24 Reasons Why Affordable Health Care for All Is the Easiest Problem to Solve in the United States of America

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Toward Affordable Health Care for All

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1. Americans worry about health care costs and coverage, some public opinion experts say. They also say that political leadership and debate of health care issues is essential to covering everyone and containing costs.[1] But Worry and Leadership are meaningless without practical solutions. And we lack those—almost completely.

2. Most health care debates in this nation are more shallow than a lake in a desert mirage.
   - Do some people lack insurance? Focus on financing coverage or seeming to finance it. Force individuals and families to buy insurance—even if some people must use money they don't have. As Massachusetts is in process of doing. Appear to make premiums affordable by cutting benefits or boosting deductibles and other out-of-pocket costs. Don't do anything about the actual rising costs of health care itself—let the cost of solid family health insurance in greater Boston rocket from $14,000 this year to $22,000 per family five years hence. Expand Medicaid with money states don't have. Borrow $750 billion from our grandchildren to subsidize a silly and politically-driven Medicare drug plan that enriches insurers and drug makers while providing flimsy coverage.
   - Are hospital costs too high? Close hospitals to save money—especially the less costly hospitals and those located in black neighborhoods.

- If overall spending is too high, the market's not working as well as the textbooks say it could, so make people pay more out-of-pocket to deter use of care. Pretend that enough people can shop for their diagnostic and therapeutic services by price and quality. After all, economists married to doctors think that's possible.

Most of the current discussion floats along the surface, never getting into the guts of health care realities.

3. Health care has never saved a single life. That's a theological or philosophical question, not a clinical question. Mercifully, health care does delay death, overcome disability, and ease pain. The core aim of health care, we believe, is medical security, which is confidence that we all will receive competent, timely, and compassionate care, without having to worry about the bill when we are sick, and without having to worry about losing our insurance ever.

4. Current U.S. health spending is enough to finance medical security for all Americans (and has been enough for at least 30 years). That's what makes health care the easiest problem to fix. We already spend enough to take care of everyone well.

- We are not able to spend remotely enough to fix other big problems—rebuilding manufacturing, shaping effective criminal justice, housing homeless people, cleaning the

environment, investing in energy independence, taking longer vacations, and all the rest. And soaring health spending is one of the main reasons we don't have enough money to address these other problems.

- You know the usual international comparison, but domestically, please consider that when Pres. Kennedy was inaugurated, defense spending was about double health spending. Now, health spending is about quadruple defense spending. Before too long, prescription drug spending alone may surpass defense spending.

5. Soaring heath care spending is the enemy of economic, social, and political stability in the U.S.A. Economically, it hobbles our ability to sell our goods overseas. Socially, it helps to drive us toward a society of rich and poor. It directly causes all other problems to fester. Politically, high cost and growing inequity of care could prove to be the detonator that sets off dangerous explosions.

6. Half of our health spending is wasted on the wrong care, paperwork, excess prices, and theft. All cost controls have essentially failed, the economy is perched precariously, and more money for business as usual will cease to flow. At some point. And all the people who direct our health care refuse to think about that. It's too scary.

7. Thirty years of cost controls have essentially failed for several main reasons.

- First, too many people wanted higher spending, and they were able to steer the cost control attempts in a different direction.
- Second, we rarely attacked the causes of high costs—
  - ✓ clinical waste that stems from financial incentives to over-serve, defensive medicine, lack of enough evidence, and failure to use the evidence we have;
  - ✓ administrative waste that stems from complexity and even more from mistrust;
  - ✓ excess prices imposed by drug makers, won by some caregivers, and lamely accepted by payers; and
  - ✓ outright theft, rationalized as a victimless crime and even a perpertratorless crime, and by weak enforcement and punishment.
- Third, none of the cost controls have been crafted cooperatively with doctors. Doctors control 90 percent of clinical decisions and spending, so they can't be ignored.

8. Doctors are absolutely central. They have to be persuaded to accept accountability for squeezing out waste and serving everyone well.

9. Suppose the people voted overwhelmingly for a single payer reform plan today. Tomorrow morning, revenue might be capped and all the money might be collected in one place. Plans to capture administrative waste would be made. But if

doctors hate the idea, and keep spending too much, cost will not be contained. If doctors bad-mouth the reform to their patients, political support will plummet.

10. Doctors are not happy. Especially primary care doctors in many states. They work much too hard. Their numbers are dwindling. They make much less than procedure-oriented specialists who often work shorter hours. Everyone is forecasting a large deficit of primary care doctors. It would take years to begin to offset that, even if we began today.

11. What's the main response—nurse practitioners at minute clinics in pharmacies? Cheaper than the ER. Maybe. Another sign of the growing inequality of health care. But better than nothing, as we will say more and more often. The minute clinic is better than the ER, especially if the hospital has closed anyway.

