Affordable and Appropriate Health Care for All—

The Easiest Problem to Solve in the U.S.A.

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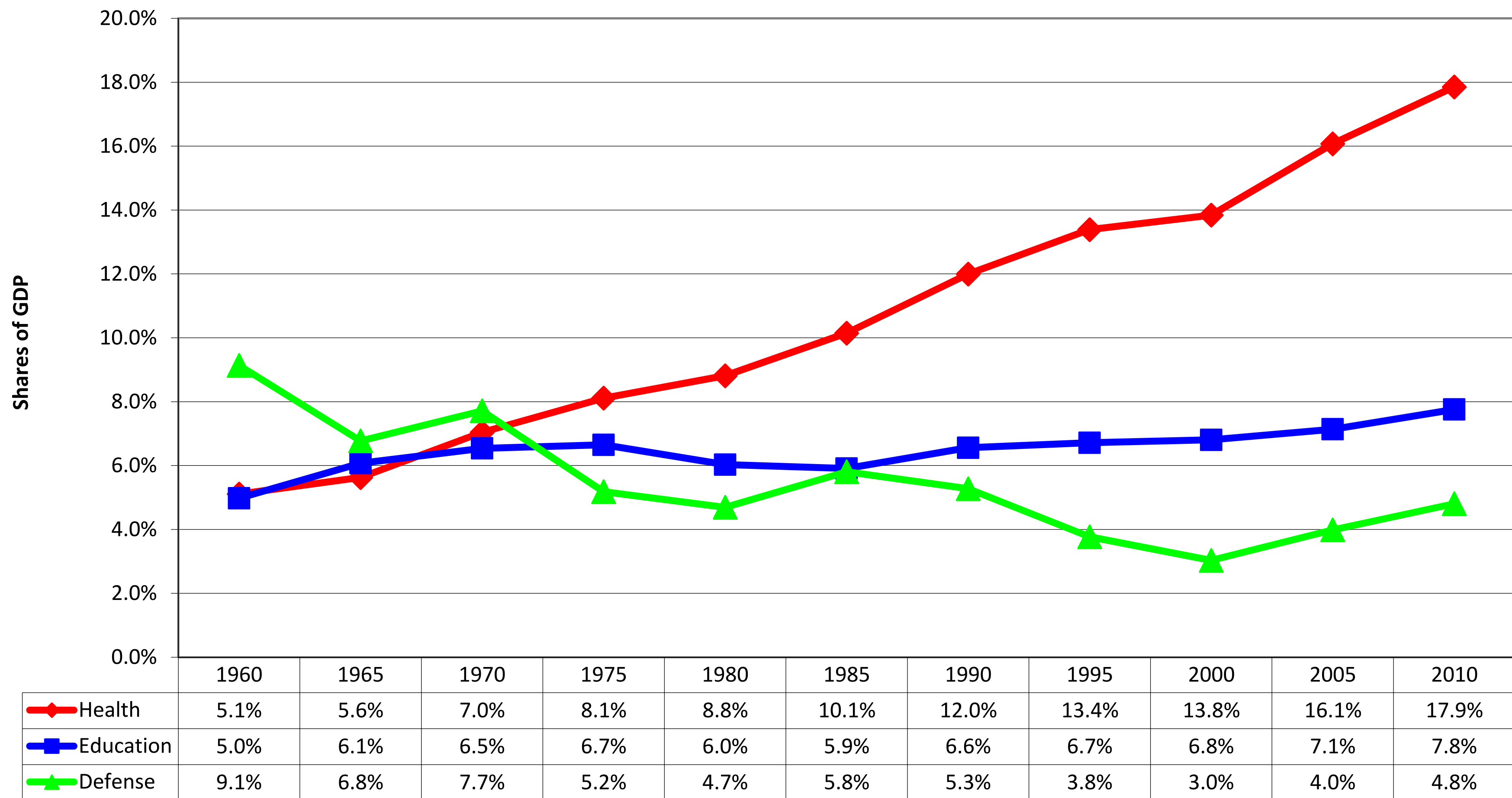
7 Themes

1. Easiest: Enough money to attain a decent and sane aim
2. Access
   - Heavy lifting
   - If ACA stays on the books, more people will be covered, but
     - Higher out-of-pocket payments
     - Caregiver shortages or low fees may impair access
3. Cost control
   - Steady rise in health's share of the economy
   - Nothing's worked—not market and not traditional government → anarchy
   - Instead of confronting problems, move them to ACOs
4. The care we get depends on the caregivers we've got, but we often have the wrong ones in the wrong places
5. More excess + deprivation of care: need + demand diverge
6. Mistrust – complexity – documentation death spiral
7. Realistic remedies

