This Year's $72 Billion in Health Spending in Massachusetts Is Enough to Finance the Care that Works

Proposals to Simply Bundle Payments to Hospitals and Doctors for Individual Episodes of Care, While Reasonable and Well-intentioned, Are Not Likely to Contain Costs

Alan Sager, Ph.D.
Professor of Health Policy and Management
Director, Health Reform Program
Director, M.P.H. Program in
Health Policy and Management
asager@bu.edu 617 638 4664

Deborah Socolar, M.P.H.
Director, Health Reform Program
dsocolar@bu.edu 617 638 5087

Boston University School of Public Health
715 Albany Street
Boston, Massachusetts 02118

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Co-chairs Kirwan and Iselin, and Honorable Members of the Special Commission—

Thank you for the opportunity to speak with you this afternoon. I speak only for myself and for my fellow Health Reform Program director, Deborah Socolar.

Your “mission is to evaluate the health care payment system and recommend reforms to be used by all payers to provide incentives for cost-effective and patient-centered care.” We offer four main points—

1. With the costliest health care in the world, we already spend enough to win medical security for all in Massachusetts.

2. Most people increasingly agree that health care cost control is essential. At the same time, most people recognize that containing costs is very hard.

Almost nothing tried to contain health care costs in this nation since 1972 has worked—not changes in units or methods or formulas of payment, not competitive market solutions, and not government regulatory solutions.

Other wealthy nations rely on political-financial-clinical negotiations among public and private payers, caregivers, and government to set health care spending levels. It would be difficult to establish the levels of confidence required to support such negotiations in the U.S. U.S. cost controls have failed largely owing to lack of political support. One way to win that support will be to enlist primary care and other physicians on behalf of cost controls that are part of a comprehensive peace treaty that benefits doctors. That same package deal can help to rebuild primary care itself, promote patient-centered health care, and stabilize all needed hospitals.

3. Generally, hospitals make more money by admitting more patients or by providing more intense services. Generally, physicians make more money when they do more for patients. Doing pays doctors more than does listening, thinking, counseling, examining, or diagnosing.

Tinkering with mechanical, partial, and formula-driven solutions like changing units of payment—specifically by merging payments to a certain hospital and physicians during one admission or episode of illness—could be helpful, but won’t do much by itself.

Although they appear to make logical sense, similar steps have generally failed in the United States. Unfortunately, such solutions are prone to gaming and evasion and marginalization if doctors, hospitals, and other caregivers are not enthusiastic about adopting them wholeheartedly and conscientiously.

4. The health care we get depends heavily on the caregivers we’ve got. Delivery of care has to be reformed along with payment mechanisms. The state and nation face an accelerating meltdown of the primary care foundation of our health care. If we don’t move more forcefully to improve primary care and care

coordination, costs will remain high. Past efforts to train more primary care physicians, while well-motivated, have simply not been commensurate with the gravity or severity of the problem.

As well, many needed hospitals have closed throughout the nation, disproportionately hospitals serving black/African-American neighborhoods. Hospitals and emergency rooms that are needed to protect the health of the people of Massachusetts should be identified and assured revenues adequate to finance high-quality care, as long as those hospitals are operated efficiently. It is noteworthy that hospital costs in Massachusetts are highest in the nation even though our bed-to-population ratio is below the national average. Because the very hospitals likelier to close are the ones whose costs are typically lower, no one should imagine that closing more hospitals here will save money.

1. As a nation and as a state, we already spend enough to win medical security for all.

As you know, U.S. health spending per person, projected to reach $8,342 this year, is roughly double the average of the world's wealthy nations.

Those other nations cover all of their people for acute care and most people for long-term care, generally live longer, and are happier with the care they get.

They do so even though they typically smoke and drink more than Americans. They spend less even though their populations are typically much older than our own.

Across wealthy nations, health care's share of GDP correlates closely with GDP per citizen. But U.S. health care spending's share of GDP is much greater than anyone would predict from the inter-nation correlation.

