system for National Institutes of Health (NIH) grants; (13) create a swine-flu immunization program; (14) create a framework for dealing with court-ordered school busing; and (15) impound significant amounts of appropriated funds. This is a short list of the major domestic battlefields of the times. I have vivid recollections of all of these and many more.

Q: I also recall that during your stewardship at OMB you became concerned about the crazy-quilt nature of the federal/state Medicaid program.

A: Yes, very much so. I became concerned and remain concerned about fundamental questions of equity that derive from the structure of Medicaid. Given its divided (federal/state) structure of financing, policy making, and administration, the scope and availability of Medicaid are wildly different from state to state. This, it seems to me, is inherently unfair. I believe that when we collect federal taxes from the general population and then say we want to help low-income people to get health care, we ought to provide uniform access across the nation.

Q: Your comments suggest that federal health policy evolved quite incrementally and chaotically, without a grand plan. Is this in the nature of democracy,
American-style, that we cannot set out broad policy objectives and pursue them?
A: Surely, no one would claim that our current situation is a consequence of a grand plan. Rather, it is the result of rampant, well-intentioned incrementalism. I do not believe this is an inescapable “natural” function of democracy.

Q: Generally speaking, then, you don’t believe that such programs are either a better or a worse value for the American taxpayer than, say, the investment in defense or transportation, public assistance or education?
A: I believe the lack of an agreed-upon social compact is a problem not only in health care, but also in education, which is another subject that I am deeply interested in and involved with as chairman of the president’s Education Policy Advisory Committee. It is interesting to see the parallels. We don’t agree on what children should be able to achieve at any particular age in their educational development. We have a thousand different notions of what the educational standard should be, but not an agreed-upon standard. As a consequence, it is very difficult to develop a targeted resource allocation strategy against which you can measure progress. This situation stems in part from our general suspicion of federal intrusion and domination and our wanting to keep decisions at the local level.

International Comparisons

Q: You are the chief executive officer of Alcoa, a worldwide company that operates in a variety of nations with different health care systems. It’s probably not a subject you dwell on in your travels or in your responsibility as chief executive, but has Alcoa noted a qualitative difference in the health systems of the countries in which you operate? For example, is it less expensive to protect employees in Germany or France or in a country with a national health service than it is to protect them in the United States? Is there a higher level of satisfaction expressed by your American employees than your foreign workers, or vice versa, in relation to the way they are insured for care?
A: It is a good question and deserves some specific research with regard to my own company and other companies that have operations in many nations. It is not possible to draw any lessons from the available information because of differences in demography, health care systems, tax structures, and environmental conditions. It would be a useful research project to take some companies like Alcoa and five others and study the contrasts in how their employees receive and pay for health care in the different countries where they operate.
Health Costs And American Business

Q: You testified before the Joint Economic Committee of Congress in May 1990 on the subject of rising health care costs. In the course of the hearing, it was clear that American business is divided on the question of whether or not these costs, the highest per capita ($2,354 in 1989) in the world, make U.S. companies less competitive in global markets. The Chrysler Corporation witness, Walter Maher, testified that high and rising health costs harm the competitive position of American companies, while you disagreed. What is your opinion on that subject?

A: My view is that health insurance premiums that are paid for by an employer are a part of the employee cost structure of doing business. While we keep an account of health insurance costs and other medical expenses as though they were separable activities, in fact, conceptually, they are all part of the cost of having employees. For example, one could think about providing $25 an hour to an employee in cash or $15 in cash and some part of the remaining $10 for health insurance, and other benefits—pension, life insurance, and so on. But in a business sense, all of these costs must be recovered in the price of the goods and services that are sold by the company. In my view, it is wrong to say that health costs are a principal cause of noncompetitiveness. One could as easily point to the cash portion of compensation and say that’s too high. There is a limit, as a consequence of international competition, to how much human resource costs can go up. It is no longer possible to set prices by adding up all of the costs of doing business and then add an increment of profit to that. But it is wrong to attribute our competitive problems to high health costs.