1. Easiest—not easy, just easier than any of our other problems



	1960	1965	1970	1975	1980	1985	1990	1995	2000	2005	2010
Health	5.1%	5.6%	7.0%	8.1%	8.8%	10.1%	12.0%	13.4%	13.8%	16.1%	17.9%
Education	5.0%	6.1%	6.5%	6.7%	6.0%	5.9%	6.6%	6.7%	6.8%	7.1%	7.8%
Defense	9.1%	6.8%	7.7%	5.2%	4.7%	5.8%	5.3%	3.8%	3.0%	4.0%	4.8%

Our Aim: Medical security

"Confidence that we'll get needed, timely, competent, and kindly care without worrying about the bill when sick, or about losing insurance coverage—ever"

(Worth recalling that health care has never saved a single life)

2. Access—financial coverage

- Massachusetts
  - Probably 95-97% covered in 2011
    - 2005 baseline was about 90% covered
- U.S.A.
  - If ACA implemented, could drop to 15 million uninsured in 2014 (95% covered)
    - 2010 baseline was 50 million uninsured (84% covered)
  - If ACA overthrown by Court or Congress, and if Medicaid maintenance-of-effort repealed
    - Could easily see 60++ million uninsured by 2016 – 2020, including 2.5 million formerly covered < age 26

