Covering People, Paying Caregivers, and Shaping Affordable Care for All

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Covering the Business of Health Care

Boston University

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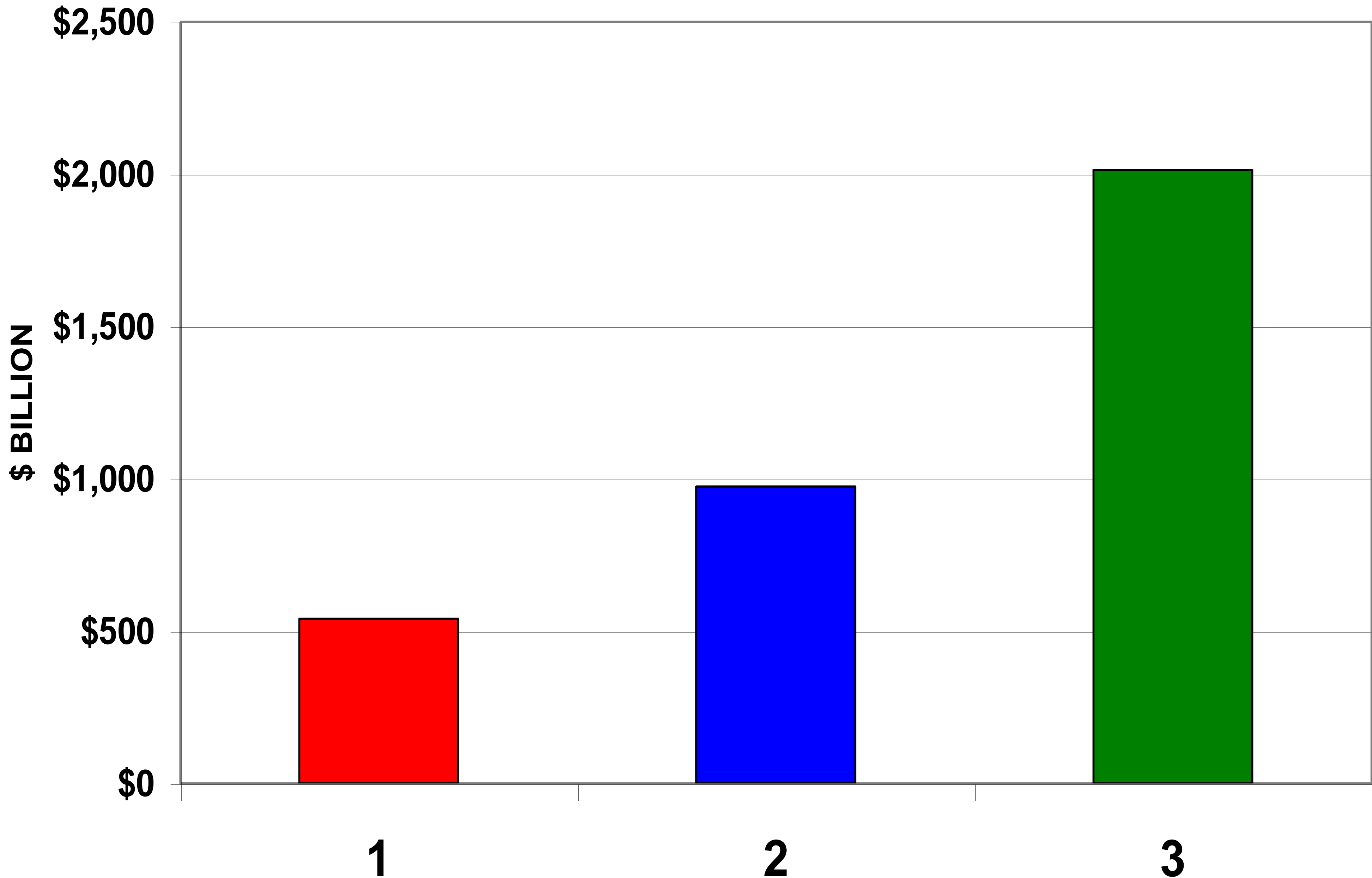
Health, Education, and Defense Spending, 2005



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Structure

A. **Covering People (Raising Money)**
B. Paying Caregivers (Who, how)
C. Soaring U.S. Health Care Costs Not Sustainable
D. The Easiest Problem to Fix
E. Reform opportunities

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A. Covering People (Raising Money)

- This is the main health care topic addressed by people running for office. Sometimes, it is the only one.

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A. Raising Money

- Covering people
- Who writes the check?
- Who ultimately pays?

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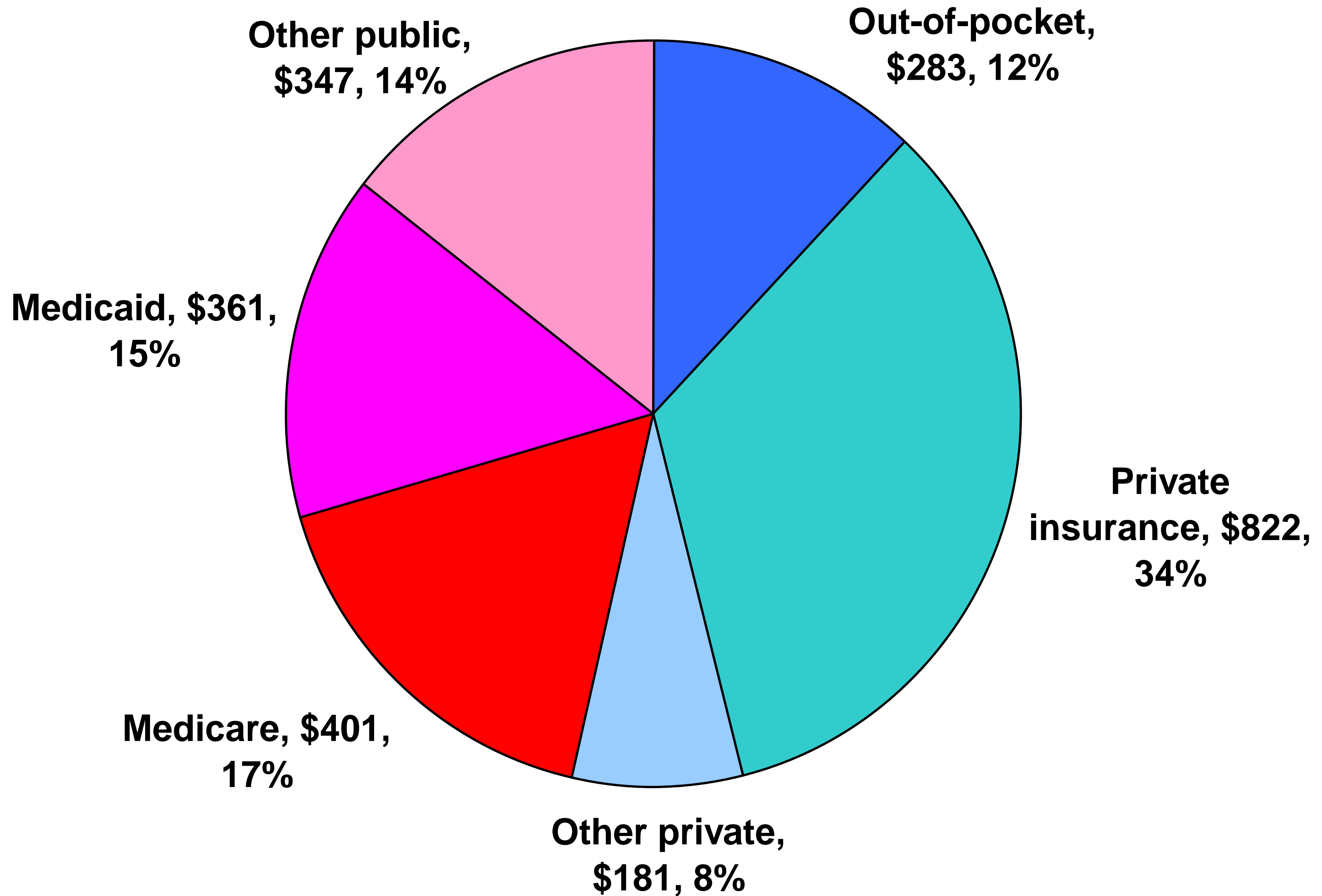
Sources of Revenue, 2008, in $ billions



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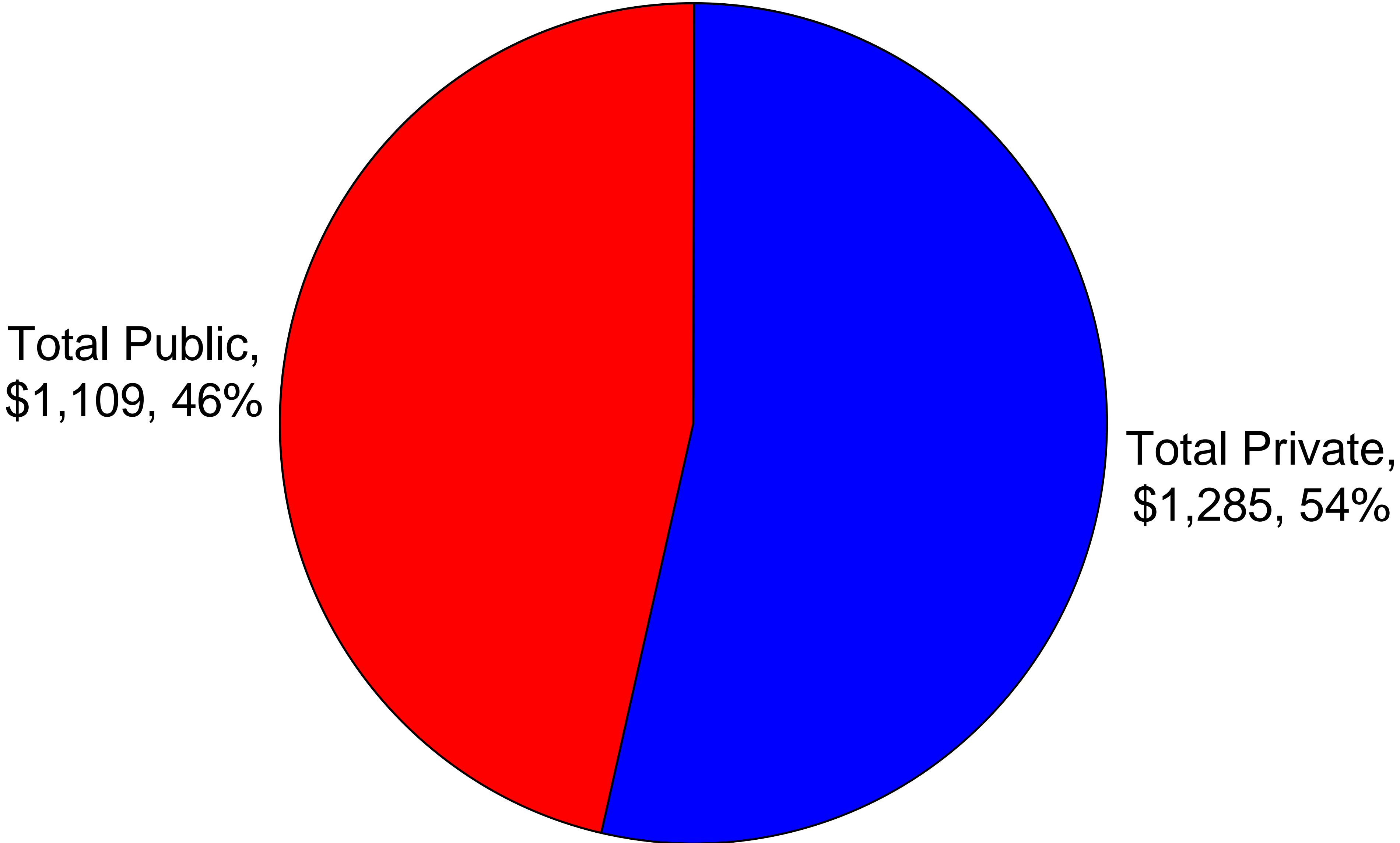
Public - Private Split, 2008, $ billions



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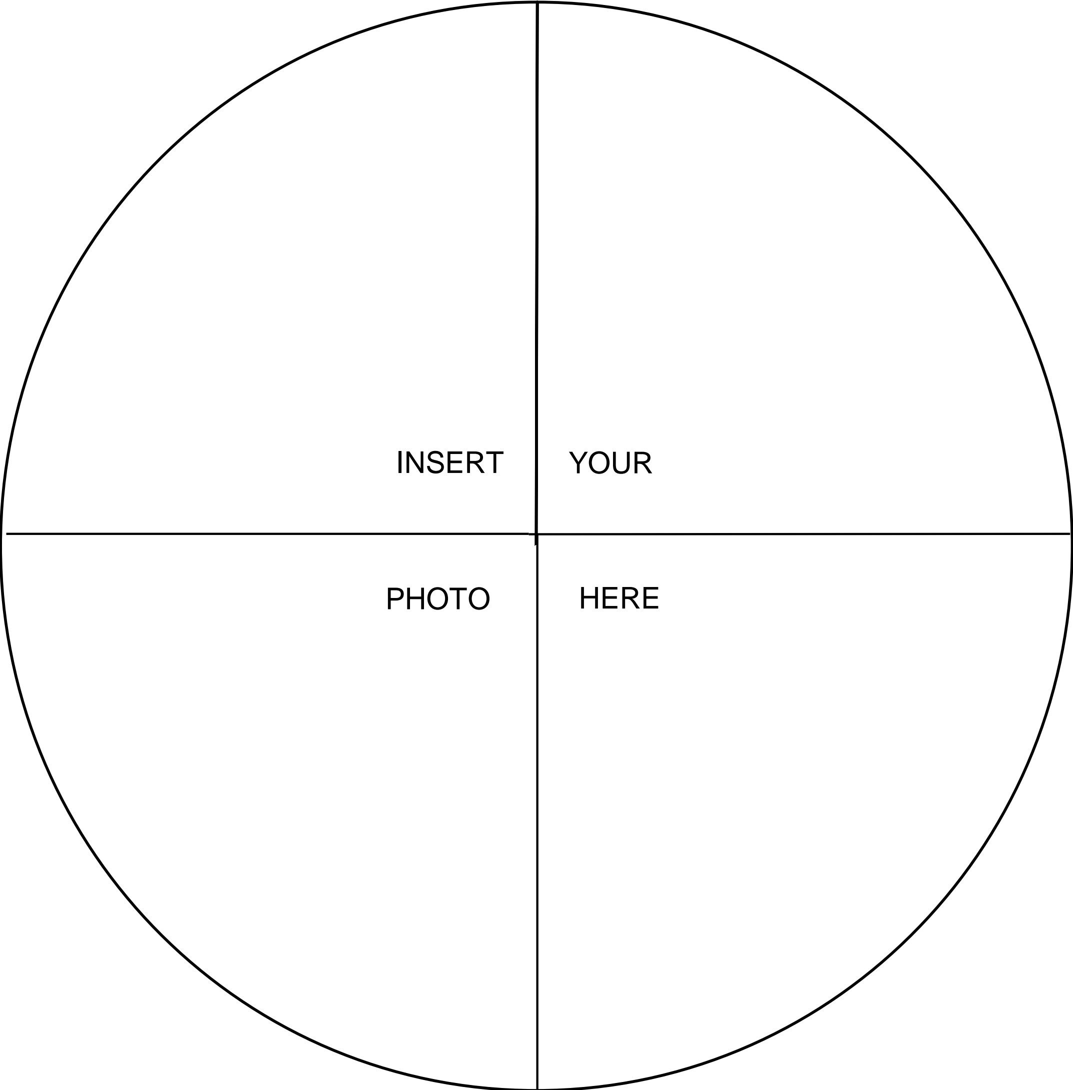
Ultimate Source of Spending, 2008, $ billions