Q: Let me return to your example and ask you to elaborate on the following. You cited a worker making $25 an hour and you allocated $10 of that amount to pay for fringe benefits. If health costs are rising at an exorbitant rate, then certainly it makes it much more difficult to expand life insurance coverage or pay higher wages. Certainly these high health costs must exert pressure on your negotiations with organized labor over compensation questions.

A: That is correct. The consequences were evident in the battle that took place last year between NYNEX and its unionized workers. NYNEX sought to persuade its employees to accept a reduction in their health insurance coverage. The company was willing to pay their employees more cash than the value of the health insurance benefits they were proposing to take away, but the employees strongly disagreed and ultimately struck over the issue. The company could not convince the employees, because the employees were so concerned about escalating health care costs. You are certainly correct in saying that rising health
costs exert pressure on company/union negotiations over compensation packages.

Q: How is this influencing the thinking of labor unions, at least as you perceive it as a corporate chief executive?

A: Behind the scenes, I think the more thoughtful union leaders are saying to themselves, we’re really becoming bill collectors for the health care providers to the extent that we’re out there insisting on more coverage. It is becoming increasingly clear to organized labor that those rising health/medical care insurance costs are a tradeoff against cash. The leaders are not getting much credit for escalating compensation because it does not show up in paychecks, but rather as increased health insurance premium costs. This trend cannot go on forever.

Assuring ‘Basic Coverage’

Q: During your testimony before the Joint Economic Committee, you made the following statement: “There is a very, very important social policy issue underneath the question that we are discussing [the role of high health costs in the competitiveness of American companies]. That social policy issue is one we have dodged and ducked and done our best to keep off the public table. And that is, does it mean anything at all for a person to be an American when it comes to health and medical care? I think the accumulation of federal health Programs and tax incentives and direct delivery of care is a dodge of the most fundamental issue. I am quite concerned that unless we address the question, what it means to be an American in relation to health insurance protection [is] that we are simply going to keep going down the path of creating [a] federal system of health insurance.” Could you be more specific on that point, particularly as it applies to your proposed prescription for reversing or deflecting the movement toward a federal system?

A: The fundamental issue we have not addressed is the moral and ethical question: What, as a society, are we prepared to provide citizens in the way of access to health care? Another dimension of that same issue is, What are the respective roles of individuals and institutions in our society in assuring access? It would be very useful if Congress would debate these questions. For myself, I believe every American should have access to basic medical care services. As you will appreciate, the difficulty comes in trying to define what it is we mean by “basic.” Most would agree that basic means, at least, acute care services, so we can say no American will die on the steps of a hospital because of lack of financial access. But the problem of defining society’s values becomes more difficult when we ask whether heart transplant surgery should be a basic entitlement for every American.
Let me just register the difficulty of the value definition problem and assert that, whether we like it or not, we now have an operational definition of our society’s values—implicit in our existing programs and ways of doing business.

Q: Specifically, on the question of the respective role of individuals and institutions in relation to the provision of health insurance, are you of the view that health insurance should derive from one’s employment? That is the traditional approach the United States has pursued for workers, but it obviously is leaving millions of employed people without coverage.

A: I do not believe that dependence on an employment-based system is adequate. I believe we should impose a requirement on every citizen to purchase adequate health insurance coverage out of their own funds to ensure that they do not become a ward of society through their own failure to provide for their own basic needs. For those falling below an economic means and assets test, there would be a societywide assistance program to provide them with “basic needs” health insurance coverage.

Q: In other words, you would place a government mandate on individuals, rather than directly on employers, that they protect themselves against the financial consequences of illness.

A: Yes.

Q: Within such a framework, would you favor a continuation of excluding as taxable income the employer contributions for health insurance premiums? As you know, the tax revenue loss of this policy now totals almost $50 billion, thus making it, in effect, the second largest federal health-related program after Medicare.

A: I would change the federal tax system so that employer-paid health and medical care benefits would be counted as income to the individual. This change is not intended as a tax-raising gimmick or a disguised attempt to reduce the total compensation levels paid by employers. To ensure that neither of these outcomes occurs, I propose that the cost of the “basic needs” insurance coverage be treated as a tax credit and employers be mandated to maintain their total compensation levels for individuals—including both cash and the value of existing health insurance coverage. Making these changes would help to reinvolve individuals in deciding for themselves how much insurance they want as a tradeoff to their cash income, while assuring through the mandate of “basic coverage” that they do not avoid their responsibility to the society.