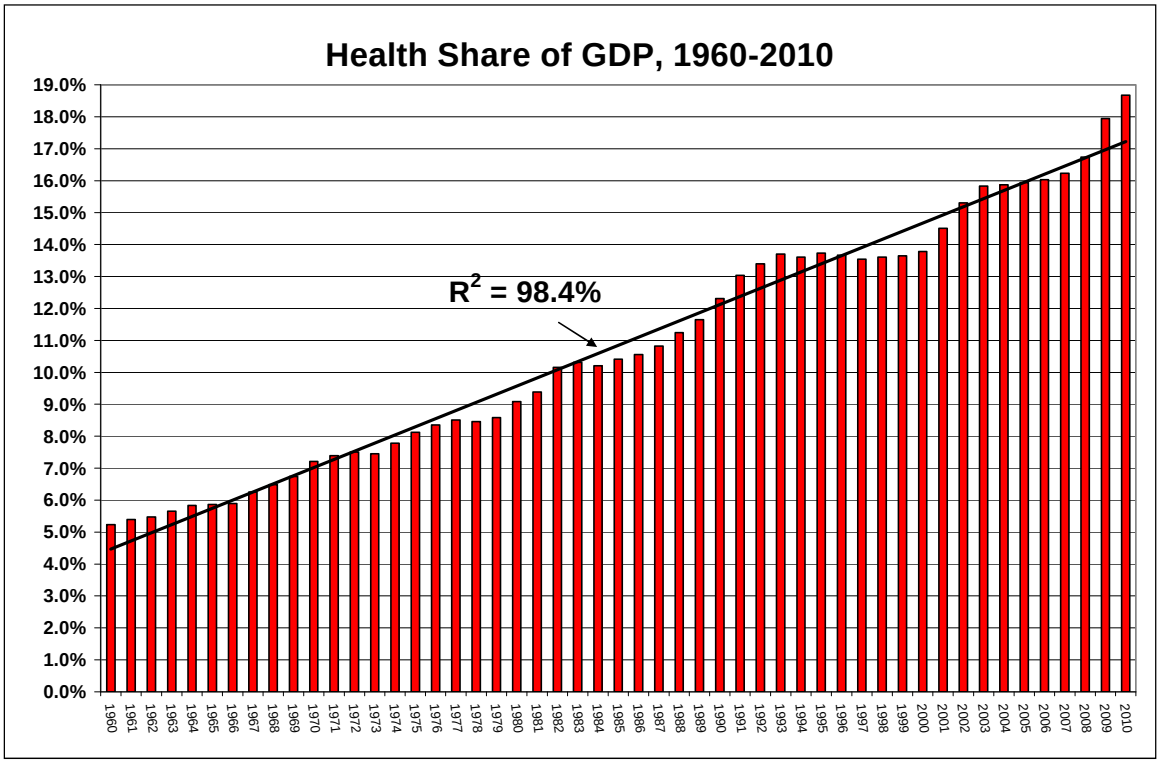
Worse, according to our analyses of the latest projections for U.S. health care spending and for GDP nationally, health care will absorb 18 percent of the U.S. economy this year and almost 19 percent next year. Please see the exhibit that follows.

If we imagine that health care is a car, it is now crashing into a stalled economy, and we are all at risk of being thrown through the windshield. No contingency plans are available, and no effective cost controls are available.

According to the latest accurate numbers from CMS, for 2004, health care spending in Massachusetts per person was one-third above the U.S. average, having risen from one-fifth higher in the early 1980s.[1]

That makes costs in Massachusetts this year about $11,100 per person, or about $72 billion statewide. And there are two new, separate reasons to fear that the Massachusetts excess has risen measurably higher than one-third above the national average spending per person. [2]

This year, if we spent here at the national average, we would save $18 billion, enough to pay the total cost of the Big Dig, and enough to buy two laptops for every school-age child in the Commonwealth, and probably enough—though I am not exactly sure of this—to extend the Green Line to Toronto.



Sources are provided. [3]

Some people will say that we spend more on health care in Massachusetts because we serve many patients from other states, nations and continents—and planets—but those numbers are actually very small, especially after making offsetting adjustments for Massachusetts residents served in hospitals in Providence, Albany, and other locations.

Other people will say that our state's higher spending buys us better health outcomes—but our age-adjusted mortality rates are almost exactly equal to Utah's, which has the lowest spending per person in the nation, while we spend exactly 75 percent more per person than they do.[4]

People will say all sorts of things, but couldn't we start by agreeing that $72 billion statewide and $11,100 per person should be enough to finance medical security for everyone who lives here?

Medical security means well-grounded confidence that we will get needed, competent, and timely care without having to worry about the bill when we are sick—or about losing our insurance coverage—ever.

2. Why have past efforts to contain costs failed, and why does anyone expect to do better this time?

a. Half of health care spending is wasted but cost controls seldom targeted waste.

b. And cost controls were designed so that any savings would simply diffuse back to payers, like a rainstorm disappearing into desert sand. Payers would enjoy a negative benefit—spending less, but no one would enjoy a positive benefit. In other words, cost controls were not tightly linked to specific concrete benefits for identifiable people—benefits those people would fight for politically. For example, money saved through past cost controls was not targeted to cover specific groups of uninsured people or to better protect under-insured people with specific benefits such as dental insurance.

That is, no one expected a new concrete benefit for anyone. Cost control has languished as an abstract good government principle, on the order of "I really should lose weight."

Under these circumstances, cost control has no strong political constituency. Why should it? There were no important new potential beneficiaries from cost control who could mobilize politically to offset the constant demands of the caregivers, who naturally sought more money for business as usual. That powerful political demand, which is totally understandable and reasonable from caregivers' viewpoints, has been instrumental in defeating or neutralizing many cost control proposals.

c. Caregivers, always closer to the money than other parties, have often neutralized or successfully gamed the new regulations or competition or pricing method.

d. Throughout the United States, very little effective government cost control regulation exists today or is politically attainable today. This contrasts radically with the state of affairs in all other wealthy nations.[5]

There, public and private payers come to general agreement with caregivers about the approximate amount of money to be made available to finance health care services in a given year. In nations with single payers, the agreement is overt and political: government collects taxes and appropriates the specified sum. In nations with multiple payers, representatives of public payers and private sickness funds or other bodies negotiate with hospitals or with doctors.