Total, $2,394, 100%

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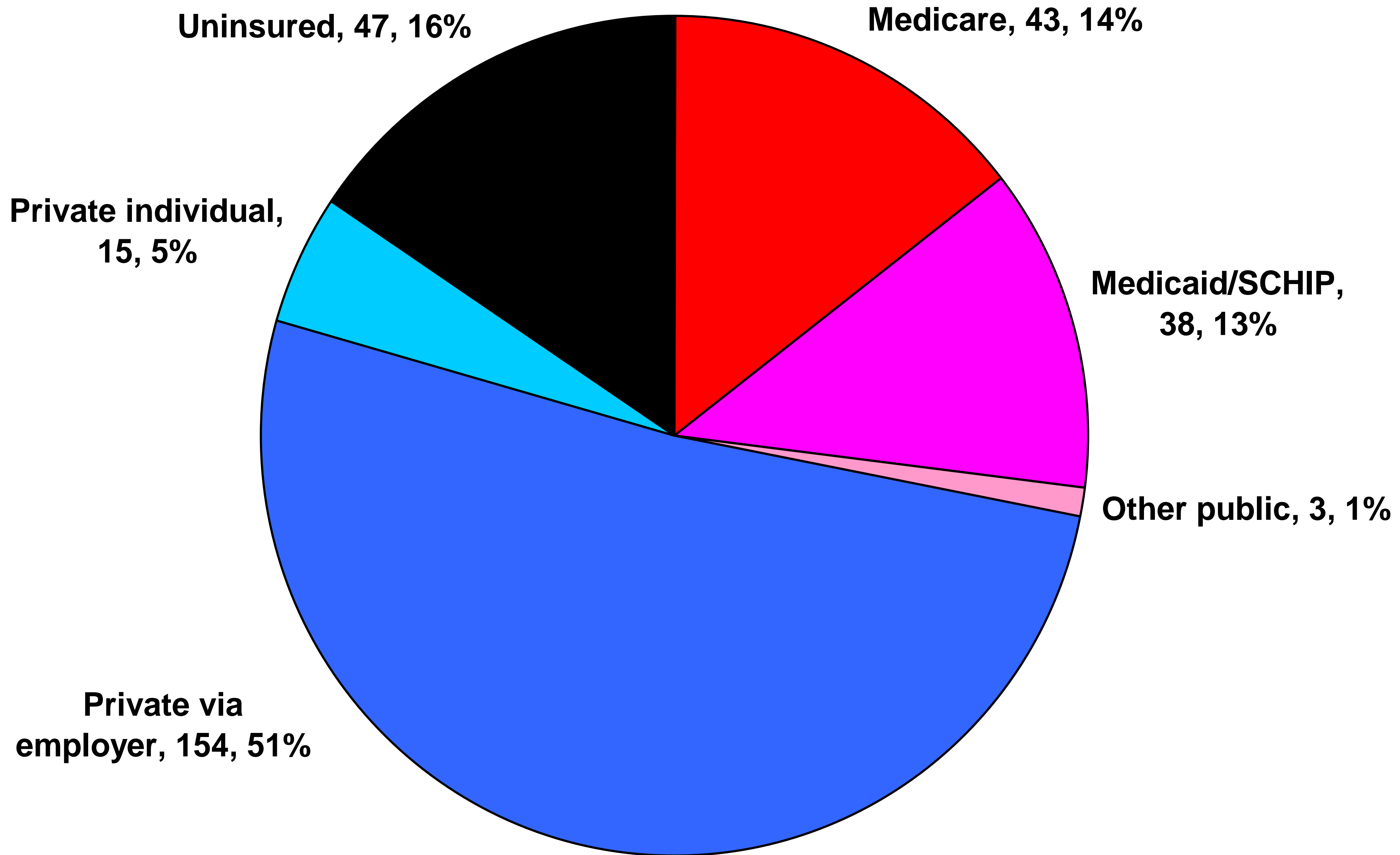
Main Source of Coverage, 2006



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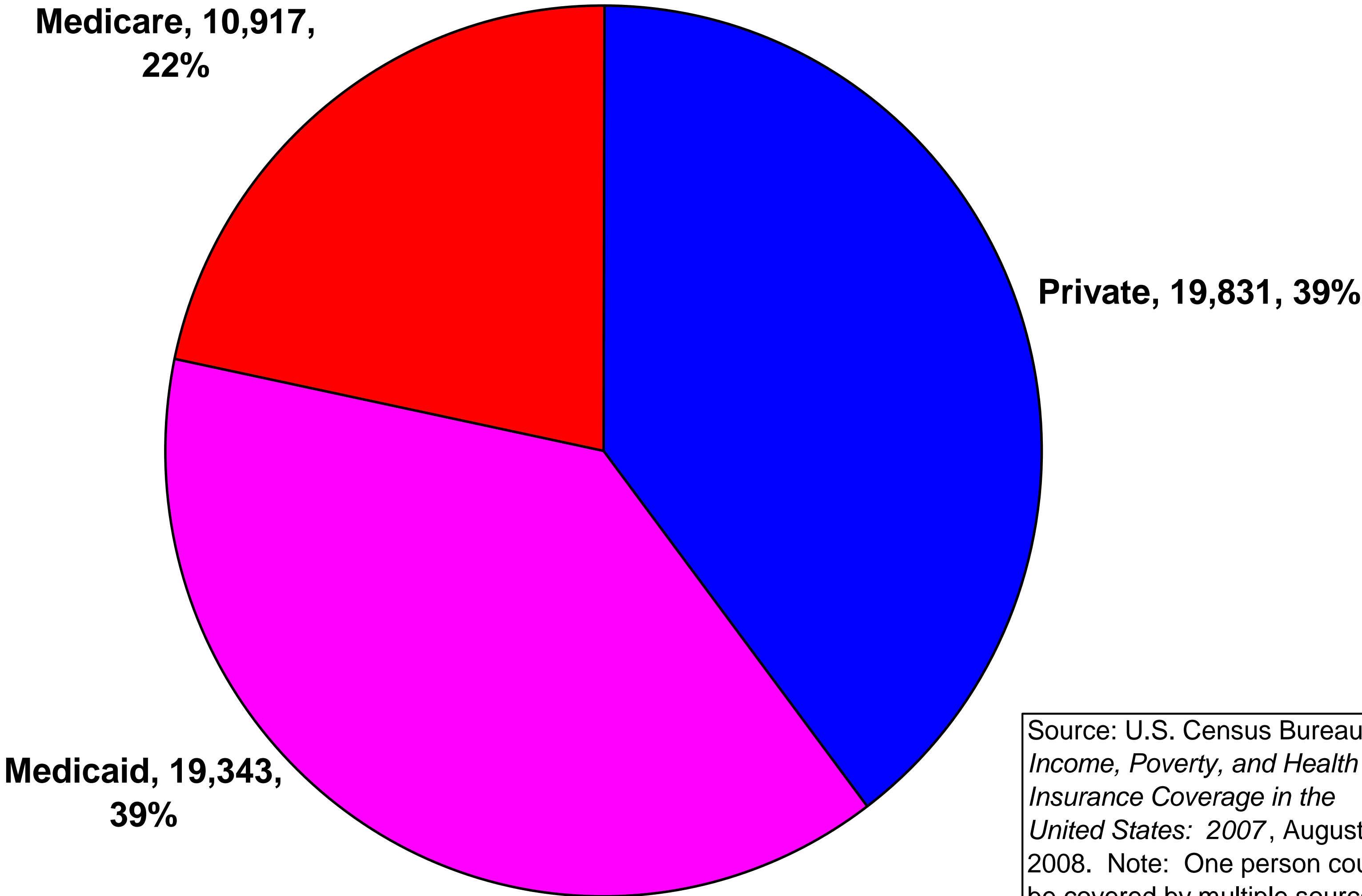
Sources of Increased Health Insurance Coverage, 1987 - 2007



Source: U.S. Census Bureau, *Income, Poverty, and Health Insurance Coverage in the United States: 2007*, August 2008. Note: One person could be covered by multiple sources in a given year.

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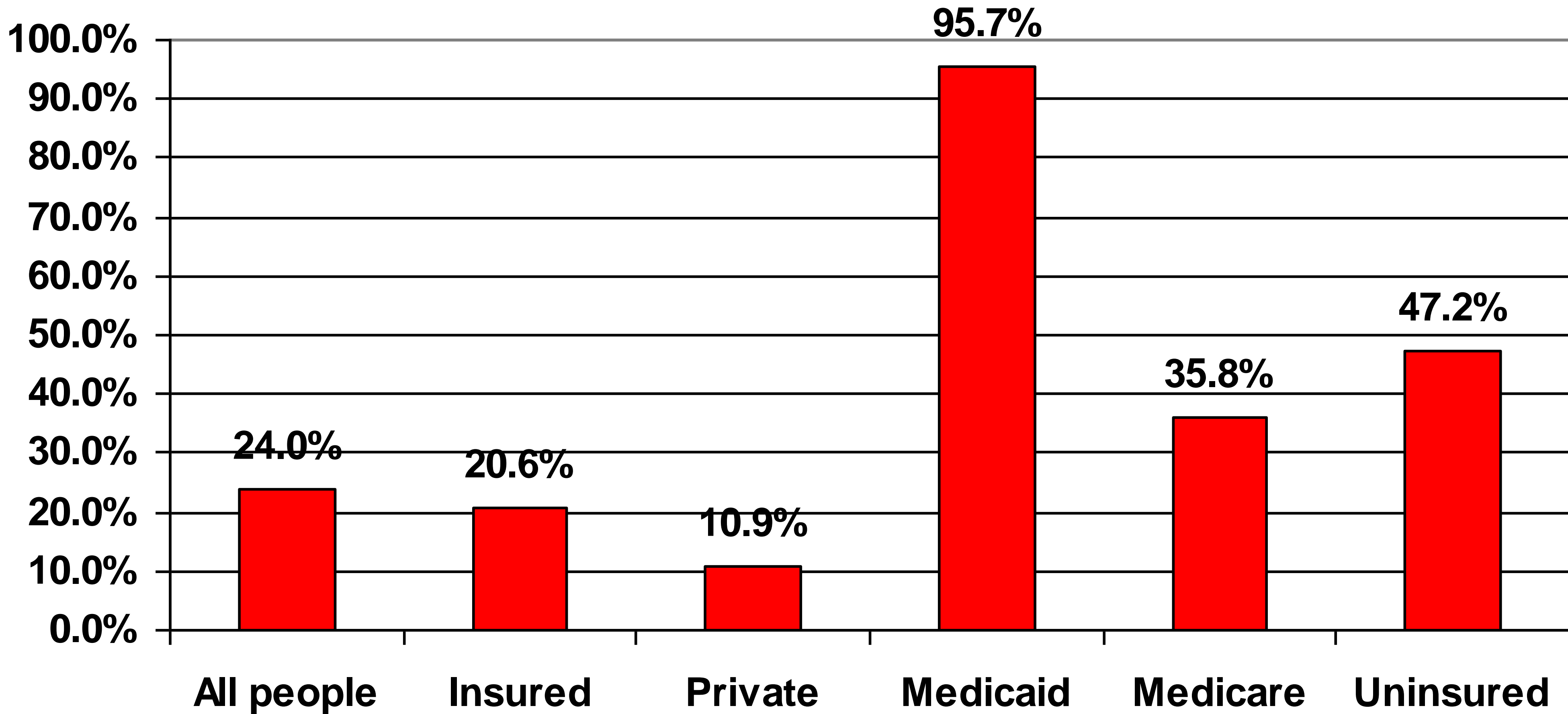

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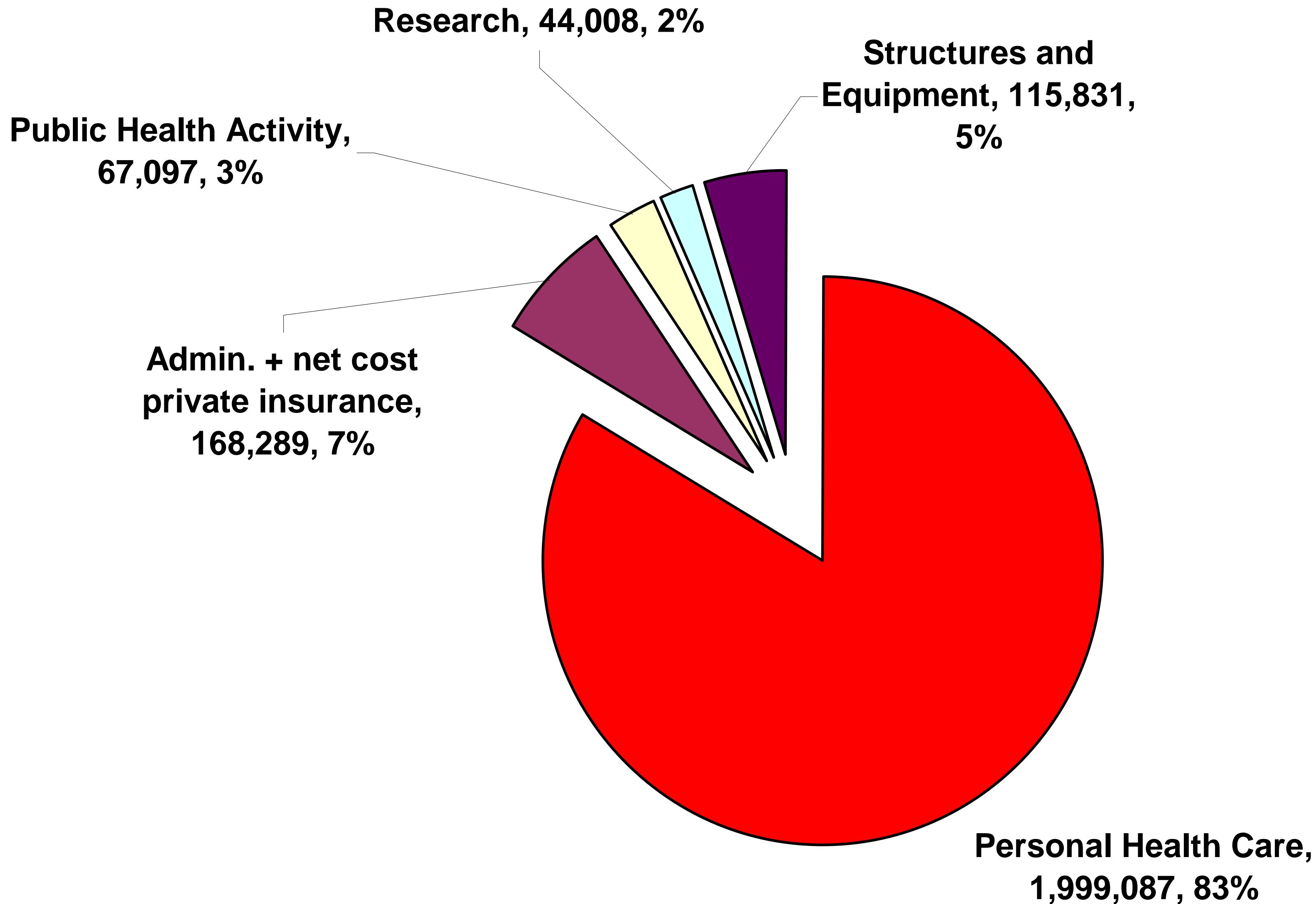
Main Categories of Health Care Spending, 2008, $ millions