Q: Moving in the direction you advocate, would employers bear a lesser financial burden for providing health insurance to their workers?

A: I don’t believe so, because I don’t think employers are bearing the burden of health care costs now. Because of the way we account for it, most people believe that employers are covering those costs now, but that
is not accurate. That money really belongs to employees and would be provided in cash compensation if it weren’t being provided in health insurance coverage. I don’t think employee compensation costs would go down at all if we made this kind of shift.

Q: Many Fortune 500 companies believe quite strongly that if only they invest enough time and energy into addressing the problems of America’s health care system, they could stem the cost spiral and significantly influence the direction of the system as major private payers of care. Do you subscribe to that view?
A: No, I do not. At the bottom of our problem is an unwillingness to deal explicitly with the underlying moral and ethical issues. We are trying to create a substitute for a price system, and I don’t know of anyone who has done that in a way that works over any extended period of time. The idea that businesses can do a better job of controlling health and medical care cost inflation than the federal government is a folly.

Q: What should companies be doing, then, in your opinion, if you believe that their involvement in these incremental exercises around utilization review and local business coalitions is not achieving much success on the cost containment front?
A: I do believe these activities have achieved some success for individual companies, but they will not stem the tide of cost escalation for society, and, as a consequence, there will be increased pressure to move toward a federal system. I think the experience of England makes the point that even a federal system does not solve the problem, because when you study that country’s experience, it’s clear they have created their own rationing system.

The Federal Government Role

Q: What is the legitimate federal role, in your opinion, as it relates to financing care and other health-related issues?
A: There are important responsibilities that the federal government has not addressed adequately in the past ten to fifteen years. They have to do with research and analysis: seeking a better understanding of what works and why it works, and which providers deliver better value. The federal government has not sponsored enough of that kind of work. I believe that the likely benefits are of sufficient interest to the whole of society that they clearly should be an object of federal responsibility and funding.

Q: The federal government already has an enormous investment in the health care system, spending about 12 percent of its budget for this purpose. But on the question of making the system work better—reforming it, if you will—presidential leadership has been in short supply, in this and previous administrations. What will it take to turn the head of the White House on this subject?
A: That is difficult. I am not very optimistic that policymakers will do
anything as fundamental as what I have suggested. The reason is that we
have gone so far down the road toward federalization that reversing these
notions now seems to be a remote possibility. Even well-informed groups
take it for granted that there is something natural about employer-funded
health insurance. Even employers who currently don’t provide health
insurance to their employees feel they have an obligation to do so when
they can afford it. If I had to forecast the flow of events over the next
twenty years, I would say we will have more and more federal involvement
and regulation. It is conceivable to me that we could get to the point at
which providers will be working for the federal government to the degree
that we regulate their annual incomes. I think we have already demon-
strated that regulating specific fees doesn’t work very well. That should
not be a surprise. If you look at our experience with wage and price
controls under President Nixon, it is obvious that for any regulatory
scheme that the human mind can invent, another mind can figure out a
way to repackage the goods to get around the regulation.

Q: But you seem to suggest that your corporate colleagues could well be on that
federal bandwagon moving toward a more centralized system.

A: I divide American business into two groups. One group would support
the federal assumption of responsibility for health and medical care. That
view is based on the projection of the health financing obligations they
have for their work force and the tenacity with which employees are
holding onto those obligations. Business people in this group believe that
by transferring their obligations to society, the cost for their firm would
be reduced. A second group of companies are frustrated with the ever-
rising health costs, but they have not thought very deeply about the
subject. Many of these firms are working hard to reduce current health
insurance obligations to active workers and their retirees by scaling back
benefits and increasing cost-sharing requirements. Some of these compa-
nies would also welcome an opportunity to unload the responsibility to
some other level of society.

Q: What is Alcoa’s philosophy toward the provision of health insurance
protection for its work force? In your testimony before the Joint Economic
Committee, you said: “I think my own firm is quite good at making alloys for
aircraft parts and for making aluminum beverage cans, but I don’t know why
everybody thinks we have some special angle on the ability to intervene in what
is perhaps the most personal of all purchase decisions, namely, the consumption
of health and medical care.”