Either way, a political accommodation is made. It reflects the balance of the political vectors at play.

Given the absence of such a political understanding in the U.S., public regulation resorts to discrete gimmicks or mechanisms or formulas that seem to promise cost controls that are painless or rational. These don't substitute for an effective political consensus. All fail for lack of political support. Viewed another way, caregivers subvert, undermine, or plow under the cost control mechanisms. For example, certificate of need is an interesting theoretical barrier, but, over the decades, politically powerful caregivers drove through it like an 18-wheeler through a paper billboard along a highway.

Certificate of need is a very useful and reasonable way to help implement a prior political agreement (among governments, payers, caregivers, and patient advocacy groups) to contain health care costs but, absent such political agreement, it is a frail mechanism. It does not by itself change much.

e. Nothing close to a functioning free market exists or is attainable in health care—except for eyeglasses and contact lenses (and maybe generic meds). So market forces can't successfully rein in health costs.

After the state deregulated hospital payments in 1988 and 2001, in hope that hospitals would compete, some hospitals closed and some survivors merged. The merger between Mass. General and the Brigham, for example, won official acquiescence (without even a public hearing), promising to save hundreds of millions of dollars through greater efficiency, but never offering even a hypothetical spreadsheet to show how their imaginary savings were calculated. In reality, these hospitals merged to win market power that would allow them to raise prices—as our Program warned in 1994. [6]

More generally, looking across 52 of the nation's cities over the past seven decades, hospitals that survive tend to be no more efficient than those that close.

Were a freely competitive market present, the more efficient hospitals would be likelier to survive and the less efficient would be likelier to close.

f. The desperate belief that price competition can cure health care cost problems has inspired efforts to push patients to get and use information about different caregivers' price and quality.

This is very difficult to do and also probably not worth it. First, imagine that you could collect valid information about price and quality. Second, imagine you could somehow coerce patients to read, assimilate, and use that information about where to seek care. Even then, you still would not address the important question, which is not where to get the CT scan or the knee surgery, but whether that care is needed to diagnose and treat the patient effectively and efficiently.

After all, today, half of all patients leave their doctor's office without understanding what their doctor has just told them, and half don't take their medications as prescribed. [7] And 70 percent of Americans are unable to name either of their two United States senators.

To define the nation's 300 million patients as health care consumers is largely a heroic and ideological leap of folly. It willfully ignores both medicine's complexity and the laws that allow only about 900,000 physicians, graduates from medical or osteopathic schools, to diagnose, perform surgery, and prescribe drugs.

Why would advocates of competition rely on patients rather than on physicians? Probably because they believe it is easier to mobilize patients than to change doctors. But if patients can't be mobilized as informed consumers and if doing so would not contain costs in any case, changing doctors' behavior must be attempted.

This is not a trivial matter. Because both competent government regulation and functioning free markets are absent from U.S. health care, anarchy prevails. It is pervasive anarchy in U.S. health care that explains soaring costs, declining coverage, uneven quality, and comprehensive lack of responsibility and capacity to address any of these problems.

g. Doctors have been squeezed on fees, manipulated or marginalized, or outright ignored by past attempts to contain costs through regulation and competition. Far from being centrally and positively involved in past cost control efforts, physicians have been generally alienated and excluded.

In retrospect, this has been silly for at least two big reasons.

First, doctors' decisions essentially control some 87 percent of personal health care spending—services and goods received by individuals. This 87 percent includes doctors' own gross incomes; spending on hospital care, which only physicians can provide or authorize; spending for prescription drugs, which only physicians can prescribe; spending on nursing home and home health care, which physicians generally must authorize; a share of durable medical equipment, and similar items. Dental care, over-the-counter medications, and other items not under doctors' control are excluded from that 87 percent. (Personal health spending itself constitutes roughly 83 percent of total national health expenditures.) [8]

Second, cost control efforts to squeeze out clinical waste are essentially a retail job, patient-by-patient, lab test by lab test, imaging study by imaging study, specialist referral by referral, surgery by surgery, med by med.

Squeezing out this waste requires the active, motivated, positive, and even enthusiastic involvement of individual physicians.

Financial incentives might help. Desire to do more clinical good with today's vast resources will help also. Professionalism will help. So will better information about which patients really need which care, and which care is really worth the money.

3. Generally, hospitals make more money by admitting more patients or by providing more intense services. Generally, physicians make more money when they do more for patients. Doing pays doctors more than does listening, thinking, counseling, examining, or diagnosing.

Tinkering with mechanical, partial, and formula-driven solutions like changing units of payment—specifically by merging payments to a certain hospital and physicians during one admission or episode of illness—could be helpful, but won't do much by itself.

Although they appear to make logical sense, similar steps have generally failed in the United States. Unfortunately, such solutions are prone to gaming and evasion and marginalization if doctors, hospitals, and other caregivers are not enthusiastic about adopting them wholeheartedly and conscientiously.