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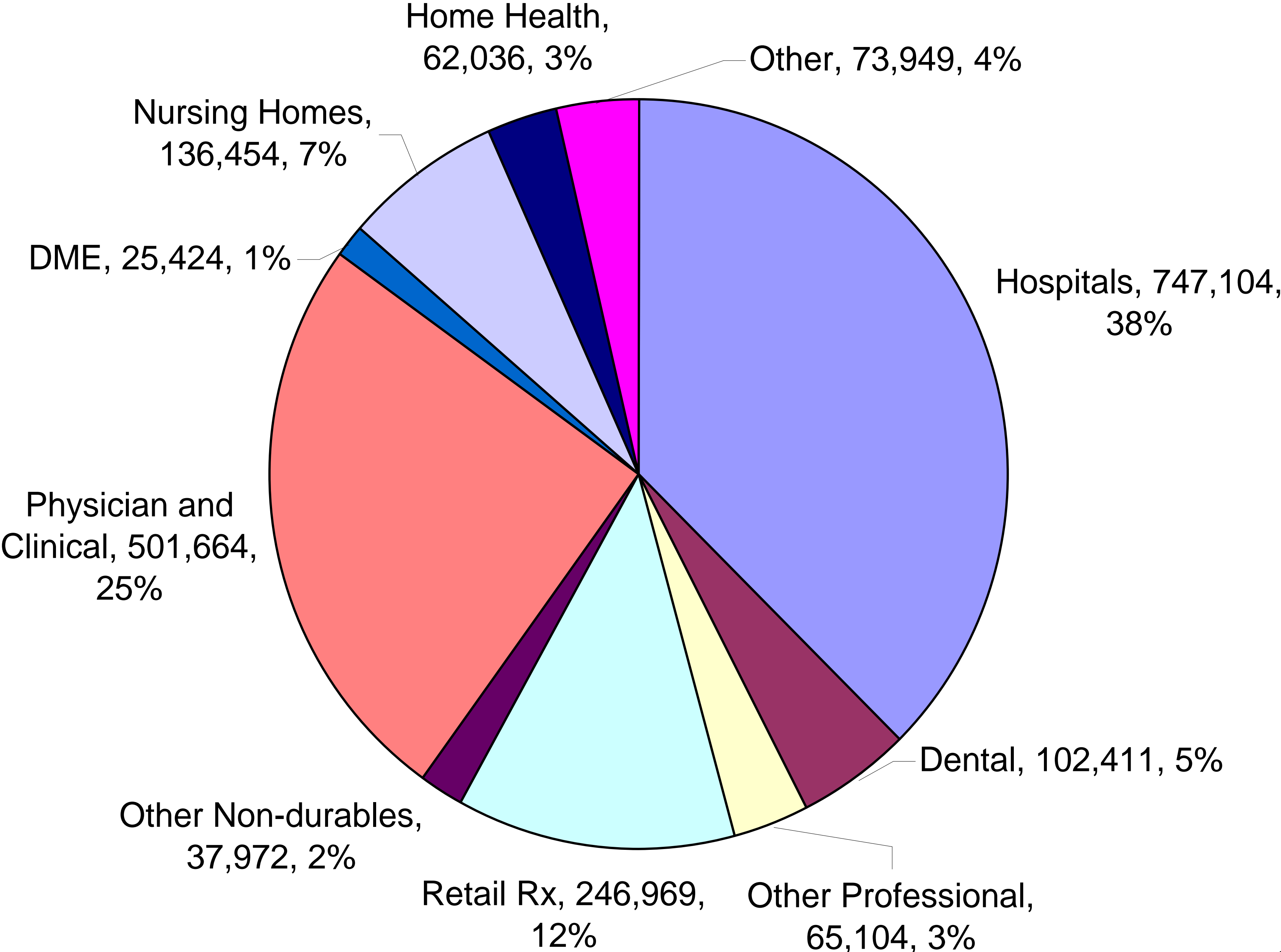
Personal Health Spending, 2008, $ millions



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DRG Payments for Hospitals

- If a hospital is paid by the discharge (Medicare DRGs, for example), the financial incentive is to care for more patients, but care for each inexpensively
- Some diagnoses are profitable and others are money-losers, distorting care patterns
- Different payers pay different amounts for the same care, again distorting who gets what

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Fee-for-service payments for doctors

- Do more of what you're paid for
- FFS under-pays for history-taking, physical exams, thinking, and care coordination (diagnosis and reassurance)
- FFS over-pays for doing things (tests, radiology, surgical procedures)
- Some doctors (cardiologists) make much more money than others (internists)
- Care patterns are shaped in part by payments

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Rx

- In 2002, the U.S. provided the world's drug makers with almost ½ of their world-wide revenue
- We comprised 4 percent of world's people
- Alone among wealthy nations, we don't regulate prices of meds
- Part D law said Medicare could not negotiate prices
- Drug makers say high prices fuel innovation
- Connection far from clear
- Drug makers generally lack credible business plans

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C. Soaring U.S. health care costs not sustainable

1. U.S. economy probably in grave trouble
2. Today, U.S. health care is addicted to more money for business as usual.
3. Adequate revenue not likely to materialize
4. No villains, but many caregivers follow the money toward excessive service for a shrinking numbers of well-insured patients
5. Affordable high-quality care for all is essential to political and social stability

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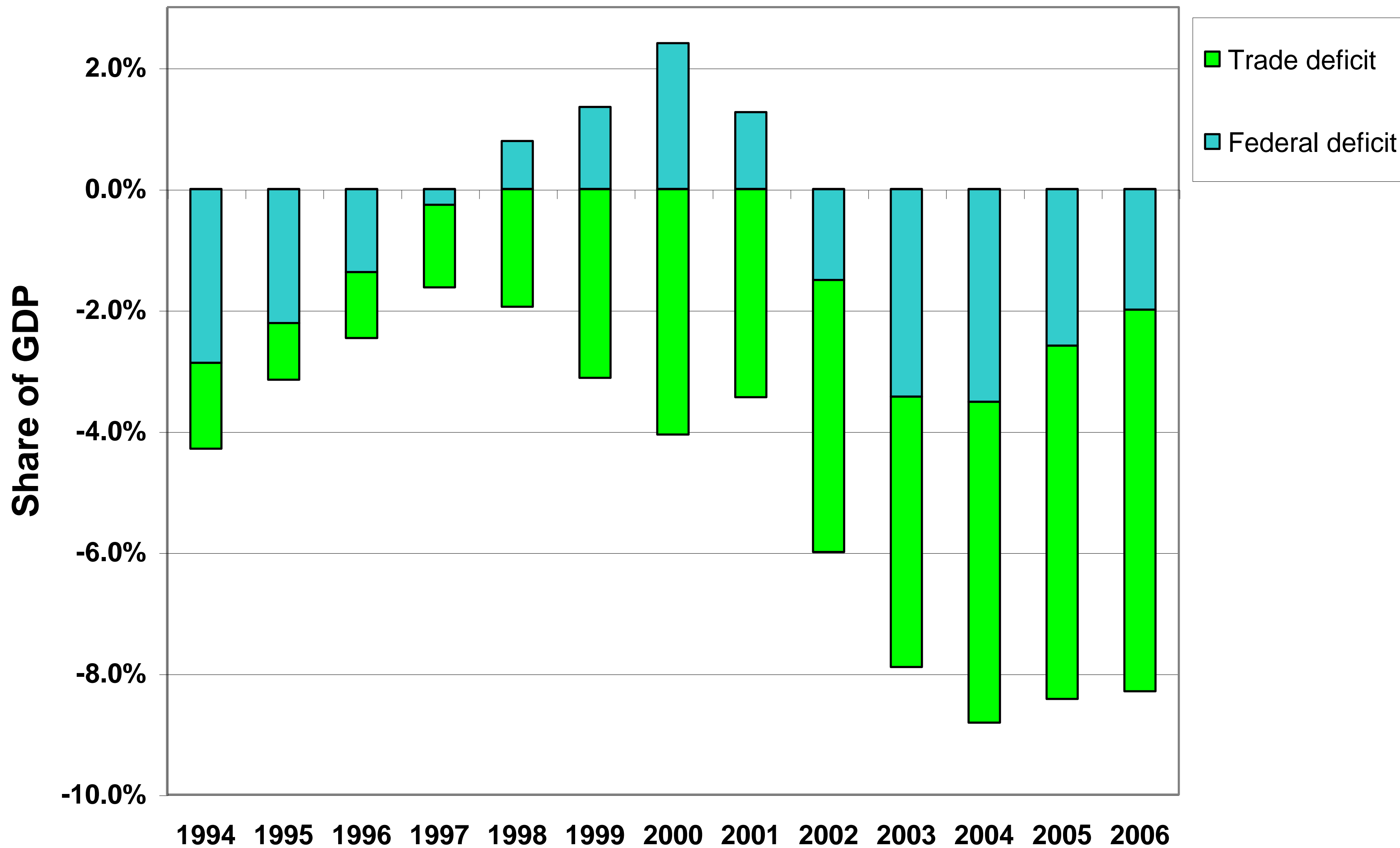

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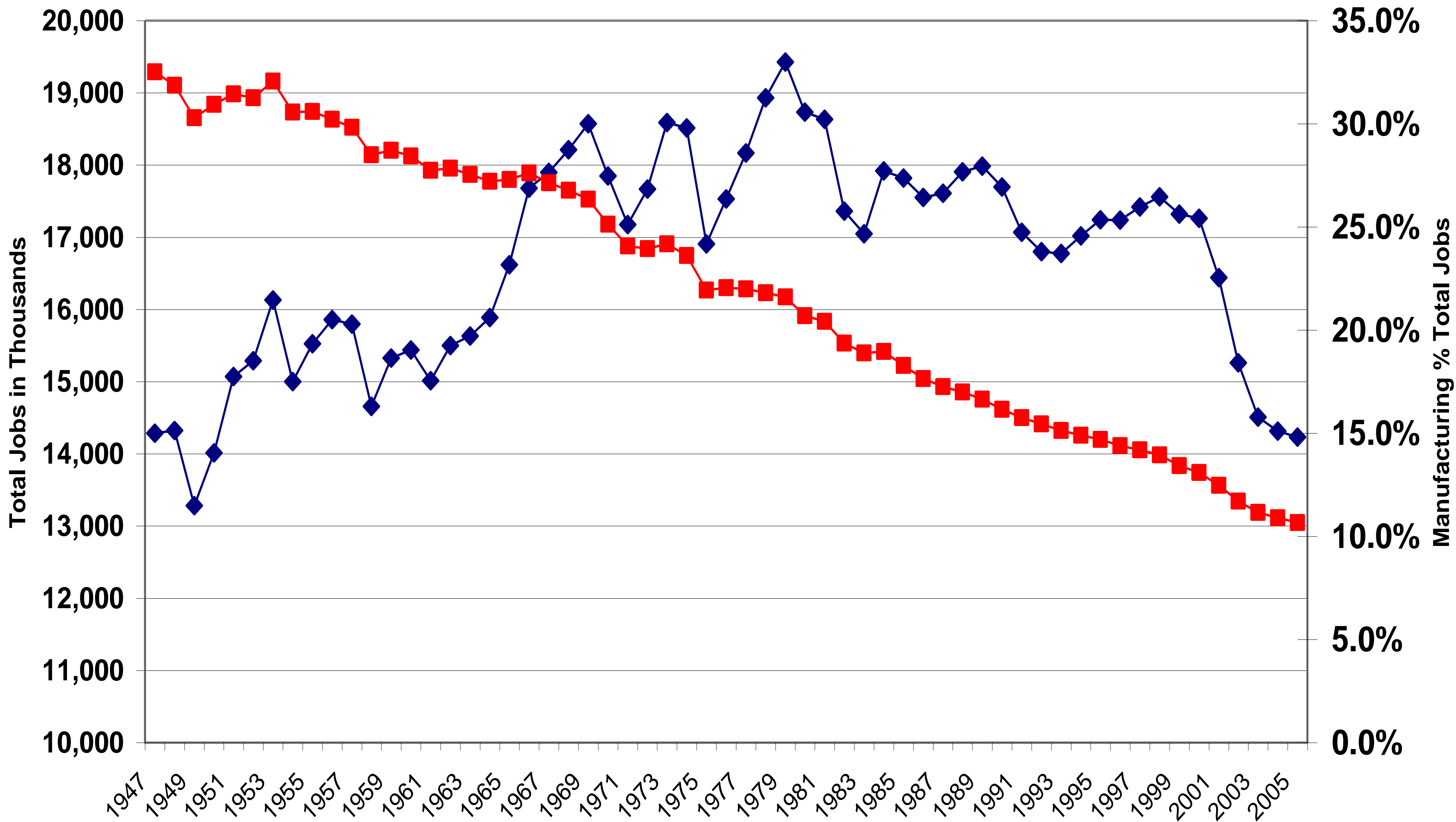
Manufacturing Employment, U.S., 1947-2005, Thousands of Jobs + % of Total Jobs