A: We have an obvious, ongoing responsibility to our employees, and we
will continue to provide first-class health insurance coverage to them.
But I don’t hold out any hope that companies, be it Alcoa or any other,
can effectively curb society's health costs. Let me put it another way. An employer or an insurer would have to be in the doctor's office with a patient/employee at the time when a decision is being made, to have much influence on what is being consumed. Obviously, that is not going to happen, because medical treatment involves a very personal set of decisions between the consumer and the provider as to what should be done in the abatement of pain or the improvement of health status. So payers are at arm's length; we're not dealing with the consumption decisions in any real way.

**Competition And Insurance**

Q: In most other Western industrialized nations, the insurance function is a not-for-profit function. In the United States, this function is carried out both by the not-for-profit network of Blue Cross and Blue Shield plans and by large and small commercial carriers. What is your view of this diversity in relation to the broad societal goals of universal access and affordable costs?

A: I think competition among providers of administrative services can help to constrain administrative costs. Some organizations are better than others at deploying resources and training people and providing the essential administrative functions of insurance. In that sense, there is great benefit to private health insurance systems. On the other hand, I am concerned that insurance companies, in order to protect themselves and their own viability, are moving in the direction of rating the people they insure on the basis of each individual's medical experience. That is, rather than spreading the risk across populations, insurers base health insurance premiums increasingly on individual health status—thus defeating the purpose of insurance in the first place. I believe in the idea of spreading the risk of illness across society, because illness is a random event that can strike anybody. I would like to see the United States move back toward societal rating systems or community rating systems. I am not sure how broad the community definition needs to be, but this is the direction in which I believe we should head. I suspect that if we community rated on a regional basis we could still have private insurance companies that competed on the basis of the efficiency of administrative processes. I do not believe that the current trend of insurance companies' becoming ever more selective will survive over the long run.

Q: In your congressional testimony, you were quite up front about the central role that cost shifting plays in Alcoa's approach to trying to constrain the growth of its health expenditures. You testified: "As long as we are confronted with the current system, I am going to see that we do our best in shifting everything we can away from us because it's the only thing we can do." Putting your public
policy hat on, what is your view of the cost-shifting phenomenon? For instance, should government, as the collective voice of our society, wield its powers to either minimize cost shifting or make it illegal? That, of course, would mean that the chief cost shifter, the government itself, would have to abandon this practice as well.

A: In the existing system, there is no way to avoid cost shifting. When a corporation like Alcoa seeks bids from providers, we are rewarded with a lower cost. To the degree that a large employer is able to negotiate preferred arrangements that do not cover full costs, providers must charge other patients more for the same service. When I spoke of our efforts to cost shift, it is this phenomenon that I had in mind.

The Future Of The U.S. Health Care System

Q: I find it fascinating that someone with the breadth of your experience and perspective holds so strongly to the view that the United States is on this inexorable path toward a federally dominated system of health insurance, even though we might not reach that point for a decade or two.

A: It is a view that comes from watching the development of social policy over the past thirty years and from listening to politicians. I don’t hear any politicians telling the people that the federal government can’t give them anything that it doesn’t first take away from them. So long as politicians promote the idea of the “free lunch” and people buy it, we’re going to continue to move toward a federalization of our health care system.

Q: In conclusion, you are a member of the Quadrennial Advisory Commission on Social Security, which is a very diverse group of individuals. Does the commission have any real hope of achieving a consensus on a package of health policy reform proposals?

A: I think the quadrennial review commission will identify perhaps three different ideas for consideration by the Health and Human Services secretary and the president about how to proceed with thinking about health and medical care. The ideas that I have been suggesting will likely represent one of those bodies of ideas. A second proposal will likely revolve around an expansion of the Medicare model—social insurance on a broader scale. A third option may be a continuation of our current momentum toward mandating health insurance protection in the non-federal sector. At this time, neither a commission as diverse as this one or, for that matter, society as a whole is likely to achieve consensus on any one of these approaches.