It is helpful to appreciate that doctors in other wealthy nations—that cover all people and live longer while spending half of what we do—are generally paid fee-for-service (where fees are set to achieve a target income for a productive physician) or salary, and hospitals are generally paid by budgets or per diems or other arrangements.

But aggregated payments to hospitals and doctors together are rare, experimental, and not yet well-evaluated. So why should they be expected to make a big difference here?

Other nations have shown that large-scale reforms—reforms that win substantial improvements in coverage or that contain costs—generally require doctors' enthusiastic support or at least their peaceful and trusting acceptance.

Back in the U.S., today, many doctors are angry and may not be particularly inclined to cooperate with payers or hospitals to change their behaviors and marshal and allocate the new aggregated payments in ways that save money without harming patients—and without harming doctors' own incomes.

Today, some doctors are angry about the paperwork they must complete to get paid. Other doctors are frustrated by the different insurers' rules about what care is covered, about the financial burdens that patients will face, about which caregivers are in which networks, and other barriers to securing proper care for their patients. Still other doctors are afraid of being sued for malpractice. And fearful people usually get angry after a while.

To address these problems, five general approaches or principles for reforming payment are worth considering.

a. **A peace treaty with doctors**. Since doctors essentially control some 87 percent of health care spending, as just discussed, the challenge is to put the money in their hands under arrangements that allow us to trust them to spend the money very carefully to care for all of us—arrangements that we craft with them, and that they embrace happily.

Effective health care cost control in the United States must, for the foreseeable future, be a retail job. Doctors are the only people who can perform that job, so they must be asked to carefully spend today's vast but still-finite health care resources.

Many doctors will say yes to that request and embrace reform happily if it eliminates the threat of being sued, if it eliminates or radically slashes payment-related paperwork, if it liberates physicians to use the best available evidence to spend money effectively on behalf of patients, and if—for primary care physicians—it boosts incomes substantially. (To address the nation's shortage of primary care physicians, as will be discussed below, it is essential to substantially narrow the wide and growing income gap between most primary care doctors and most other doctors.)

This approach addresses cost and coverage in ways that change health care politics. It cuts waste to contain cost and recycles savings to protect people who are uninsured or under-insured today. And it mobilizes many physicians on behalf of reform because it radically and tangibly improves their professional lives.

b. **Malpractice litigation fails at both of its jobs, so it should be eliminated**. One of the provisions of a health care peace treaty would be an end to malpractice litigation.

Malpractice today is like a heavily-drinking person at a party who tries to sit down but falls heavily between two chairs. Malpractice today does a terrible job of identifying, re-educating, or extruding dangerous doctors. And it does an equally terrible job of fairly compensating victims of medical error or other harm suffered in the course of diagnosis and treatment.

These two jobs are very different. They should be separated and each should be addressed by distinct tools. For example, compensation through litigation should be replaced by a combination of universal coverage of health care costs to pay for initial and restorative care, no-fault insurance to finance lost earnings, and a new mechanism to decide on compensation for pain and suffering.

c. **End payment-related paperwork**. Another provision of the health care peace treaty would be the elimination of almost all payment-related paperwork. How can that be done?

Several approaches to eliminate payment-related paperwork have been proposed or can be imagined. One is single payer. Another is to require billing by standardized electronic forms. Here, we suggest a different approach, one stemming from our views of the two causes of administrative waste.

Complexity is an important cause of administrative waste in health care. It stems from the need to determine who is eligible for what services, provided by which caregivers under what circumstances. Allowing hundreds or thousands of plans, eligibility categories, covered services, networks of doctors and hospitals, formularies, and other variations makes for an administrative sickness that plagues both patients and their caregivers.

But as bad a mess as it is, the greater source of payment-related paperwork is probably mistrust. In the U.S., in the absence of reasonably simple, politically negotiated caps on spending, payers seek to trim costs by finding ways to withhold payment from caregivers. Doctors and hospitals seek creative ways to extract more money from payers.

There are many opportunities. Insurers, managed care organizations, and public programs mistrust doctors and hospitals, and the latter fully reciprocate. Ongoing fights about which services are needed and which are covered, units of payment, coding of episodes of care, unbundling, fairness of fees, payment formulas, and similar matters stem from mistrust and reinforce it.

We call this, death by a thousand paper cuts.

Clearly, payment-related paperwork stemming from mistrust can be slashed only when payers and caregivers essentially trust one another. This requires different thinking about money at different times. Today, too often, doctors and hospitals think about money in the wrong ways and at the wrong times. They think about what care, how much care, and care for which patients, covered by which payers, will benefit them (the caregiver) financially. Doctors rarely act as fiduciaries for the patient, for the payer, or for the public interest in affordable, effective, high-quality care.

In the absence of either competent government or a functioning free market, as described earlier, anarchy prevails in health care. Some naïve free market economists and others hope to overcome anarchy by imposing on health care enough of the requirements for genuine competition. This is impossible but theirs is still a well-motivated (though incompetent and doomed) quest for a health care system that can be trusted to regulate itself. Reliance on the market is doomed. Government cannot competently micro-manage cost control through regulation or through changes in units of payment like bundling of payments to hospitals and doctors for episodes of hospital care.