Manufacturing jobs — Manufacturing % total jobs

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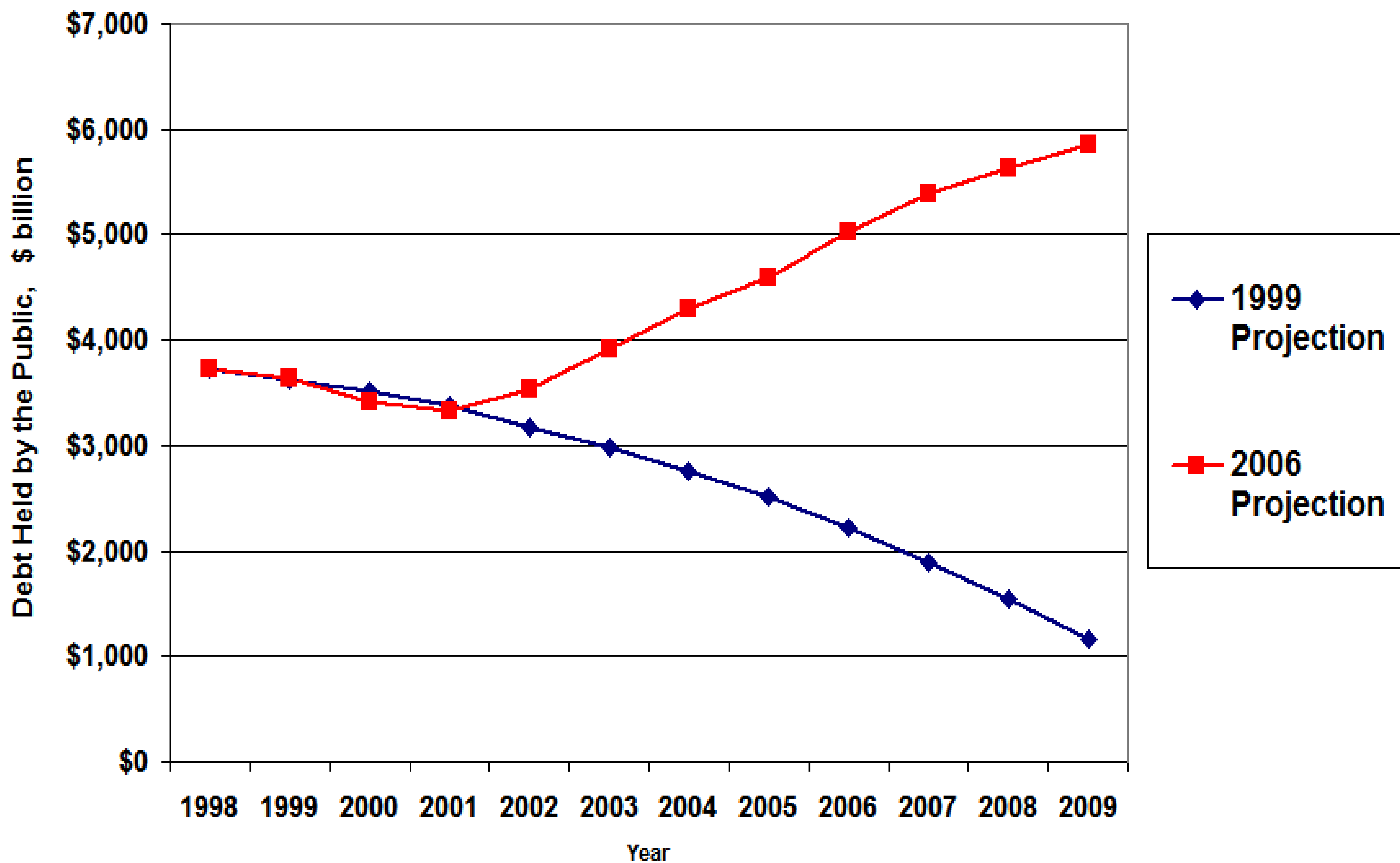
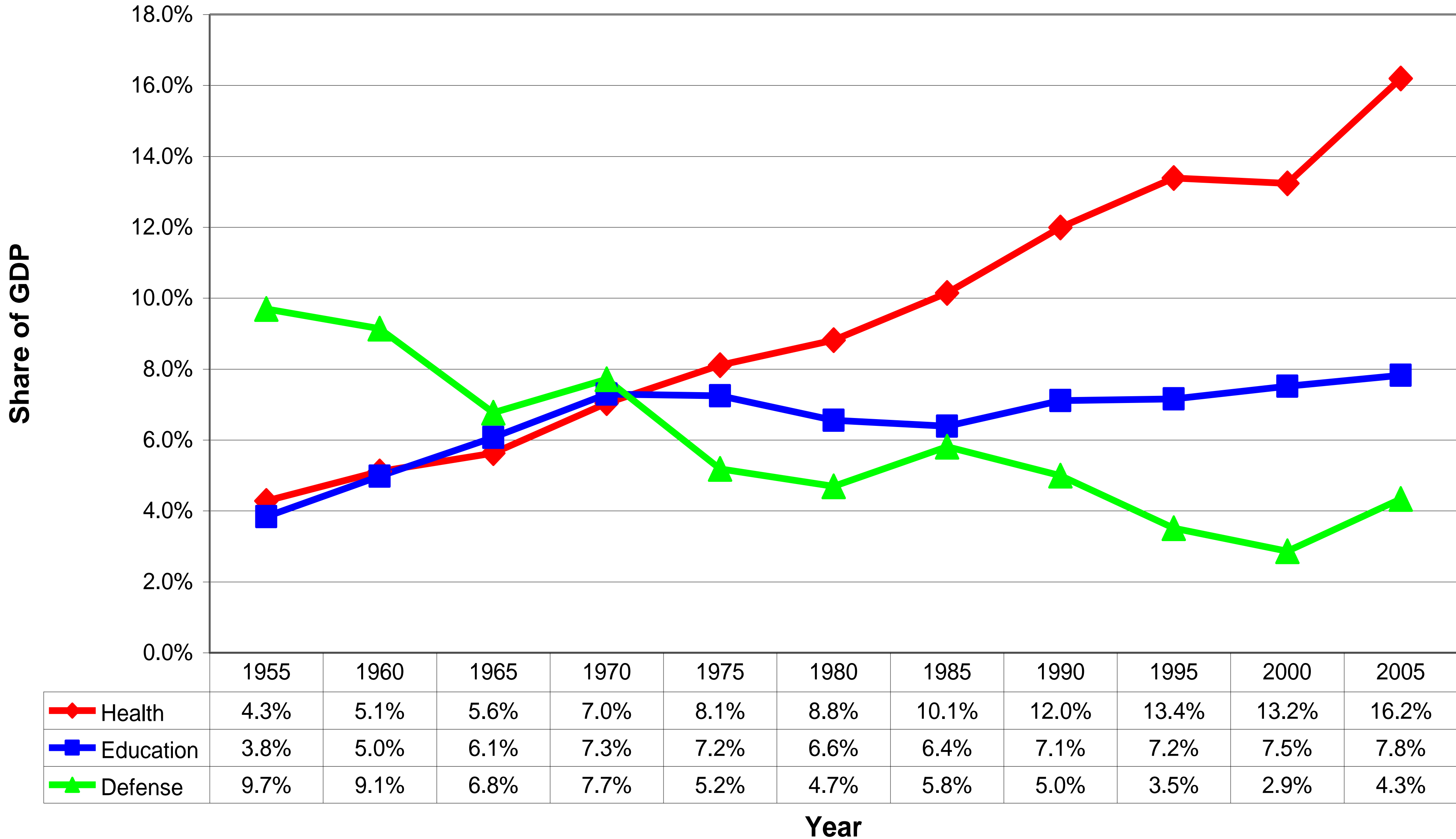
U.S. National Debt Held by the Public, 1999 and 2006 Projections, $ Billion



HEALTH, EDUCATION, AND DEFENSE SHARES OF U.S. GDP, 1955 - 2005



	1955	1960	1965	1970	1975	1980	1985	1990	1995	2000	2005
Health	4.3%	5.1%	5.6%	7.0%	8.1%	8.8%	10.1%	12.0%	13.4%	13.2%	16.2%
Education	3.8%	5.0%	6.1%	7.3%	7.2%	6.6%	6.4%	7.1%	7.2%	7.5%	7.8%
Defense	9.7%	9.1%	6.8%	7.7%	5.2%	4.7%	5.8%	5.0%	3.5%	2.9%	4.3%

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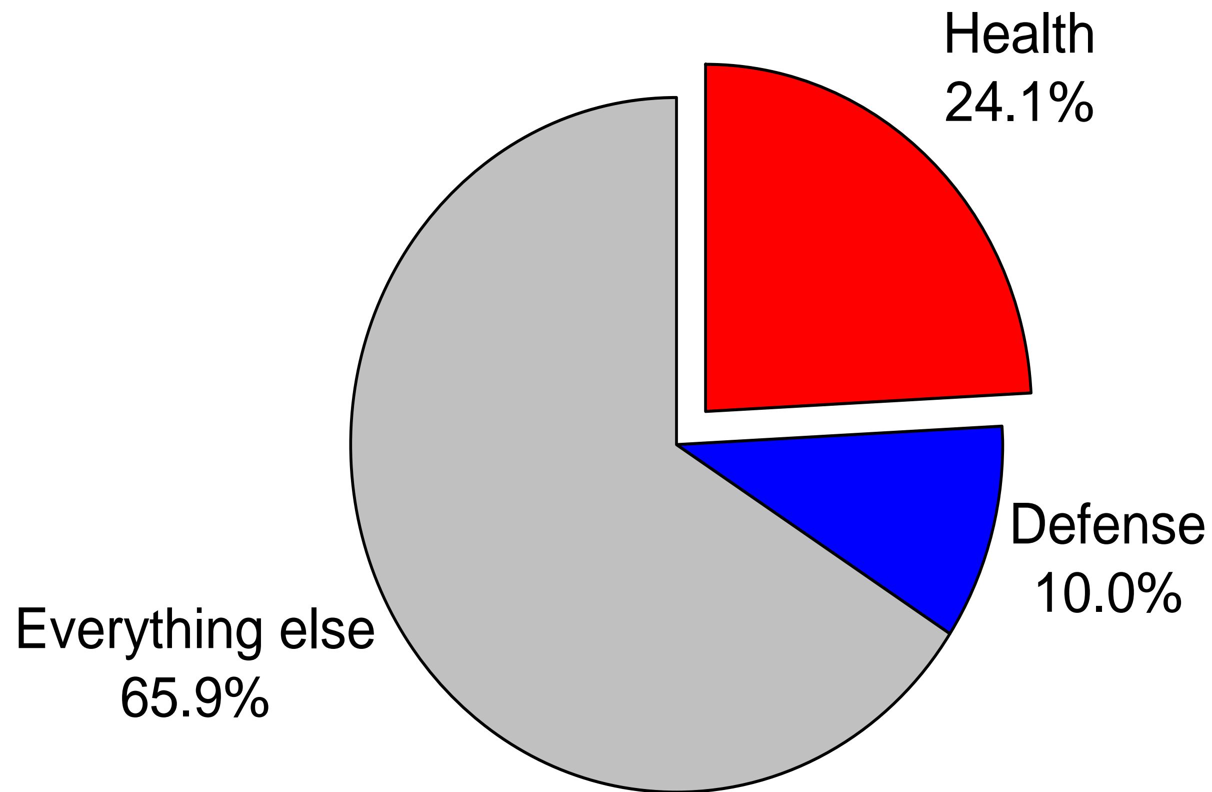
SHARES OF GDP GROWTH, 2000 - 2005



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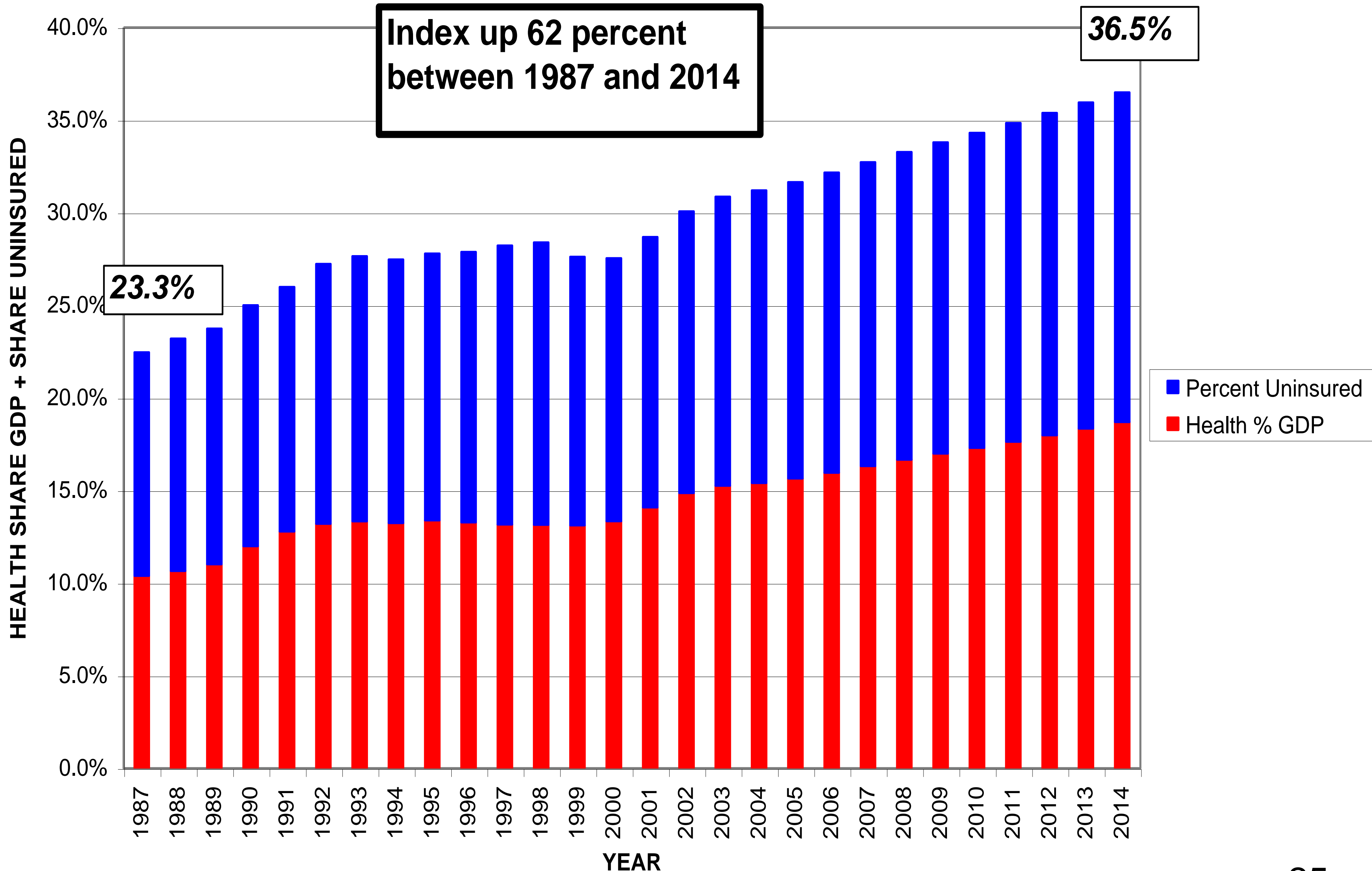
HEALTH'S SHARE OF GDP + SHARE OF PEOPLE UNINSURED, 1987 - 2014



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How Would We Cope?

- If a bad recession caused real revenue for health care to drop by 10-20%, and
- If we went from 50 million uninsured people to 75 million or more?

- Impossible to safely shed cost that fast
- Bankruptcy? 1000 of 5000 hospitals close?
- Slash doctors' incomes?
- Pressures for prescription drug price controls
- Cut services for Medicaid, uninsured patients
- Offset revenue losses by doing more for fewer insured people

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Latest Projection

- From 1/6 of GDP now to 1/5 in a decade
- Some economists: “What, me worry?”
- Where would that money come from?
  - ? Medicare—trust fund worries growing
  - ? Medicaid—federal cap? states lack $
  - ? Employers—Ontario passed Michigan in car assembly

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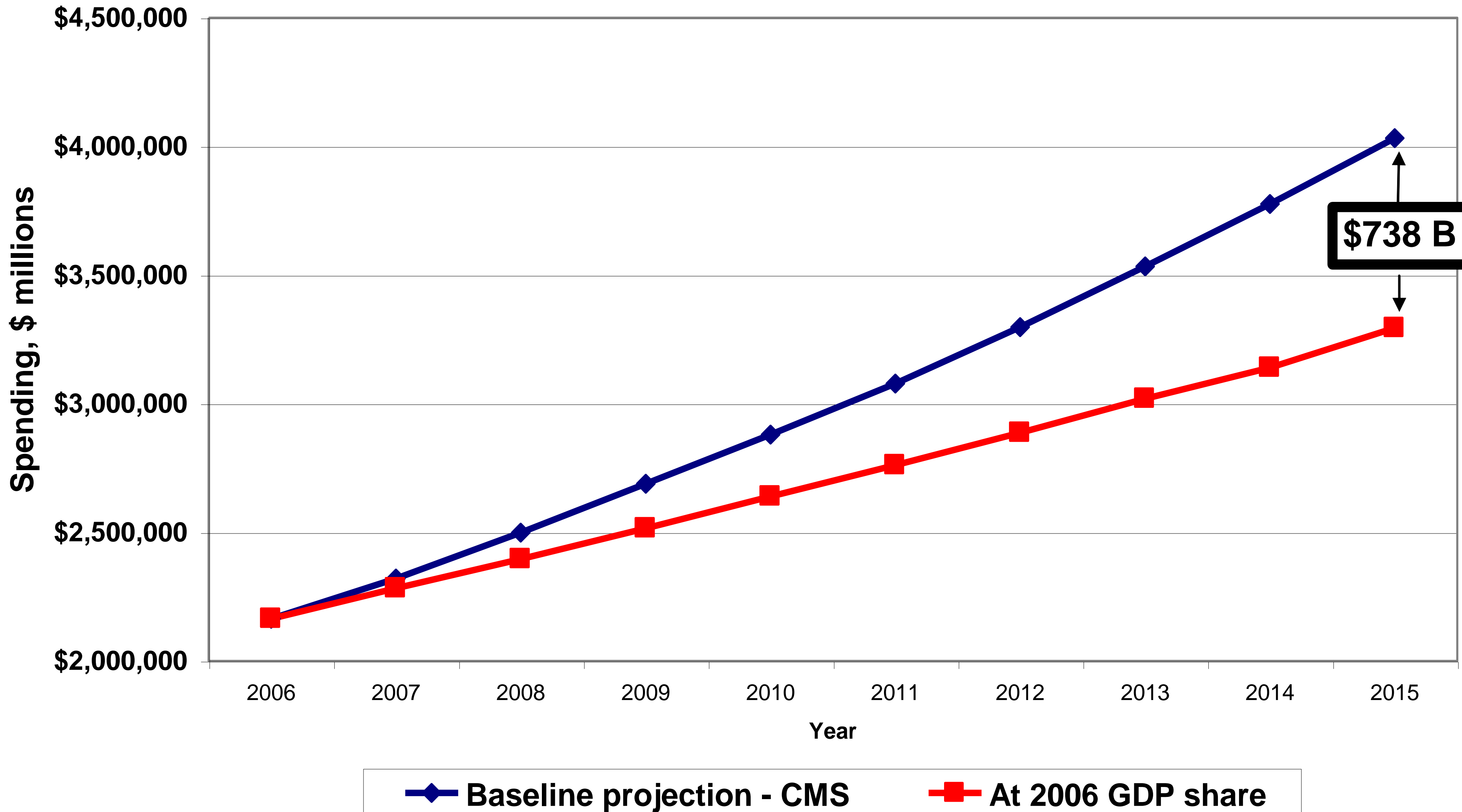
Health Spending - CMS Projections versus Flat Share of GDP, 2006 - 2015