12. There's an alternative. We can imagine the shape of a political, clinical, legal, and financial peace treaty with doctors.
    - We ban malpractice litigation. It doesn't do either of its putative jobs well. It doesn't effectively weed out dangerous docs and it doesn't fairly compensate victims of harm.
    - We eliminate payment-related paperwork. But we can only do that if we and doctors agree on a trustworthy method of paying doctors. Mistrust is the genesis of most waste, not complexity.

- So doctors will have to agree to serve as fiduciaries and care for all of us well with the huge sums already available.
- Consider a few Massachusetts health care realities. A primary care MD with a panel of, say, 3,000 patients is caring for people whose total health care expenses this year will be some $23 million. With help, a primary care physician can marshal those dollars.
- Good budgeting will be part of that help—one budget to pay doctors. A second budget to pay the things that doctors authorize—labs, radiology, meds, surgery, other inpatient care, most long-term care, and most DME. A third budget for the dentists, acupuncturists, OTC meds, and other kinds of care that doctors don't control. Each budget is in its own watertight compartment.
- In sum, doctors, would need to accept an obligation and a method of payment that would allow us to trust them to spend carefully.

13. But today, there's almost no one to talk with on the physician side. "Organized medicine" is the loudest oxymoron in health care. Rivalries and anti-trust laws prevent most U.S. doctors from combining to negotiate with us even if we recognized the usefulness of negotiating with them.

14. The U.S. economy is fragile, hollowed out, floating on borrowing more money from people who know we can't pay them back, but who don't dare cease to lend more, lest we

collapse and deflate the world. Think of Germany in 1927. Economic crisis, when it comes, will boost political pressure for reform, but that will be almost useless--maybe worse than useless--if we don't know what to do.

15. Fears of bird flu and bioterrorism engender disaster plans (feeble ones, but attempts). But we don't have a disaster plan for health care's financial and organizational meltdowns during a deep recession. Single payer is a framework—a good one, and a slogan—a bad one, but single payer itself is only about 10 percent of a real solution. We need much more.

16. We need to imagine various contingencies and plan responses.

17. From 2000 to 2005, rising health costs absorbed one-quarter of all economic growth in the U.S. During roughly the same years, health care added some 1.7 million jobs. The rest of the private economy all together—no added jobs. That won't be allowed to happen during the next recession, especially if it's a bad one. Too many other real needs will be competing for increasingly scarce dollars. There will be too much social and political ferment. Doctors and hospitals and drug makers will be told to be quiet and sit down.

18. Suppose that real GDP slides by, a total of 20 percent over three years—

- how many people lose insurance through the job, how much does tax revenue drop, and what hits do Medicare and Medicaid take?
- how many more people are uninsured?
- how deeply will public programs and private insurers seek to cut prices at which they pay caregivers for the remaining people with insurance?
- how are various hospitals, doctors, nursing homes, drug makers, and other caregivers affected, and how do their views of the world change?
- how much does the dollar drop against other currencies, leading to how big a drop in real living standards as the price of imports soars?
- what is the level of political and social disruption?

19. How can we offer patients, payers, and caregivers a soft clinical, financial, organizational, and political landing—one that ensures medical security for all Americans, squeezes out waste, and protects all needed caregivers--at the time that citizen-patients, payers, and caregivers dearly want those things.

20. And we need to talk with doctors, hospital CEOs and trustees, and politicians about how to get ready.

21. Incidentally, it's always helpful to fight ineffective, discredited, and clumsy efforts that promise to slow cost increases--like the doomed-to-fail Pataki-Bush hospital closings fiat in New York State. And it's helpful to identify the shortcomings of well-intentioned but financially unsustainable attempts to force people to buy insurance, like this year's Massachusetts bill. In April of 2006, our Massachusetts legislature passed the best bill our governor would sign. But future reform efforts will be undermined or discredited if a widely- and uncritically hailed bill fails. The problem is not that the problem can't be solved, but that today's coverage-focused reforms won't solve them. Today, the bill that can pass can't work and the bill that can work can't pass.

22. We need to do two important things now. The first is to continue to devise and test ways of paying doctors (and hospitals and drug makers) and organizing care that are durably sustainable and trustworthy.

23. The second is to figure out how to make the transition from a) where health care is now, through b) the clinical and financial and organizational crises and human suffering of a deep recession, to c) sustainable and trustworthy care--so that we land not only softly but also in the right place.

24. We need a *Constitution*al solution: One hand for yourself and one hand for the ship."

[1] Drew E. Altman and Robert J. Blendon, "Health Reform: Time for a Wake-up Call," 30 October 2006, http://healthaffairs.org/blog/2006/10/30/health-reform-time-for-a-wake-up-call/.