Therefore, the challenge is to pay doctors (and hospitals) in ways that are inherently trustworthy.

It is helpful to recognize that a competitive free market is not the only mechanism for attaining self-regulating, equilibrium-seeking, and trustworthy health care.

One key to building trust is financial neutrality for doctors so they make decisions on clinical grounds—how to do as much clinical good for patients as possible with the money available. (Financial neutrality signals the absence of financial rewards or pressures from giving more care or less care, or care of various types.) The peace treaty sketched in this statement aims to persuade doctors to act as fiduciaries, not as businesspeople.

A second key is a structure for paying doctors and other caregivers that is inherently trustworthy. This year, some $2.6 trillion will be spent by doctors. When doctors themselves are financially neutral in their clinical decisions about how to marshal finite but vast dollars, and when they are motivated to cut waste to ensure coverage for all people, both patients and payers will have greater confidence that doctors will spend money well.

One specific way to promote trust is by capping revenue available to pay for care. Then, physicians must carefully marshal finite resources. From the standpoints of caregivers and payers, providing more care does not generate more revenue or less revenue for themselves. From the standpoint of patients, caregivers are not motivated to give more care or less care to make more money for themselves. Rather, the only motive is to be able to afford care that offers greater clinical benefit. Patients will need reassurance that the money available will be sufficient to care for all people well. Doctors will be able to provide that reassurance if they believe in the peace treaty's package of reforms.

A second way is to provide adequate and fair amounts of money through risk-adjusted capitation.

A third way is to pay caregivers in ways that make it impossible for caregivers to make more money or less money by providing more care or less care or different care. Instead of relying on financing incentives to squeeze out waste, doctors and hospitals would be paid in fair, adequate, and predictable ways. Decisions about care and its costs are made to do as much clinical good as possible for patients with the money available.

d. **Cost control and universal coverage should mesh smoothly**, the way the accelerator and clutch of a stick-shift car must be worked to manage the gears of the manual transmission. Money saved is retained and recycled to finance services for previously uninsured and under-insured citizens.

e. **Not only large, mandatory, focused, and top-down changes, but voluntary, small-medium, broad, and integrated reforms**. Congress's 1983 switch from cost reimbursement of hospitals to prospective payment by DRGs constituted a large, mandatory, focused, and top-down change.

Instead, we urge consideration of changes that are voluntary for both doctors and patients, that are reasonably small or medium-sized, that thoroughly integrate payment for care with delivery of care, and that are carefully evaluated. One example of this second type of change is sketched in the next section. It will include both bottom-up elements, such as reform of primary care and physician payment, and top-down elements, such as Medicare, Medicaid, and ERISA waivers that allow the money to follow the patients.

4. The health care we get depends heavily on the caregivers we've got. Delivery of care has to be reformed along with payment mechanisms. The

state and nation face an accelerating meltdown of the primary care foundation of our health care.

If we don't move more forcefully to improve primary care and care coordination, costs will remain high. Past efforts to train more primary care physicians, while well-motivated, have simply not been commensurate with the gravity or severity of the problem.

As well, many needed hospitals have closed throughout the nation, disproportionately hospitals serving black/African-American neighborhoods. Hospitals and emergency rooms that are needed to protect the health of the people of Massachusetts should be identified and assured revenues adequate to finance high-quality care, as long as those hospitals are operated efficiently. It is noteworthy that hospital costs in Massachusetts are highest in the nation even though our bed-to-population ratio is below the national average. Because the very hospitals likelier to close are the ones whose costs are typically lower, no one should imagine that closing more hospitals here will save money.

Ultimately, financing and delivery reforms are essential to save money.

One useful step would be to recognize the extraordinary value of good primary care physicians in giving patient-centered care that is coordinated and continuous, and that saves money.

It is a good idea to promise a medical home to each person who wants one. But this benign rhetoric means little without adequate financial and organizational support.

Primary care is dying before our eyes.

Too few physicians are entering primary care, and not always the right physicians.

Many are leaving.

Primary care should be the wide and solid base of the health care delivery pyramid. But today, increasingly, that pyramid is instead balanced on a primary care point. Primary care is being crushed by the weight of demands from the rest of the pyramid.

Charts X and Y on the following page illustrate these views.

Chart X: the traditional health care pyramid, resting on a broad and solid primary care base.