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Medical Insecurity Threatens Our Economic, Social, Political Stability

- Economic
  - High health costs help make U.S. goods uncompetitive, boost trade deficit
  - Health costs crush living standards of non-wealthy Americans, threaten bankruptcy
- Social
  - Affordable and high-quality health care for all should be a glue that helps to hold us together as a people, as a society
  - Other wealthy nations, with very unequal incomes, still finance health care for all
  - Health care could crash during next bad recession → insecurity
  - What would Bismarck say?
- Political
  - Spending more money to finance less care for fewer people is a recipe for massive inequality, insecurity, and political fury
  - Local and state governments feel the crisis well before feds

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Suggestion: Aim of Health Care Is Medical Security

- Medical security is not a promise of immortality
- It is honest, grounded confidence that
  - We will get competent and timely care from clinicians and institutions who know and care about us
  - We won’t worry about the bill when we are sick, or about bankruptcy
  - We won’t worry about losing insurance coverage ever, in good times or bad

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Two Paths Forward

1. Affordable, sustainable high-quality care for all
   - More insured patients
   - Less waste and greater share of money for care
   - Care tracks clinical need, evidence on what works
   - Financial security for all needed caregivers
     - Family doctors and specialists
     - Community and teaching hospitals

2. Less care for fewer people at greater cost
   - Provision of care increasingly tracks the increasingly uneven distribution of income and insurance
   - Growing over-service to shrinking pool of well-insured patients
   - More hospital closings
   - Threats to doctors' incomes

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U.S.A. Already Spends Enough to Care for Everyone Well

1. U.S.A. spending trends
2. Insurance coverage trends
3. Comparisons with other wealthy nations
4. The easiest problem to solve

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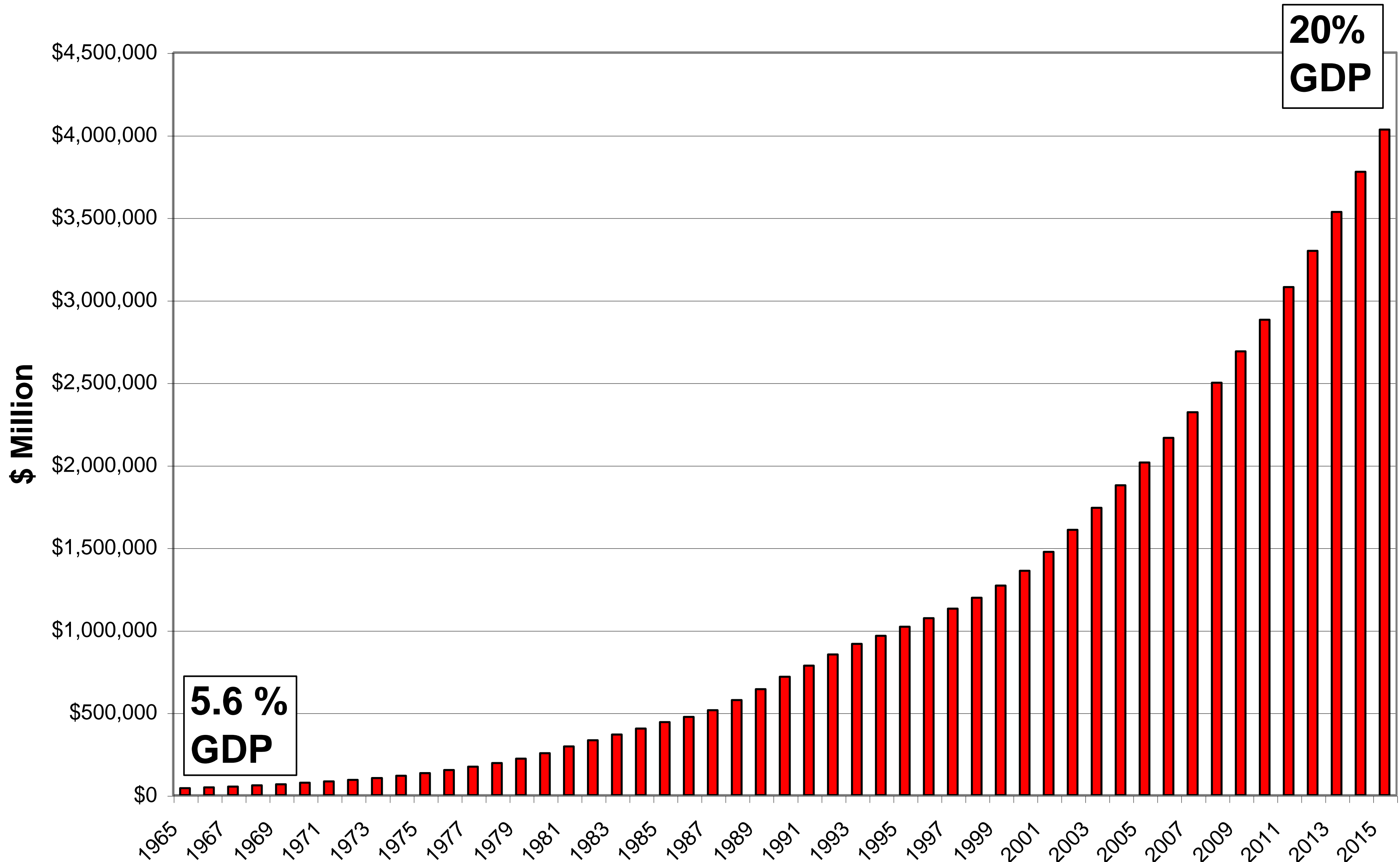
U.S. Health Spending, 1965 - 2015



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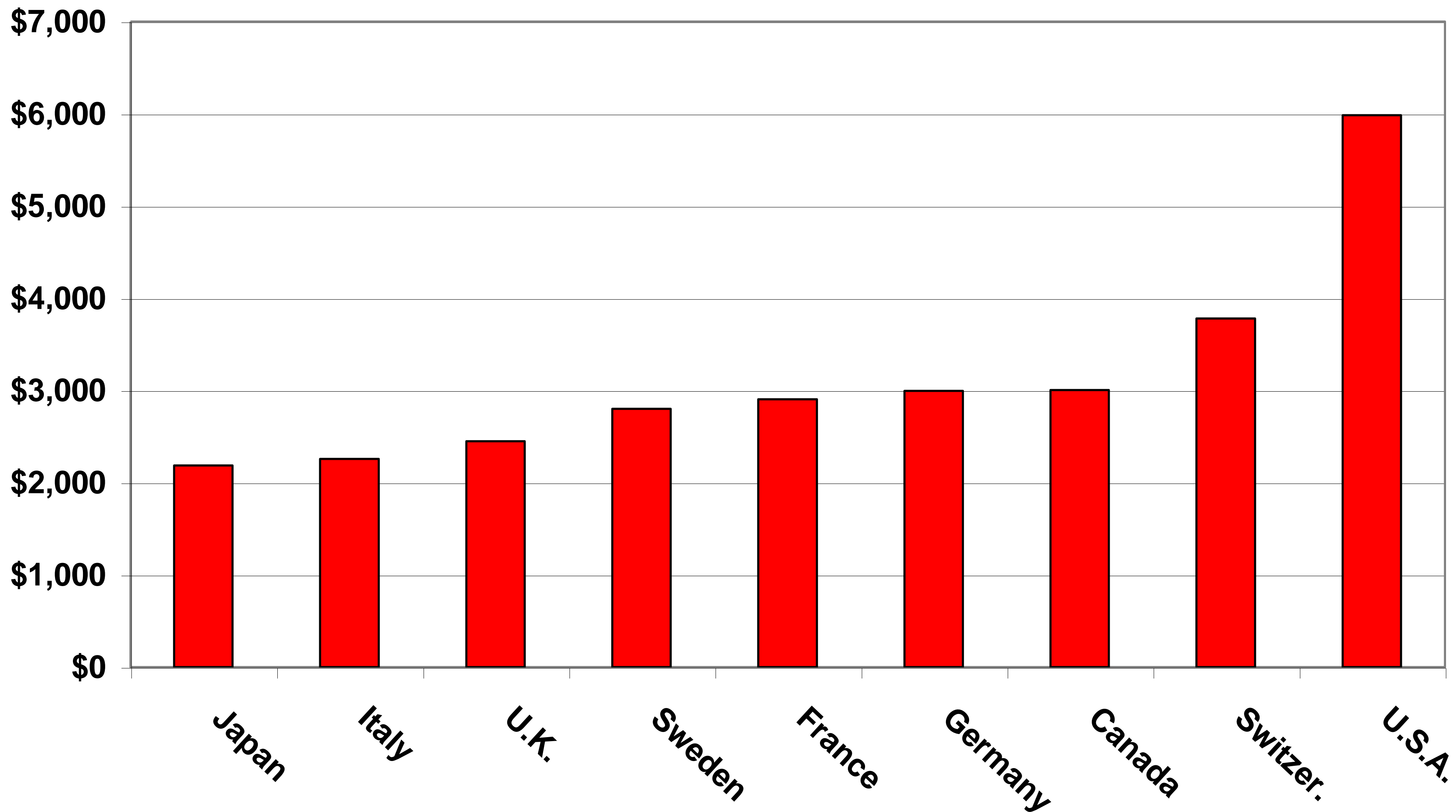
Health Spending per Person, Selected Wealthy Nations, 2003



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U.S. Savings in 2006

If we spent at the German-French average health spending per person	$1.1 trillion
If we spent at the U.K.-Japanese-Italian average health spending per person	$1.3 trillion

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Insurance coverage

- Nationally,
  - 1 in 5 working-age adults lack health insurance
  - 1 in 4 Americans have no Rx insurance
  - About 1 in 2 have no dental insurance
  - Few have adequate mental health insurance
  - Under 15 percent have any long-term care insurance

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Comparisons, 2003

	Per 1,000 people			MRI /	% adult	alcohol	% adults	Expected		$/person	Public %
	MDs	Acute Beds	Nurses	million	smokers	L/adult	BMI>30	years at birth	% > 65	PPP	total $
Australia	2.5	3.6	10.2	3.7	19.8%	9.8	21.7%	80.3	12.8%	$2,699	67.5%
Canada	2.1	3.2	9.8	4.5	17.0%	7.8	14.3%	79.7	12.6%	$3,001	69.9%
France	3.4	3.8	7.3	2.8	27.0%	14.8	9.4%	79.4	16.3%	$2,903	76.3%
Germany	3.4	6.6	9.7	6.2	24.3%	10.2	12.9%	78.4	17.7%	$2,996	78.2%
Italy	4.1	3.9	5.4	11.6	24.2%	8.0	8.5%	79.9	19.1%	$2,258	75.1%
Japan	2.0	8.5	7.8	35.3	30.3%	7.6	3.2%	81.8	19.0%	$2,139	81.5%
U.K.	2.2	3.7	9.1	5.2	26.0%	11.2	23.0%	78.5	16.0%	$2,231	83.4%
U.S.A.	2.3	2.8	7.9	8.6	17.5%	8.3	30.6%	77.2	12.4%	$5,635	44.4%

Definitions, Sources and Methods per country: www.irdes.fr/ecosante/OCDE/210060.html

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Medical security for all Americans is the easiest problem to solve

- Not easy
- But easier than any of the others
  - because we already spend enough
- Strategic value of medical security
  - Demonstrate competence + compassion
  - Enhance economic, social, and political stability
- Free up attention, energy, and money to cope with tough problems → →
  - **Public education**
  - **Rebuild manufacturing, exports, economy**
  - **Energy independence**
  - **Good jobs at good pay**
  - **House homeless people**
  - **Cooler world + clean environment**
  - **Criminal justice**
  - **Fighting terrorism + genocide**
  - **Greater income equality**
  - **Infrastructure**
  - **Longer vacations**
  - **LTC + mental health**

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Getting Ready

- National or state health care crisis might spark demand for reform, but what would we do then?
  - In 1930s, many New Deal reforms worked well because they'd been tested in various states
  - Today, federal/state governments, insurers and HMOs, hospitals, and doctors have <u>no contingency plans</u> to deal with a health financing crisis
  - Now is time to learn how to cut waste, pay for care, and organize delivery of care
  - States need to be able to experiment—that's very hard today
  - States differ greatly, so one-size-fits-all is unrealistic

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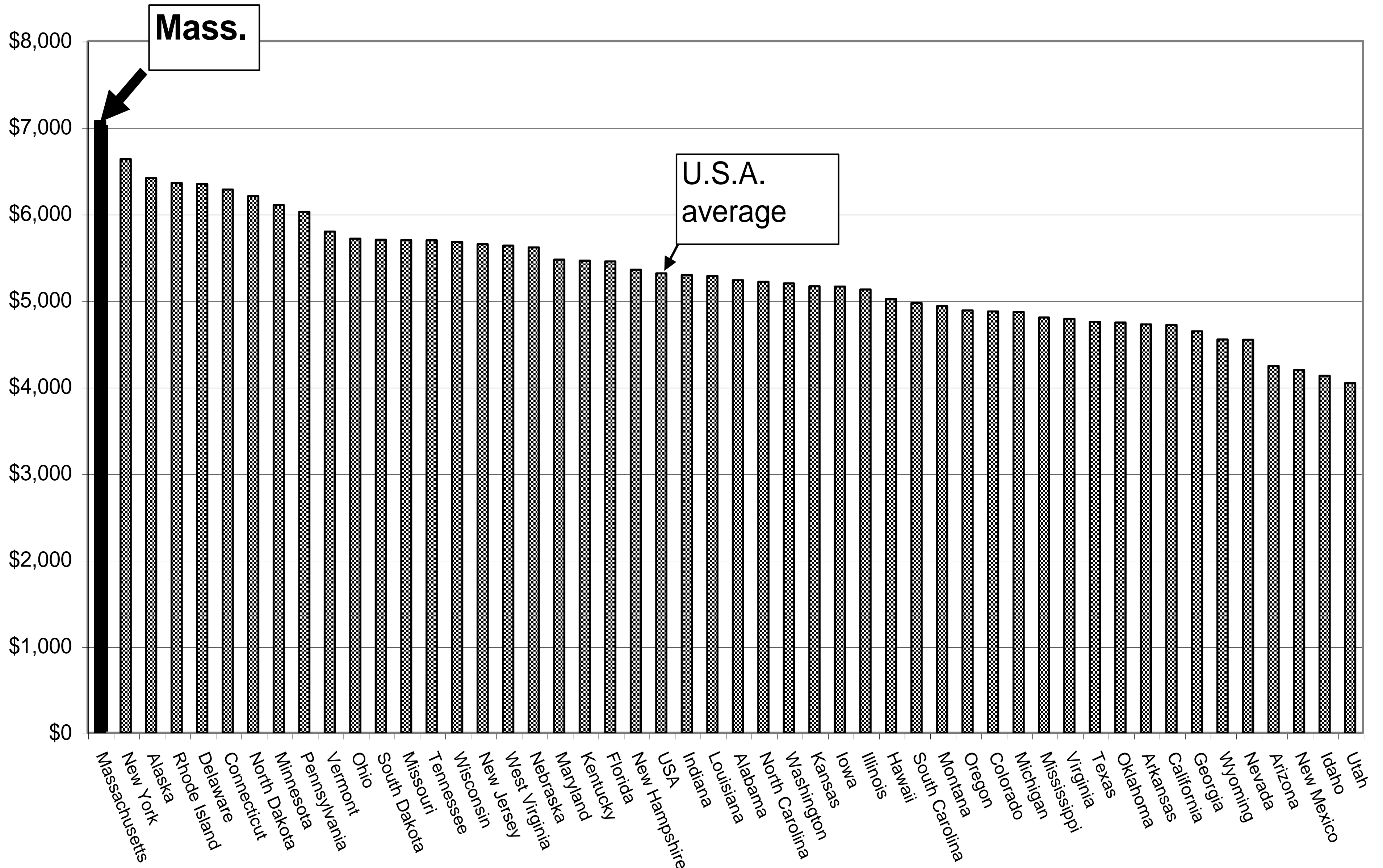
Personal Health Spending per Person, by State, 2004



