Negotiating a Peace Treaty for Massachusetts Health Care

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Reclaiming Internal Medicine as a Profession:

Formulating an Action Plan for the Revitalization of Internal Medicine in Massachusetts

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Disclaimer: As always, I write and speak only for myself, not on behalf of Boston University or any of its components.

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Thank you. It is an honor to have the chance to speak with you this morning.

I'm delighted that you are interested in formulating an action plan for the revitalization of internal medicine in Massachusetts. So few people appreciate the value of planning.

That's my first theme. Without anything close to a free market anywhere in health care (with the exception of eyeglasses in the wake of anti-trust prosecutions), the alternative to reasonable planning is anarchy. Any anarchists in the room? I say this with strong affection for the free market, but I'm loathe to worship a golden calf.

Second, market rhetoric has been used a great deal in health care, usually as a smokescreen behind which powerful parties can advance their self-interest at the expense of others'.

Third, the main challenge is to devise practical approaches that advance the core interests of all stakeholders. Implementing those approaches will require compromises. Sailors talk about "one hand for yourself and one hand for the ship." In health care, too many people use two hands for themselves, preferably in someone else's pocket.

Fourth, revitalization means seizing the high ground in the discussion. Here's what's good for us. And here's why we think it will be good for everyone else.

Fifth, politically, if health care faces a grave crisis, with 80 million uninsured people, hundreds of hospitals going broke, and the rest, there will be votes for change in Congress or on Beacon Hill. But how will government be able to make anything better then—if it does not know what to do now? Getting ready requires engaging in contingency planning—if this or that happens, how could we respond. What do we need to design, think out, and test now, so we will be ready later?

Some people call contingency planning an act of despair. I think of it as an act of faith, that we can make it easier to overcome even the gravest of problems if we prepare. Denial is the real act of despair.

To get concrete, let me lay out my view of the main problems afflicting Massachusetts health care, describe their causes, and suggest a few solutions that will be useful to physicians and to other parties.

The problems

High costs

Massachusetts already has the world's most expensive health care, with spending this year running at over $80,000 per minute, for all 525,000 minutes this year, for a total of about $44 billion this year.

If Massachusetts spent on health care at the U.S. average per person, we would save almost $9 billion this year alone.

Breakdown of Mass. excess by main sector: ***See Exhibit 4*** in accompanying PowerPoint presentation***.***

We can try to legitimate the higher spending, but it remains high when we are done trying.

Care is increasingly unaffordable in Greater Boston family health insurance premiums rising 50 percent in present 4-year span, from about $6,000 to $9,000 annually.

Families' out-of-pocket payments for health insurance premiums are rising much faster than that, as employers shift costs to patients. Recent state data show a 36 percent rise in the past year in families' payments for health insurance.

Caregiver malconfiguration and financial distress

Having closed half of Massachusetts acute care hospitals and almost half of our beds in recent decades, there is a looming or real shortage of hospital beds. These changes mean longer trips to the hospital and to the ER, and longer waits on arrival, other things equal. When a hospital closes, doctors who rely on that hospital are often forced to retire or relocate their practices.

Financial distress faces many hospitals, many or most nursing homes, and many physicians. Many caregivers seek more money, asserting that their profits or incomes are below national averages.

It would take over $2 billion annually to bring Mass. caregivers up to national income or profitability levels. ***See Exhibit 6.***

Coupled with a looming substantial rise in the number of uninsured people.

The number lacking health insurance doubled from 1987 to 1994. It then fell again, with a booming economy and especially an expanding Medicaid program. Now, the numbers are on the way back up.

Loss of insurance means less health care. Loss of nearby hospitals reinforces this problem.

I've long predicted that these problems would unfold. I take no pleasure in describing them to you. I would rather have been wrong.

The causes

Causes of high costs

Most caregivers don't feel individually responsible for containing costs. Most patients don't either. And most want it that way.

Massachusetts provides a great share of its inpatient care in costly teaching hospitals—the nation's highest share by some measures. There is excessive reliance on costly hospital outpatient care as well.