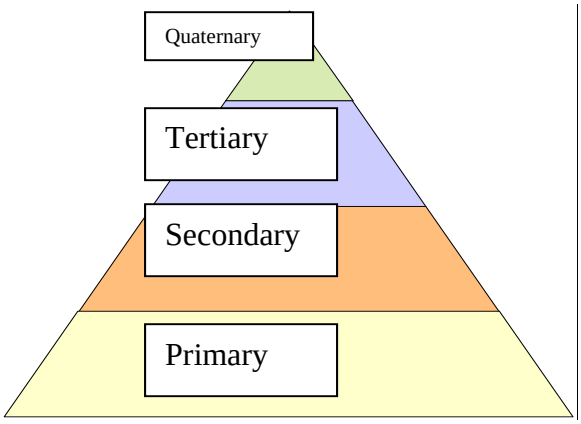
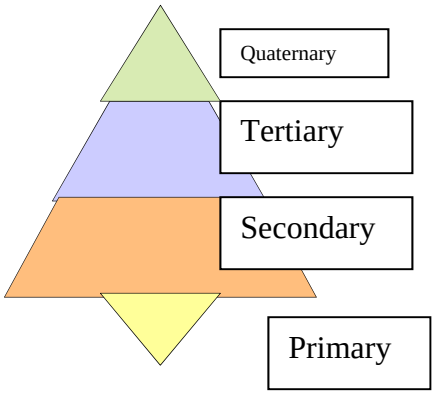


Chart Y: Today's inverted primary care pyramid, in which growing pressure and disruption are imposed on primary care doctors by health care delivery and financing.



In chapter 305 of the Acts of 2008, the Massachusetts legislature took a useful step to increase the supply of primary care physicians by assisting graduates of the University of Massachusetts Medical School with debts if they practice in primary care. But much bigger steps—financial and non-financial—are essential.

The value of tuition debt forgiveness, while large in absolute dollars, is small relative to doctors' earning powers. Please consider that the *average total medical school debt* of about $150,000 today is less than the *difference in one year's average earnings* in 2004 between a primary care doctor and a cardiologist or diagnostic radiologist. That is, in one year, the difference in before-tax income between a primary care doctor and a cardiologist or diagnostic radiologist is enough to extinguish the average medical school debt. [9]

Going back at least a half-century, primary care physicians have been systematically underpaid by non-market forces stemming mainly from peculiar types of private regulation. Years of public responses have been far too weak to

overcome this systematic bias against primary care physicians. And market forces are too weak and scarce to bid up prices—incomes—for primary care doctors.

Shortly, we suggest ways to improve payment to primary care physicians that also contain cost by reducing clinical and administrative waste, thereby freeing up funds to finance equitable and durably affordable care for all Americans.

In other nations, these various functions have long been separated. Essentially all people are covered in all other wealthy nations, using a variety of mechanisms (social insurance, mandated coverage through the job, and other elements). Costs are contained through overt or subtle political negotiations. Caregivers are paid sums adequate to keep them in business by fee schedules, payments per discharge, budgets, and other mechanisms—all generally designed to move agreed sums of money to agreed places. Supplies of specialists are limited through various combinations of residency training slots and salaried positions at teaching hospitals.

In all wealthy nations, primary care doctors' incomes have been raised up toward specialists' incomes. Cutting specialists' incomes has rarely been attempted and has succeeded even more rarely.[10]

Raise primary caregivers' incomes. To attract more of the smartest, kindest, best-trained, and most energetic and personable medical students to primary care, and to Massachusetts, we propose that average before-tax incomes for primary care physicians in Massachusetts be raised to at least $250,000 per year.

We also propose that more primary care physicians be trained to take care of the citizens of the Commonwealth. The higher incomes are necessary to move toward a market-clearing price for primary care doctors.

Please consider that, even if average panel size is dropped from today's 2,000 – 2,500 per FTE primary care physician to 1,000, only 6,400 FTE primary care physicians will be needed to care for the Commonwealth's 6.4 million citizens (6,400,000 people/1,000 people per primary care physician = 6,400). It is worth noting that Massachusetts was reported to have had 8,884 primary care physicians in 2002. [11]

At $250,000 per primary care physician, that would be a total of $1.6 billion annually to pay primary care physicians, or 2.2 percent of this year's health spending in Massachusetts. And $1.6 billion is only about 4-5 months of the coming year's rise in spending here.

If the average Massachusetts primary care physician currently makes $150,000 before taxes now, the average increase will be $110,000 per year, or a statewide increase of about $700 million in spending.

The smaller panel size would allow substantially longer and more relaxed primary care visits, thereby addressing problems now associated with the lack of adequate primary care. These include

- the tyranny of the urgent problem, which can result in deferral or incomplete management of chronic problems; [12]
- doctors' tendency to quickly interrupt patients who are trying to describe their symptoms, worries, or aims (the 23-second rule); [13]
- the ability of only one-half of patients to be able to recall the doctor's main recommendations; [14] [15] and
- the compliance of only one-half of patients with ordered medications.

Just as important, doctors would have the time to engage in shared decision-making with patients, thereby lowering the share of decisions controlled by doctors from the 91 percent now prevailing. [16] Physicians would also have the time to promptly respond to patients' e-mails and telephone calls. Physicians would also have time to assimilate evidence from history and physical exams, lab and imaging results, specialist referrals and hospital notes, and other sources to better diagnose and treat a patient.

This year, 2009, is not a good time to discuss an increase in health care spending in the Commonwealth. We raise this idea for four main reasons.