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Reform Opportunities

- Waste
- Cost control and covering everyone
- Caregivers shape care
- Doctors: powerful but largely ignored

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If Health Care for All Is a Moral Right, Then Cost Control Is a Moral Duty

1. Outcomes not commensurate with spending
2. One-half of health spending wasted

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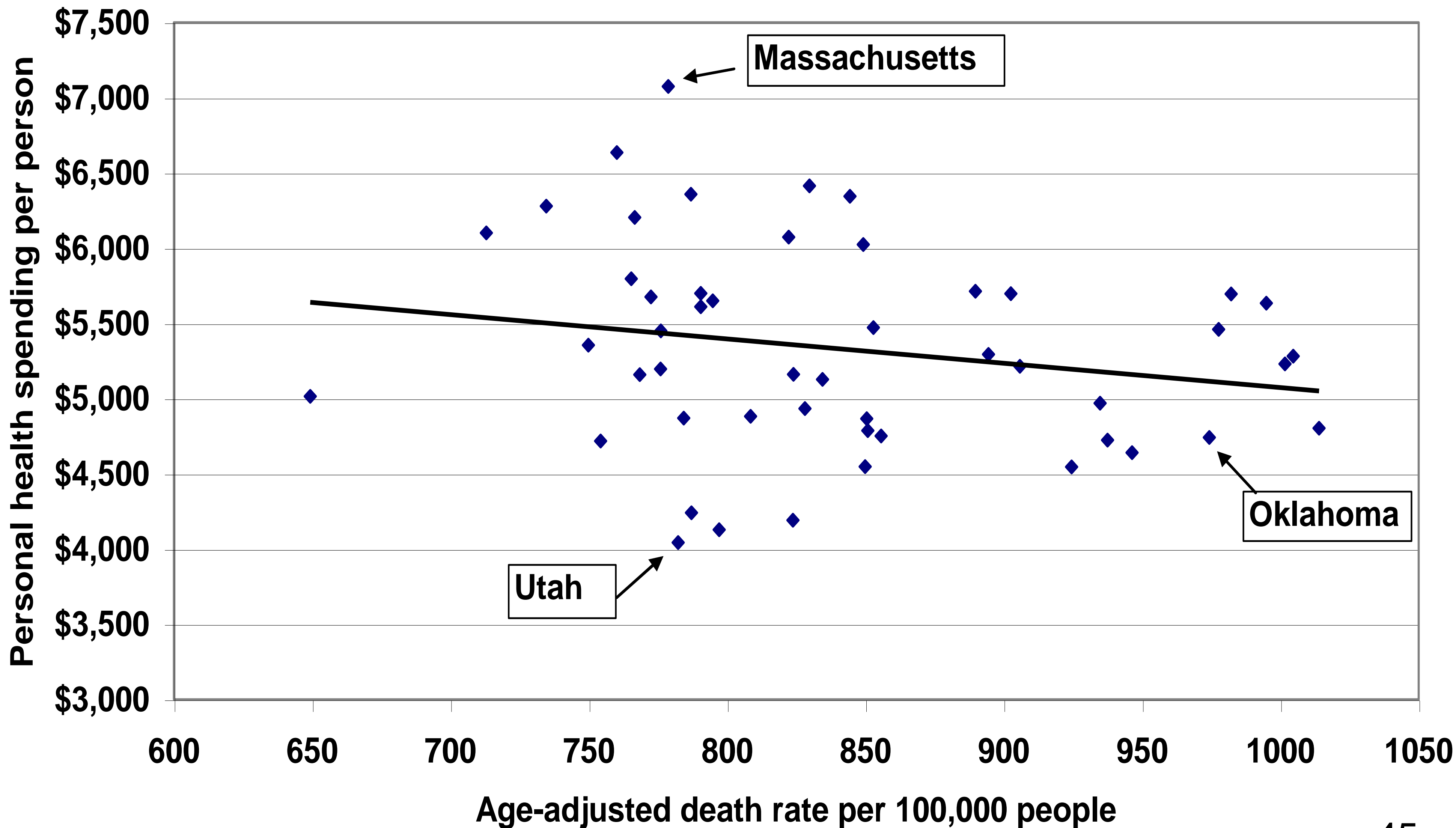
Correlation between Personal Health Spending per Person and Age-Adjusted Deaths per 100,000 People, 2003



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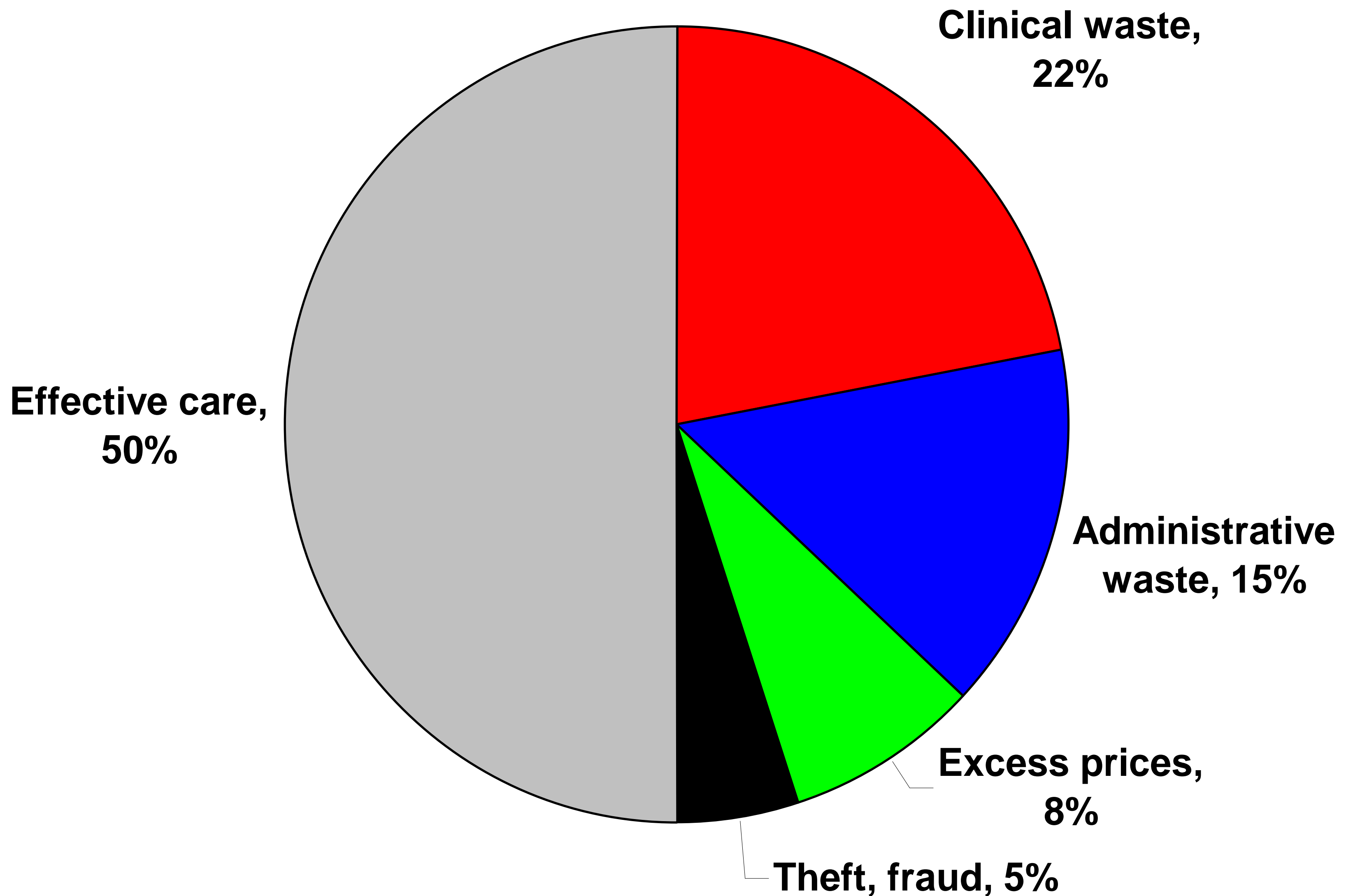
U.S. Health Care Waste, Estimated



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Waste: types and main causes

Clinical: unnecessary or incompetent care

- Piecework payment → financial incentive to do more
- Fear of being sued → defensive medicine
- Too few well-insured patients → they are over-served
- Lack of evidence or failure to use it
- Increasingly specialized and costly hospitals and doctors

Administrative

- Some: complexity (eligibility, referrals, formularies)
- Most: mistrust between payers and doctors, hospitals

Excess prices

- Rx, medical supply, durables, caregiver industry power

Fraud, theft

- Light punishment, perception that no-one's hurt

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Linkage: Cost control is essential to covering everyone and stabilizing all needed caregivers

- U.S. health care accustomed to 3-4% yearly rise in real health spending
- Next bad recession: Health care crashes through windshield
- Current spending is enough to care for everyone
- Without cost controls, health care business-as-usual sponges up available dollars
  - Making health care still costlier
  - Boosting the number of uninsured people
  - Making it harder to solve all other U.S. problems

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Repent!

- Health care is addicted to more money for business as usual.
- <u>No past cost controls have worked</u>, and there is little reason to trust those now proposed—such as higher patient payments, electronic medical records, or disease management.
- Current spending is enough to finance the care that works for the people who need it.
- No villains (very few, anyway)
- So let's try some things that could work.

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All past U.S. cost controls have failed

<u>Market, both wholesale and retail cost controls</u>

- There is not (and can't be) anything close to a free market in health care, so it can't work to contain cost
  - All six main requirements for market are unattainable
- Market rhetoric usually becomes smokescreen for
  - Allowing anti-competitive mergers and monopoly
  - Erecting deductibles, co-pays, and other financial barriers between sick people and needed care
  - Rationalizing yet another tax-favored savings vehicle (HSAs)
  - Avoiding honest talks with doctors, hospitals, drug makers

<u>Wholesale regulation by government</u>

- Regulation half-hearted
  - No motivation to contain cost—<u>no palpable benefit</u>
  - Public has never wanted cost control for its own sake
  - Caregivers game regulations—perhaps as intended

<u>Doctors: essential but treated as objects or ignored</u>

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Free markets' 6 requirements—

and barriers to free markets working in health care

1. Many small buyers and sellers, so all parties are price takers, not price makers. The market makes the price. No one has power in the market to extract a higher or lower price.

   In many regions, a few hospitals dominate delivery of acute care and seek higher prices. Often, a few large private insurers, HMOs, or public programs demand lower prices.

2. No artificial restrictions on supply, demand, and price. Consumers decide how much to demand; producers decide how much to supply. Their interactions determine price. Consumers of care are sovereign—they make the decisions and spend their own money as well as they can.

   Most patients are patients, not consumers. They are worried and inclined to listen to well-trained experts. Also, when patients have insurance, they are not spending their own money, so they are not aware of the price or total cost of the care they get.

3. Easy entry and exit to and from the marketplace. If a producer or provider gains a monopoly, which allows it to extract fat profits, those profits attract new providers, which bid down prices to free market levels.

   Once some hospitals close or consolidate in a region, it can be very costly or hard for new hospitals to open. Also, drug makers have legal monopolies (patents) on new drugs.

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4. Good information about price and quality informs the decisions of consumers and producers.

   But patients and families often have trouble finding valid information. And many people are worried when sick. Caregivers have much greater access to information.

5. Constant mistrust or suspicion—“let the buyer beware!”)

   But patients are likelier to recover, other things equal, when they trust their doctor, nurse, or other caregiver. (“White coat effect.”)

6. Price tracks cost closely, so when you buy something with a low price, you almost always buy something that has a low cost of production. Price is a signal for cost.

   Often, health care prices are not even close to cost of care. Some prices are much higher than cost, and others are much lower.

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All past cost controls have failed

Failure of market + failure of government + marginalization of doctors =

HEALTH CARE ANARCHY

- No effective cost control
- Shrinking, insecure coverage
- Weak protection of quality, appropriateness

<u>Nothing and no one is responsible, accountable</u>

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Real Cost Controls

1. Cost control is essential to covering everyone and stabilizing U.S. health care
2. Consolidating the financing is essential to cutting administrative waste stemming from complexity, but it is not enough
3. Physicians are central to cutting waste—not "consumers"

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Linkage: Financing, caregiver payments, and actual organization/delivery of care

- Understandable but unaffordable obsession with financing coverage—raising money to insure more people

  → higher spending
- Less attention to methods of paying caregivers
- Almost no attention to actual organization and delivery of care
- All three needed

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The care we get is shaped substantially by the caregivers we’ve got.