We have seen the closing of many of the less costly community hospitals, and of hospitals in lower-income communities.

Managed care and price competition have failed to save money durably—in large part

- because patients got worried or angry when their HMOs, doctors, or hospitals might make more money when patients got less care, and
- because when HMOs squeezed hospitals, some hospitals closed and many of the survivors merged, giving many hospitals the upper hand in price negotiations.

Hospital closings have failed to save money. The less efficient hospitals have been more likely to survive. This might be called "survival of the fattest."

Hospital mergers have failed to produce demonstrable savings—that is, to make public the evidence of any asserted savings and to show how savings were calculated.

Massachusetts health care has apparently evolved toward a relatively elaborate and expensive pattern of clinical practice, one that grew naturally out of a soil rich

in teaching hospitals, specialist physicians, and a high ratio of physicians to patients. But this pattern did not mean high average incomes for physicians.

Causes of caregiver financial distress

A desire to do as much good as possible with the dollars available—and even some that are not available. Massachusetts hospitals' financial margins have been way below those of hospitals nationally for five decades. ***See Exhibit 11.***

Hospitals garnered $1.7 billion in surpluses from 1990 to 1997, but fell into deficit statewide in 1998 and 1999. The reason? Our hospitals' revenues rose faster than those of hospitals nationally, but our hospitals' costs rose much faster still. ***See Exhibit 12.***

The Mass. Hospital Association's insistence on across-the-board Medicaid payment increases to all hospitals means that half of any revenue hike goes to the 20 hospitals that least need the money—because the bigger hospitals, with the greater Medicaid volumes, tend to be doing better financially.

Lots of doctors—the nation's highest physician-to-population ratio, by every measure. ***See Exhibit 13.***

I am not saying that these numbers mean that Massachusetts has too many physicians—rather that having as many physicians as we do weakens physicians' bargaining power and places substantial stresses on many physicians' incomes.

Total spending per person on physicians in Massachusetts is about one-quarter above the national average. But we have so many more physicians in relation to population—40 or 50 or 60 percent more—that physician income suffers arithmetically.

The gap between Massachusetts and U.S. physician-to-population ratios grew for most of the past three decades. Some have suggested that this is no longer so.

Still, efforts to raise physician incomes in Massachusetts would be likely to attract still more physicians here. (Please note that the nation licenses almost 100,000 additional physicians every five years, net of death and retirement.) This presents Massachusetts physicians with a serious dilemma.

The long-standing Blue Shield ban on balance billing plus a relative patient shortage plus lots of teaching hospitals and specialists seem to have meant a

gradual evolution toward a more elaborate and costly pattern of care, just as little kids in Italy wake up speaking Italian. One result has been relatively low physician incomes but high health spending.

Further, we see weakening physician bargaining power in the face of hospital monopolies and oligopolies, and of HMO mergers.

Causes of lack of insurance coverage

Reliance on job-based insurance, which is a regressive tax on low-wage workers and an impossible burden on many smaller businesses—especially those in competitive industries and with high labor shares of costs of doing business.

Mandating employers to offer health insurance angered them. That anger contributed greatly to stymieing the Dukakis universal health care law in Massachusetts in the late 1980s, and to defeating the Clintons' efforts in 1993-1994.

The solutions

With the failures of managed care, price competition, and hospital closings as cost control mechanisms, there are virtually no ideas left in the good-currency warehouse that purport to deal with any of this, apart from the usual—

- more money for business as usual—proposed by many caregivers
- less money for business as usual—proposed by some employers and other payors
- make someone else pay—as employers are advised by their benefits consultants to shift cost to workers through higher worker shares of the premiums and medical savings accounts (have these ideas been secretly designed by union organizers?), OR
- create additional small and incredibly inefficient new programs to provide insurance protection to people who can't afford it today

If you think we can muddle through with a rising insurance premium here, a higher co-pay or an MSA there, and another hospital closing there, you don't need to listen any further.