First, we believe that higher incomes for primary care physicians are one of three key steps to mobilize powerful, enthusiastic, and durable support from primary care physicians and other physicians for effective cost control reforms. (The other two are slashing payment-related paperwork and effectively ending the fear of being sued that engenders costly defensive medicine.)

Together, these three steps will constitute a dramatic change in the professional lives of primary care and all other physicians. They will be three of the provisions of a new health care peace treaty. Physicians will enjoy these three benefits if they are willing to take on the jobs of spending today's vast but finite dollars more carefully, to care for everyone well, by providing or authorizing only needed care and by weeding out clinical waste in diagnosing and treating patients' health problems.

Second, we raise this idea today because we believe that primary care is so important and in such bad trouble, both in Massachusetts and nationally, that much bigger steps must be taken to avoid an accelerating down-spiral of primary

care physician supply. It is essential to work quickly to retain today's primary care physicians and to begin to attract more.

Third, we believe that financially effective and politically acceptable cost control requires much greater reliance on highly-trained, competent, self-confident, energetic, kind, and personable primary care physicians.

Fourth, we believe that a number of voluntary, small or medium-size, and innovative options for care delivery and financing need to be pursued simultaneously to contain costs, sustain universal coverage, and improve appropriateness of care in Massachusetts.

The patient-centered medical home, sketched by Goroll and colleagues, is one such option. [17] It features capitation for primary care only. Goroll and his colleagues propose capitation rates that would be adequate to boost primary care physicians up to the $250,000 level and also enough to hire non-physician primary caregivers to work on teams with physicians. These expanded primary care teams promise to better address patient needs for both chronic care and acute episodes.

We suggest a somewhat different option.

That would be to offer risk-adjusted full capitation through primary care physicians. In this option, capitation rates would average just about $8,000 yearly in 2009 in Massachusetts.

This $8,000 yearly is the share of the $11,100 in this total state's health spending per person in 2009 that is controlled by physicians. We calculate it in this way.

First, 83 percent of total health care spending is devoted to personal health spending; [18] these are the services and goods provided to individual patients, including visits to the doctor, lab work, prescription drugs, or surgery. Excluded are research, construction, government public health activities, and certain administrative costs and profits.	83 percent of total health spending per person of $11,100 = $9,213, personal health spending per person in Massachusetts in 2009
Second, 87 percent of personal health spending is controlled by physicians; this excludes excluding dental care, over-the-counter medications, and the like.	87 percent of personal health spending per person of $9,213 = $8,015, average personal health spending per person that's controlled by doctors

The capitation rate would be adjusted to patients' expected risk or cost of treatment. This would make it unnecessary for physicians to try to cherry-pick inexpensive patients or to dump costly ones.

Primary care physicians who sought to work under capitation would invite their patients to voluntarily enter into this arrangement.

Small clusters of 8-12-20 or so primary care physicians could agree to receive capitation in common. They could then share certain overhead expenses associated with electronic medical records, decision supports, setting standards of care, managing budgets, and the like.

This arrangement could attract some of the many solo, duo, and other very small primary care physician groups that otherwise are unattractive to organized systems of care.

If patients did follow their doctors into these new capitated arrangements, the money would follow the patient. Medicare, Medicaid, and ERISA waivers would be needed to allow this to happen.

To ensure confidence that money would be spent carefully and flexibly to finance needed care, the $8,000 capitation would immediately be divided among three distinct budgets, each in its own water-tight compartment—

1. one for the incomes of the primary care physicians themselves, and for salaries of their support staff, rent and other office costs, and costs of technical assistance with management, budgeting, clinical guidelines, conflict resolution, and related functions;

2. one for specialist physicians who consult, perform surgery, and the like; and

3. one—the largest—to finance hospital care, lab work and imaging studies, medications, long-term care, mental health services, and other services ordered by primary or specialist physicians.

Confidence in this arrangement would rest in large part on its structure: primary care physicians could not make more money by providing or authorizing more care or less care. They would be financially neutral, though they might receive small bonuses for competence, kindness, and energy. All of the money in the other two budgets would be authorized by primary care physicians and would spent annually, but those budgets could not be over-spent.

This means that primary care physicians would need substantial management and financial support.

Confidence in this arrangement would also rest on the aims and orientation of the primary care physicians who voluntarily participated in it. Physicians would serve as fiduciaries, not as entrepreneurs. They would be financially emancipated—freed of financial incentives to under- or over-serve their patients, and they would therefore enjoy clinical freedom to serve their patients as well as possible in light of the both the best evidence about how to diagnose and treat patients and the total sums available. They would face no financial incentives to provide more or less care, or to otherwise distort their clinical judgments. They would accept responsibility for balancing the books of health care. In return for substantially higher incomes, an end to payment-related paperwork, and freedom from malpractice suits, they would take on these jobs of spending money more carefully and more productively.

While there would be ample reasons to trust these groups to self-regulate and spend money carefully, robust and simple monitoring would be put in place to assure reasonable behavior.

One is white collar crime prevention. Every $100,000 stolen translates into a year in jail in a safe facility.

A second is access and outcomes monitoring. This would include measures of vertical equity of care in proportion to clinical guidelines and horizontal equity by income, race, language, and geography.