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Hospital and doctor configuration matter

1. U.S. has fewer beds per 1,000 people than most other wealthy nations, and a greater share of beds are apparently concentrated in costly teaching hospitals
2. U.S. has fewer physicians per 1,000 people than most other wealthy nations, and a greater share of doctors practice in procedure-oriented specialties (and fewer in primary care)

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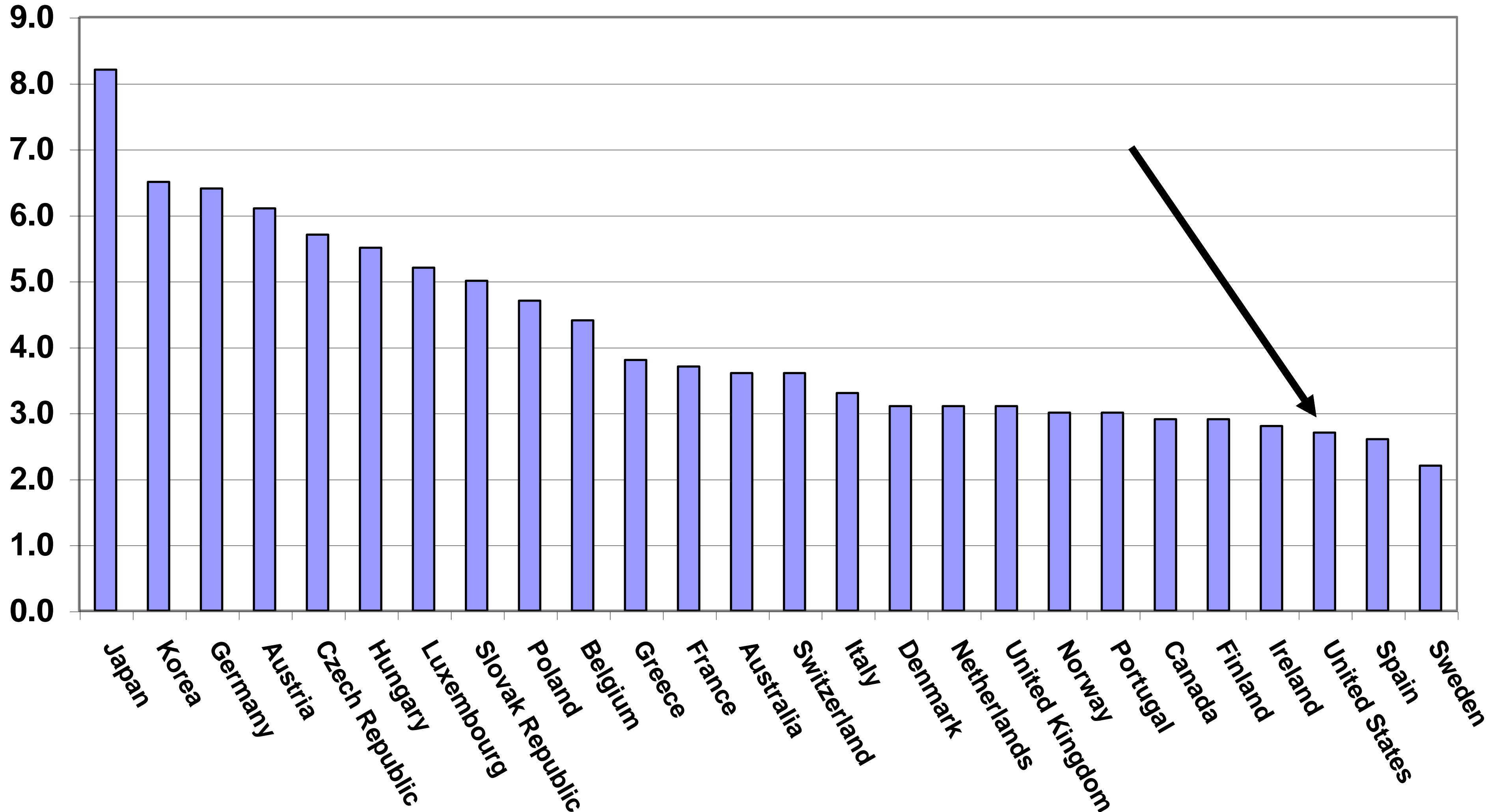
Acute Beds per 1,000 People, Wealthy OECD Nations, 2005



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Closing hospitals predictably won’t save money

- Smaller and less costly hospitals are easier to close politically.
- Teaching hospitals survive; hospitals in black neighborhoods close (controlling for other factors)
- When they close, care, workers and costs migrate to costlier surviving hospitals
- Bigger hospitals and medical centers provide costlier care, but they are politically impossible to close
- <u>Efficiency has no value in predicting hospital survival</u>

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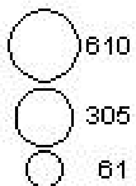
Detroit, Michigan

★ Hospitals Closing, 1936 - 2003

● Hospitals Open, 2003

pitals: Final Year Beds

Hospitals: 2001 Beds



ent Black & Hispanic, 1990

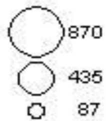
Washington, District of Columbia

★ Hospitals Closing, 1936 - 2003

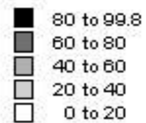
● Hospitals Open, 2003

Closed Hospitals: Final Year Beds

Open Hospitals: 2001 Beds



Tract Percent Black & Hispanic, 1990



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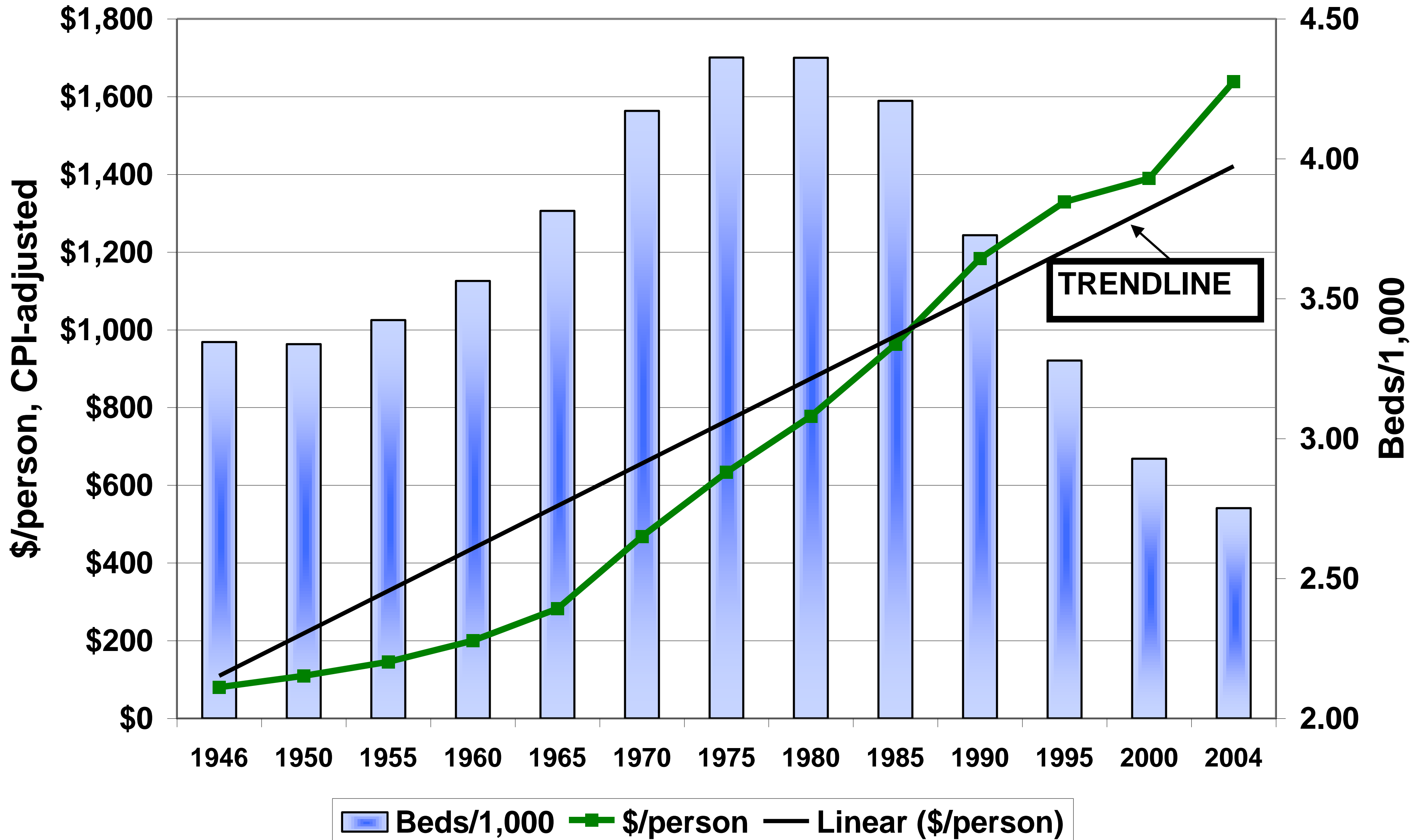
Hospital Cost/person (Consumer Price Index-adjusted) and Beds/1,000, U.S. 1946 - 2004



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Configuration of Doctors

- Primary care underpaid
  - Retire, boutique, closed practices
- Geographic maldistribution
- Many hospitals lack needed doctors on staff

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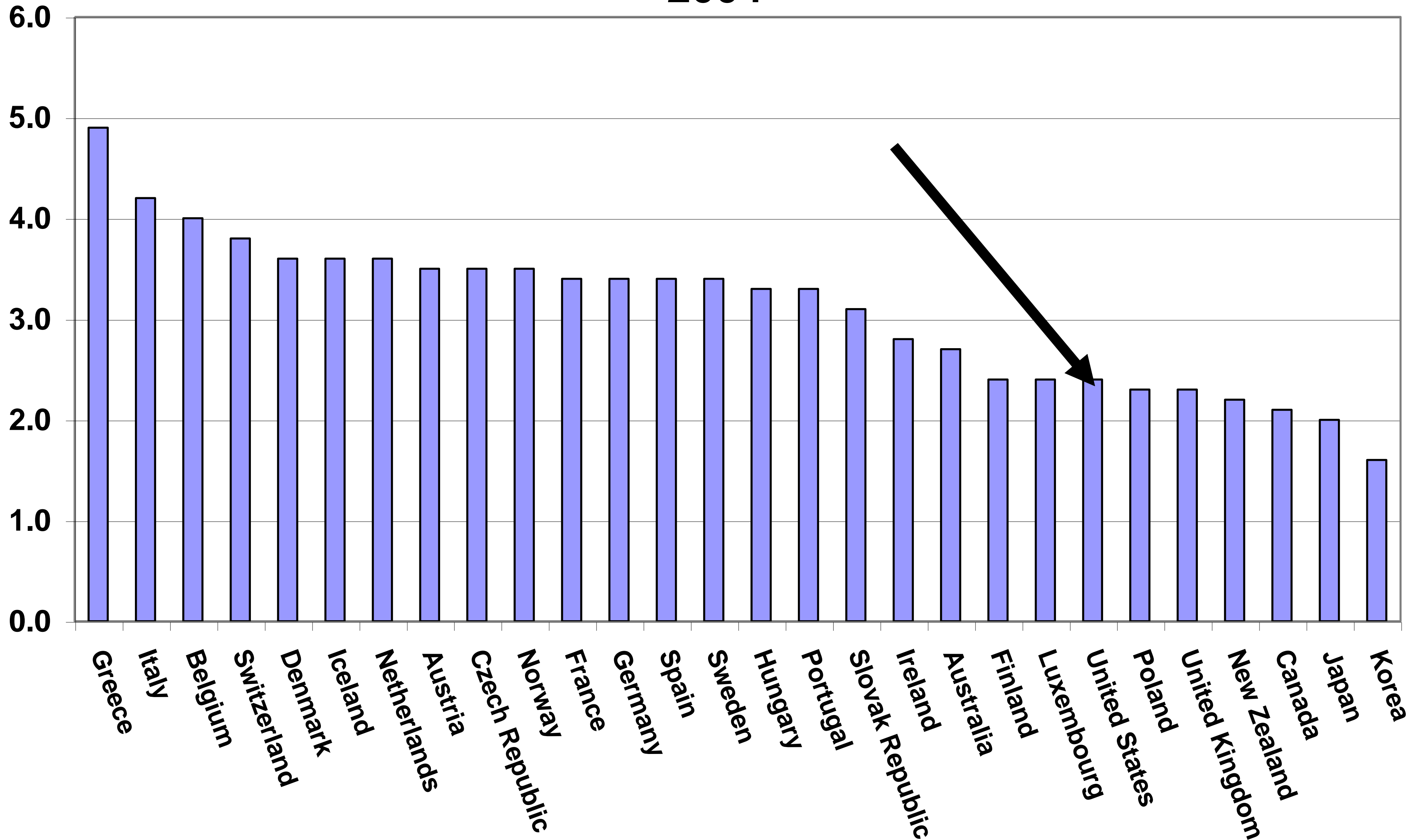

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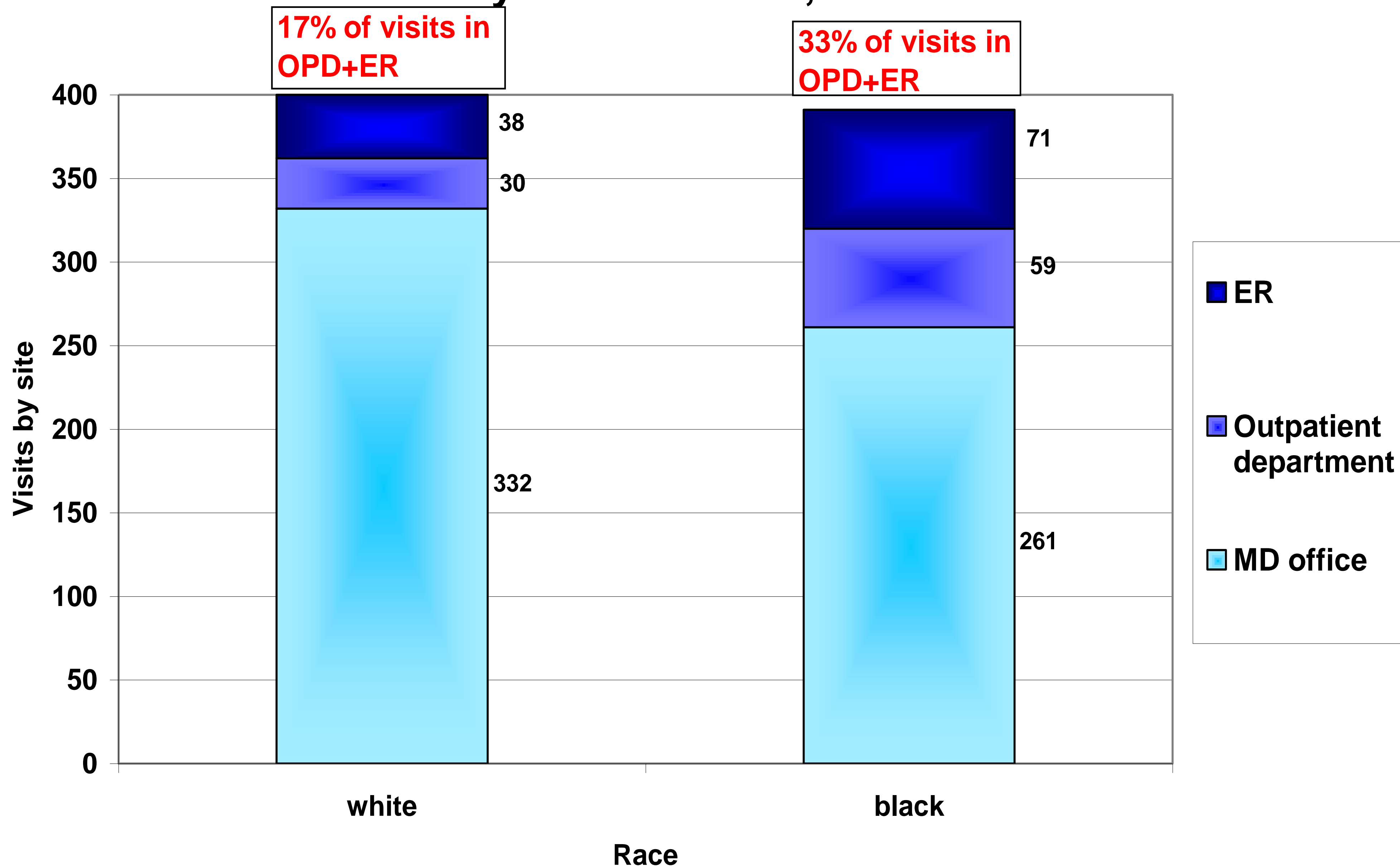