If you think that bigger reforms are needed, here are a few options:

1. Single payor. Single payor would be a valuable way to reduce administrative costs, and to cover everyone. It would be mainly a short-term solution, though a valuable one, because it would give us a breathing space. Still, we will need

short-term solutions while we figure out longer-term ones, so we should figure out how to make single payor acceptable to all stakeholders in case it gets legislated at the bottom of the next crisis.

2. Cost-reducing technologies. Clearly, it is vital to develop more new technologies that reduce cost—cheaper ways to do things we already know how to do. Some will substitute drugs for surgery. Others will weed out clinical waste.

3. Acknowledge that $44 billion is enough. Enough for what? After all, pathology is remorseless and resources are finite. Enough to provide the care that works to the people who need it, if we spend carefully.

Let's commit ourselves to spending money better to cover everyone. Isn't it remarkable that we have learned to spend so much without learning to insure everyone?

We can stop torturing ourselves if we acknowledge a few realities. The more we spend on health, the less is available for housing homeless people, job training, education, cleaning the environment, anything else you like. No, the extra money for health care won't come from sinking an aircraft carrier battle group. Total annual defense spending now equals only about 3 or 4 years of health care spending ***increases***. ***See Exhibit 16.***

4. Identify and stabilize all needed hospitals

Draw up a list of the hospitals and emergency rooms that are needed to protect the public's health.

Draw up another list of financially distressed hospitals.

Hospitals on both lists qualify for managerial and, if necessary, financial assistance from a revolving trust fund financed by those hospitals that can afford to pay.

Institute all-payor rate regulation that guarantees each needed hospital enough money to remain open and provide high-quality care, as long as it is operated efficiently.

5. Tackle prescription drug prices and fill all needed prescriptions, at an incremental cost of about $200 million yearly.

- Cut prices by 40 percent or so through state legislation, saving about $1 billion yearly.

- Recycle the savings to buy more medications—for people who can't afford them now—through a combination of higher private market volume and higher publicly subsidized volume.

- Protect drug makers' revenue and profits; compensate drug makers for extra manufacturing cost and retailers for extra dispensing fees.

- End drug marketing and advertising—substitute objective evaluation of efficacy and cost; use the savings to double or triple today's investment in breakthrough drugs.

6. Devise forms of managed care and of risk arrangements that patients and payors and physicians can accept. Physicians must be paid well, in proportion with their value to society. But they must be kept financially neutral in their clinical decisions. If they are not, they will not be trusted to make the clinical and financial trade-offs that alone can safely contain health care costs, cover everyone, and protect quality. Physicians must be encouraged spend money carefully—and only financially neutral payment methods can permit that.

This means segregating physicians' incomes on one side of a fire wall. Here's your money. Your income does not depend on your clinical decisions.

And on the other side is the rest of the money for patient care. You must spend that money as well as you can to take care of all 6.3 million people of the state. Make it last for 12 months. Weed out what doesn't work at all or what this patient does not need.

Patients will be willing to accept less than the maximum available care—care that might be of any hypothetical benefit—if they know that the money saved by withholding treatments of marginal value are used to finance care of great value to other patients.

Doing all this requires several things.

- Better information on what works and which patients need it.

- Financial security for physicians, possibly featuring salaries.

- Good management—with physicians who are more competent, energetic, and kind rewarded with higher incomes.

- Physician willingness and ability to make trade-offs to spend inevitably finite dollars carefully.

Physicians might be grouped in separate non-profit HMOs that compete by quality, not by price. The trouble here concerns artificial barriers to referral, dividing family members' physicians among several physician groups, and other plagues.

It is easier to talk about the need to do these things, and to sketch out a general approach, than it is to devise and test practical, durable, and acceptable ways to do so. But talk and thought have to precede action. The devising and testing should follow soon. State government, employers, unions, health maintenance organizations, and others should pursue this approach.

The worst thing we could do is to deny the possibility that Massachusetts health care could melt down around us—with soaring insurance premiums, many more uninsured people, more closed hospitals and emergency rooms, and more angry and frightened voters. The best thing we could do is to design ways to prevent meltdown. The second-best is to prepare ways to cope with it and to reverse it as quickly as possible. Failure to prepare will cause large-scale but preventable human suffering.