General long-term considerations in paying and protecting hospitals, and in neutralizing financial incentives facing hospitals

Looking forward, we think it would be valuable to pay hospitals in ways that rewarded efficiency, not marketing and volume growth, and that eliminated incentives to attract patients with certain diagnoses or those covered by certain payers.

First, the hospitals and emergency rooms needed to protect the health of the public would be identified by state government. The baseline assumption should be that surviving hospitals are needed unless demonstrated not to be needed. That's because

- so many hospitals have been closed in recent years,
- aging Americans are likely to need more hospital care,
- further closings are unlikely to save substantial sums,
- of the bias of current financing and past closings against generally lower-cost community/non-teaching hospitals (especially those located in black/African-American or lower-income areas), and

- there has been no correlation between efficiency and probability of closing. [19]

The next steps should be taken to set a fair rate by which the newly-capitated physician groups would pay hospitals. As has been done in Maryland since the 1970s, a flexible budget would be prepared for each needed hospital. [20] It would assure that revenues adequate to finance these hospitals would be available, subject to reasonable and efficient operation.

Second, these hospital budgets would be flexible for both volume and case mix. This means that fixed costs are covered and variable costs are covered separately. The result is that hospital revenues rise and fall in proportion with volume and case mix. Financial incentives to give more care or less care, or this care or that care, are eliminated.

Third, all payers would pay the same price for the same care, and all care is equally profitable, thereby eliminating cross-subsidies by payer or by type of patient. More important, physicians' and hospitals' decisions about which patients should receive care—and the types of care they should receive—would not be distorted by artificially-set prices and profitability.

Fourth, the capitated physician groups would contribute to covering hospital fixed costs using money from their third (non-physician) budget.

Fifth, payment of variable costs would be in direct proportion to use of various types of hospital care.

<u>More immediate considerations affecting the newly-capitated physician groups' payments to hospitals</u>

It will be useful to devise a method of paying hospitals that is fair to the newly-capitated physician groups. In a free market, after all, all payers pays the same price for the same good or service.

Small physician groups should not suffer disadvantageous prices, and large hospital groups should not be able to enjoy advantageous prices. The new capitated physician groups would pay for different types of care at prices set equal to the weighted averages paid by Medicare, Medicaid, and large managed care organizations and other insurers operating in this state.

In conclusion, vast sums are already available to pay for health care in Massachusetts. Today's $72 billion is enough to pay for the care that works for the people who need it.

Without cost control that squeezes out waste, it will be difficult to cover everyone—or to preserve and restore primary care or sustain all needed hospitals.

The main lessons from decades of failure of efforts to contain health care costs in Massachusetts and throughout the U.S. are

- that cost control through traditional free markets or traditional government actions is ineffective and so are gimmicks like tinkering with units of payment,
- that cost control can't work without solid political support,
- that political negotiations that work to contain cost in other wealthy nations are not yet attainable here,
- that better individual care decisions by doctors are the key to squeezing out waste, and
- that a political deal or peace treaty needs to be struck with doctors—an arrangement that gives doctors an end to fear of being sued, an end to most payment-related paperwork, and (for primary care doctors) higher incomes.

New capitation arrangements that are designed for trustworthiness, equilibrium-seeking, and as much self-regulation as possible; that combine payment reform with delivery reform; that are voluntary; and that combine top-down and bottom-up reforms can be crafted to liberate and oblige doctors to act as clinical and financial fiduciaries for their patients.

Notes

[1] Health Reform Program calculations from CMS data on personal health spending by state, 1980-2004, and national health expenditures, 1980-2009.

Source for state health spending

http://www.cms.hhs.gov/NationalHealthExpendData/05a_NationalHealthAccountsStateHealthAccountsProvider.asp#TopOfPage

Sources for national health expenditures

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[5] See, for example, William A. Glaser, *How Other Nations Do It*," http://www.healthpaconline.net/rekindling/Articles/Glasser.htm, access confirmed 9 November 2008; and William A. Glaser, "The United States Needs a Health System Like Other Countries," *JAMA*, Vol. 270, No. 8 (25 August 1993), pp. 980-984.

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[7] One-half of patients don't understand how to take meds and take them differently than prescribed. See Dean Schillinger, Eddie Machtinger, Frances Wang, Maytrella Rodriguez, and Andrew Bindman, *Preventing Medication Errors in Ambulatory Care: The Importance of Establishing Regimen Concordance*, AHRQ Advances in Patient Safety, 2005, http://www.ahrq.gov/downloads/pub/advances/vol1/Schillinger.pdf, access confirmed 5 February 2009.

[8] Authors' calculations from CMS national health expenditures data.

[9] For one listing of salaries by specialty, see Tom Bodenheimer, *Transforming Primary Care for Patients with Chronic Conditions*, Urban Medical Symposium: Shock to the System: Preparing Primary Care for the Baby Boomers, Urban Medical Care Conference, Boston, 4 April 2008, http://www.kaisernetwork.org/health_cast/uploaded_files/Bodenheimer%20Slides.pdf.

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