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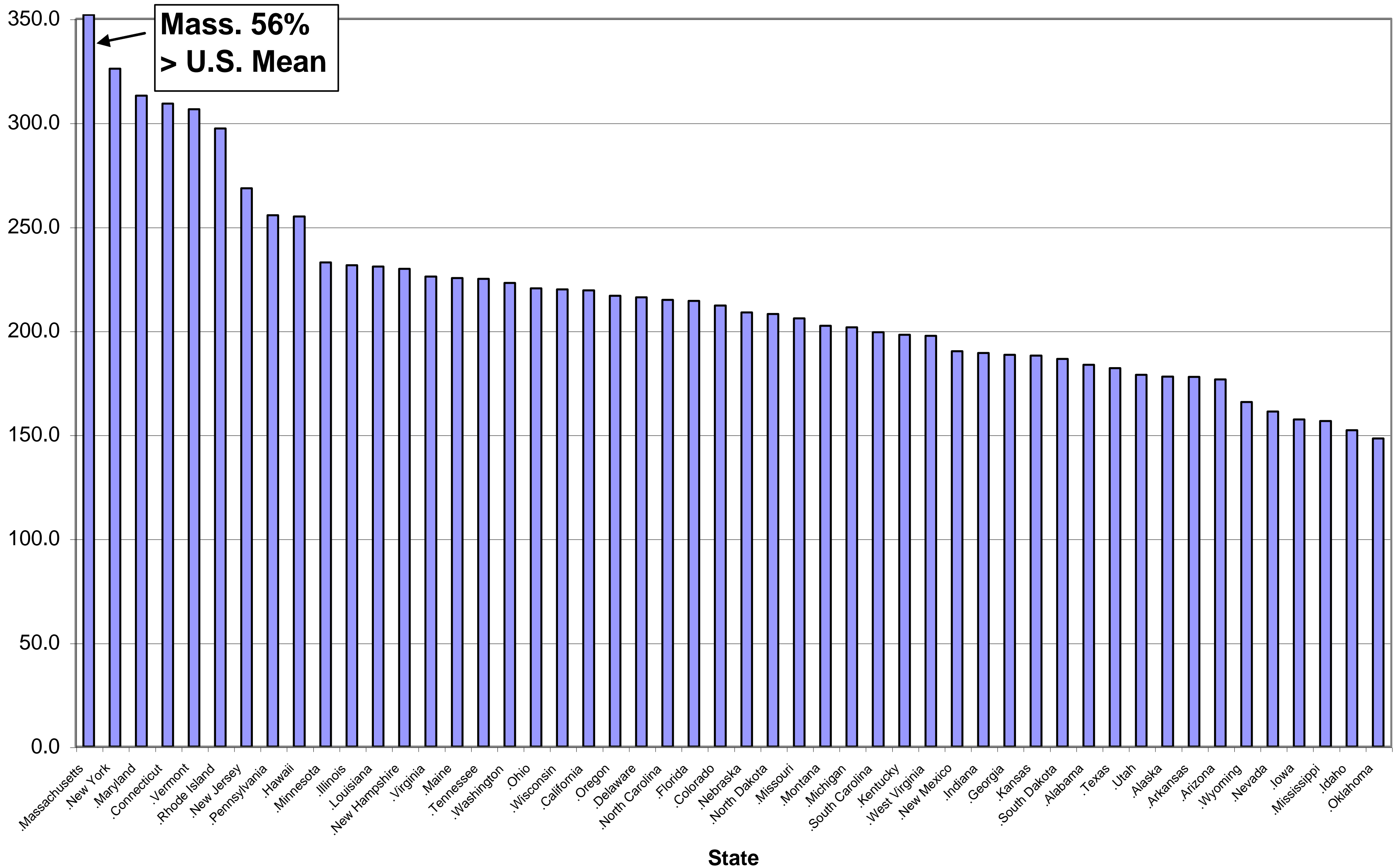
Patient Care Physicians per 100,000 People, by State, 2002



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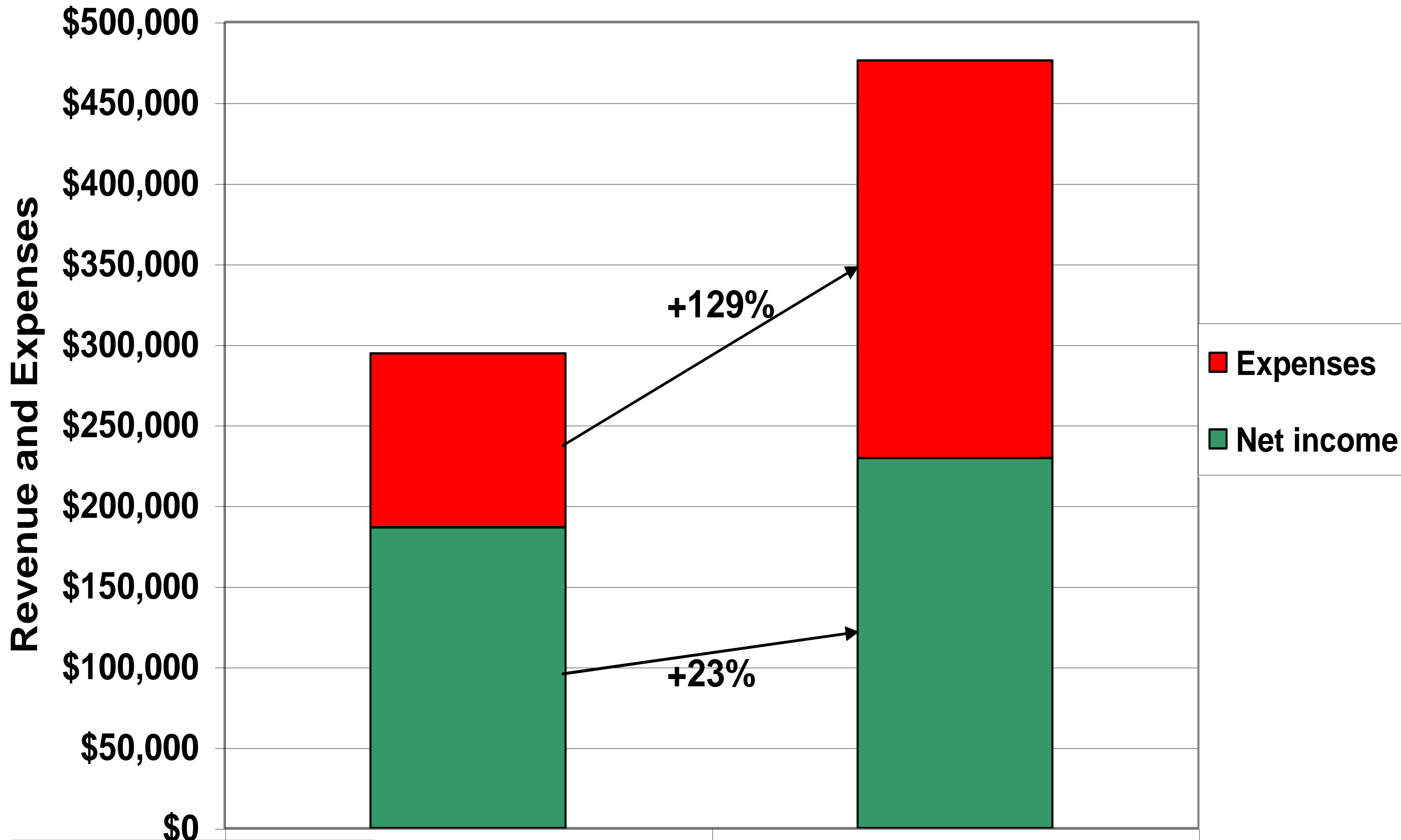
U.S. Physician Net Revenue and Expenses, 1970 + 2000



Real 2000 dollars, adjusted for consumer price index

Source of data: Rodwin and others, *Health Affairs, 2006.*

Containing costs and covering all Americans

Why Have Cost Controls Failed?

- Didn't target waste
- Mechanical reliance on market or regulation
- Politically powerful caregivers see cost cut as revenue cut (no recycling of savings)
- Bloodless "right thing to do" but no payoff
- Doctors were
  - Manipulated,
  - Squeezed financially, or
  - Ignored

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Methods of containing cost—which cut waste?

	Wholesale	Retail
PUBLIC	**A** Payers cut fees to caregivers, Regulate supplies of caregivers	**B** Empower MDs to spend carefully→ they cut clinical waste + paperwork
MARKET	**C** Hospitals, HMOs, and drug makers compete by price	**D** Make patients pay more→ they shop more carefully by price, quality

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Most waste persists after payment is consolidated

<u>Consolidated financing (single payer) makes it</u>

- <u>easier to cap revenue and cover all, and</u>
- <u>to cut waste from complexity of financing, but</u>
- <u>doesn’t address waste caused by</u>

- Hospitals’, doctors’, others’ financial incentive to give more care
- Paperwork stemming from payer-caregiver mistrust
- Patient mistrust of some payers’ desire to trim care to make money
- Absence of limits on spending (cost of care) if caregivers play “chicken” with budget’s revenue caps
- Lack of need to make trade-offs, spend carefully
- Actual organization and delivery of care
- Causes of defensive medicine

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NEGOTIATING A PEACE TREATY WITH PHYSICIANS

- **Let’s recognize that doctors essentially control or commit 87% of personal health spending**
- **Doctors’ support is vital to win patients’ votes**
- **Needed: a solid public structure for doctors’ good private efforts**
- Doctors are disaffected and angry. They could be strongly motivated to do something different.
- Negotiate a peace treaty with doctors, one that
  - Ends threat of malpractice suits
  - Ends paperwork stemming from mistrust/complexity
  - Liberates physicians to use evidence to care for all
- In exchange for doctors’ agreement to
  - Act as fiduciaries, not businesspeople, and care for everyone well
  - stay within budgets (that have much more money than is available today)
  - weed out waste patient-by-patient

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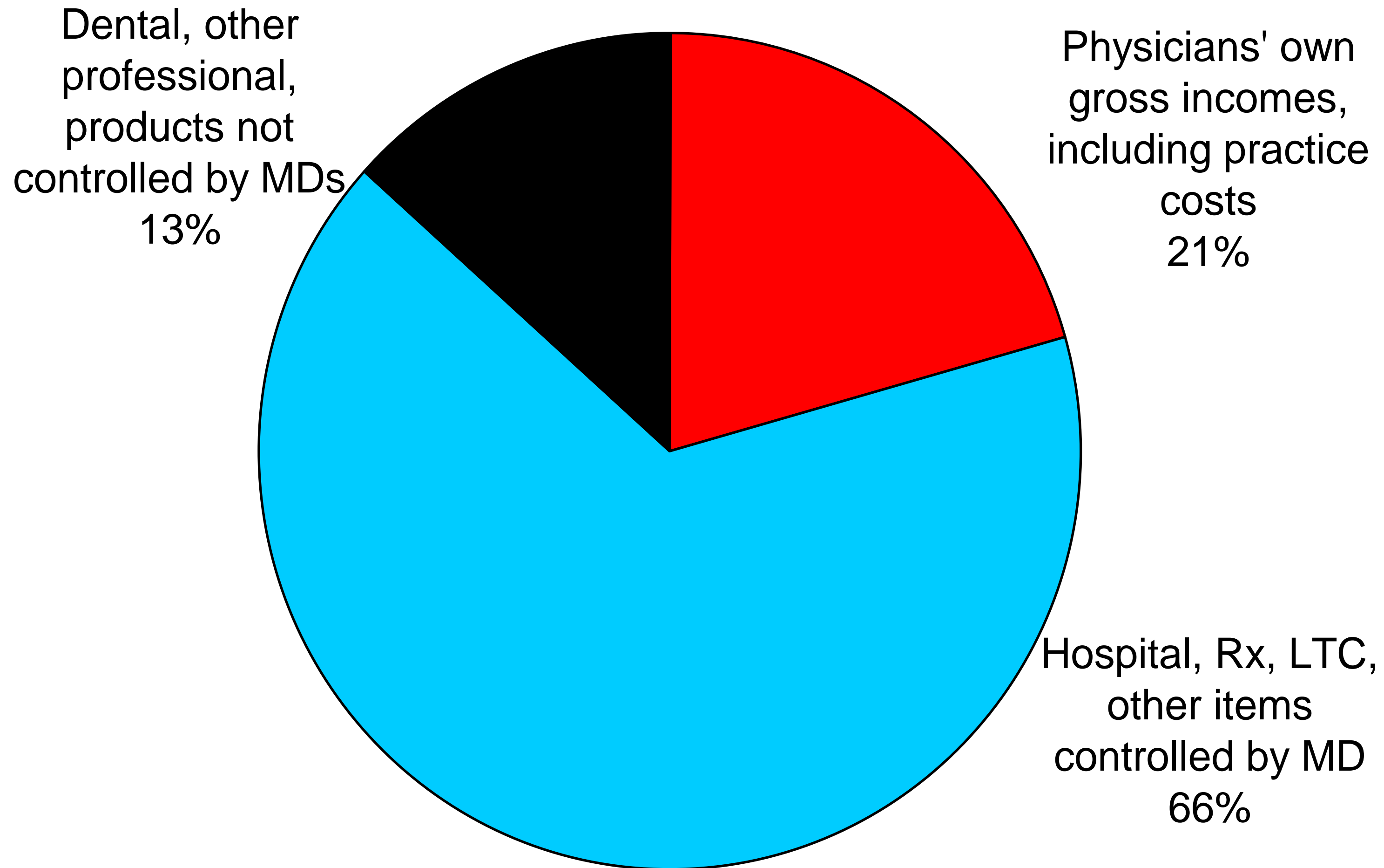
PHYSICIANS RECEIVE OR CONTROL 87% OF U.S. PERSONAL HEALTH SPENDING, 2005



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A few means of cutting waste

a. Assemble all dollars in one place
   - ✓ that's all there is
   - ✓ If I'm denied care, the only motive is to husband $s to finance needed care, not to enrich someone

b. Acknowledge that
   - ✓ pathology is remorseless but resources are finite
   - ✓ so need spend carefully

c. Pay doctors in ways that allow us to trust them to spend the money carefully
   - ✓ Doctors get about 21 cents on health dollar but keep only about 9-10 cents after practice costs—
   - ✓ **how they garner the 9-10 cents is critical**

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A few more means to cut waste

d. End malpractice litigation. Substitute
   - ✓ evidence-based care,
   - ✓ no-fault compensation for victims of harm,
   - ✓ education and then weeding-out of chronically error-prone or dangerous clinicians

e. Regional budgets

f. Three separate watertight compartments
   - ✓ One for physicians' 21 cents/9-10 cents
   - ✓ One for the other 66 cents doctors control (inpatient care, medications, nursing home care, others)
   - ✓ One for dental care, public health, capital projects, other activities

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Saving money and recycling it

- Doctors practice professionalism within budgets.
- Doctors are not at financial risk. They know that their own income is secure, if they work hard.
- They could be paid by fee-for-service or salary, in light of competence, energy, kindness
- Acting as fiduciaries for patients, doctors marshal and carefully spend the money for hospitals, labs, meds, long-term care.
- Groups of physicians set standards of care, using evidence, to cover everyone with the money that's available.

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Why would doctors save and recycle?

1. More money for care + more insured patients + cut in practice costs

   → doctors' net incomes (after expenses) rise

1. Higher incomes stem from professional patient care, not entrepreneurial ownership of MRI or surgery center
2. Doctors can do their jobs better because have clinical freedom to care for all, using evidence
3. No fear of being sued
4. No mountains of paperwork
5. Business-as-usual is doomed
6. Make medical profession attractive to their children

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Saving money and recycling it (more)

- Flexible budgets for hospitals, adjusted for volume and severity of illness → secure and adequate financing for each needed hospital (as in Maryland)
- More money for clinical services (less for administration, theft) → caregivers' budgets grow
- Savings from cutting wasted clinical services are recycled and available to finance care for all
- Theft and fraud come directly out of budgets for care → whistle-blowers deter theft (Theft kills!)

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To spend finite dollars more carefully, doctors would need

- Galvanizing, dramatic hope of something better
- Better data on costs and value of various diagnostic/therapeutic interventions
- Financial pressure/reward
- Fair, agreed target incomes for primary care and specialist physicians
- A structure of finite budgets to serve patients
- Technical assistance with budgets and cooperation among doctors
- Possibly, a sea change in attitudes
  - Like the English + Welsh Nonconformist denominations that may have helped to motivate the industrious machinists who enabled the U.K.'s industrial revolution to march forward
  - Where would that sea change come from?

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One hand for yourself and one for the ship

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