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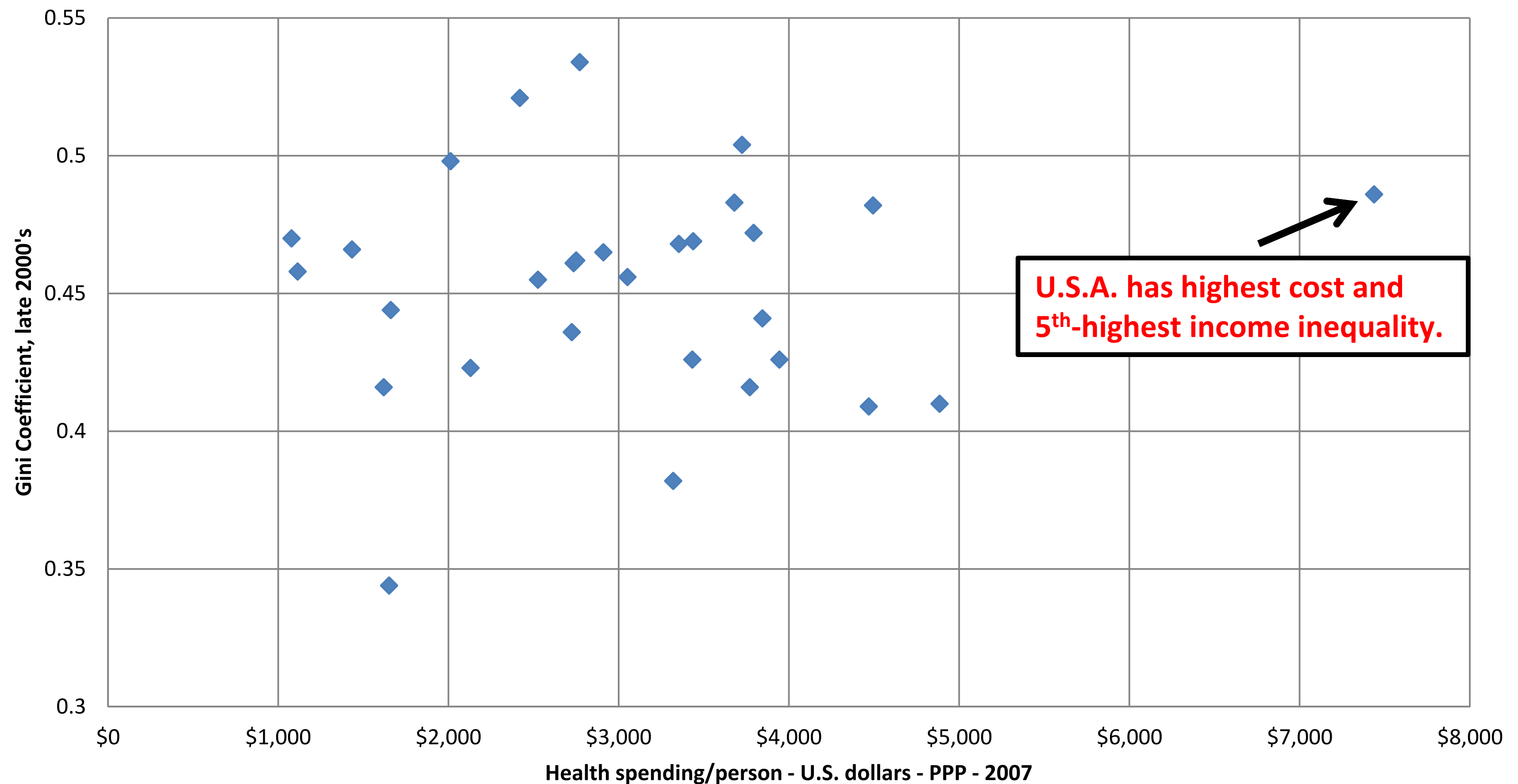
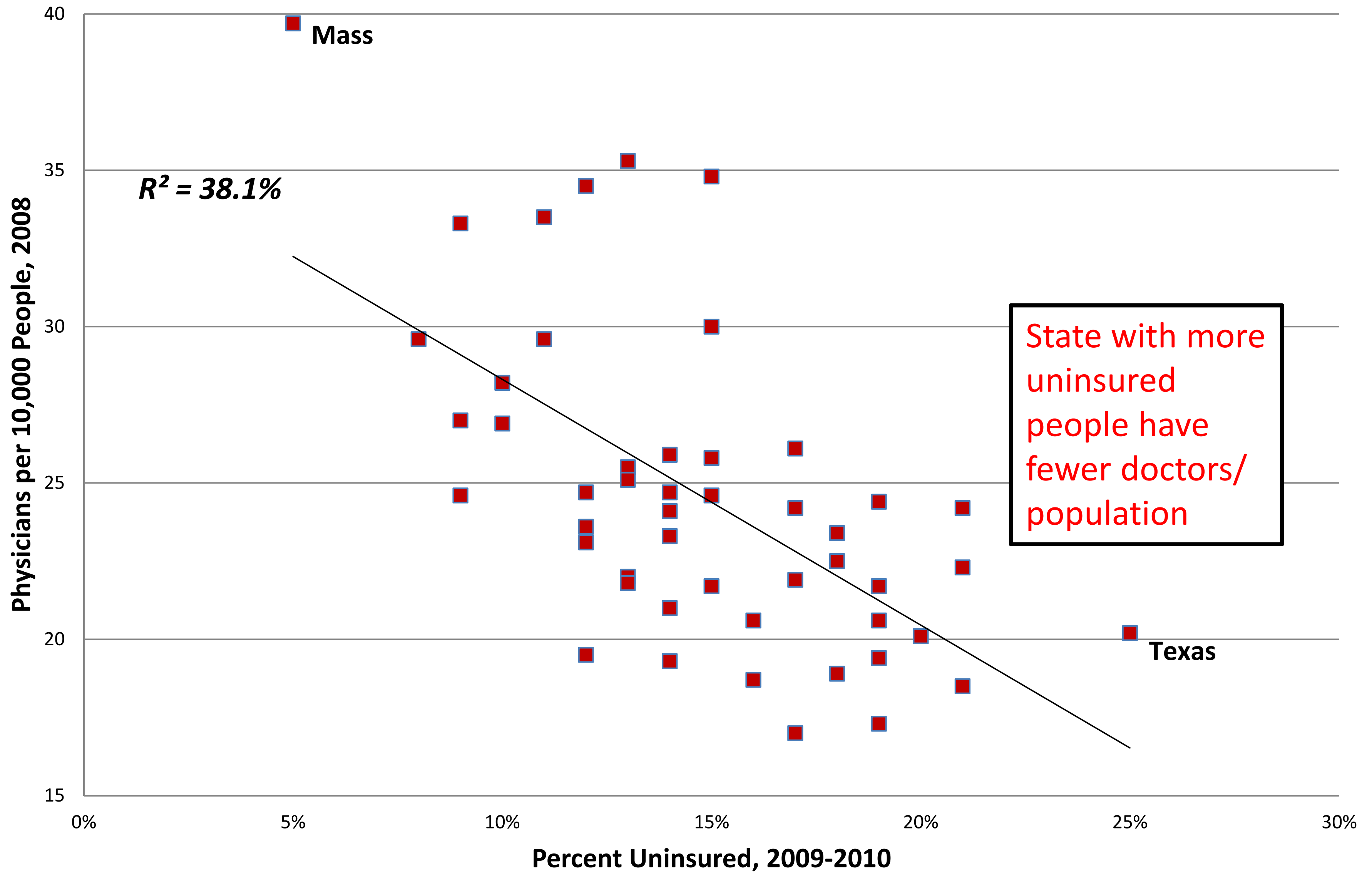
Long haul – heavy load



Access

- Financially, for many patients, ACA coverage through exchanges = catastrophic insurance, with high out-of-pocket payments (OOPs)
  - High deductibles + 20% co-insurance up to high annual OOP ceiling
- Across 50 states, physician capacity varies very inversely with numbers of newly-insured patients = we lack doctors where most needed



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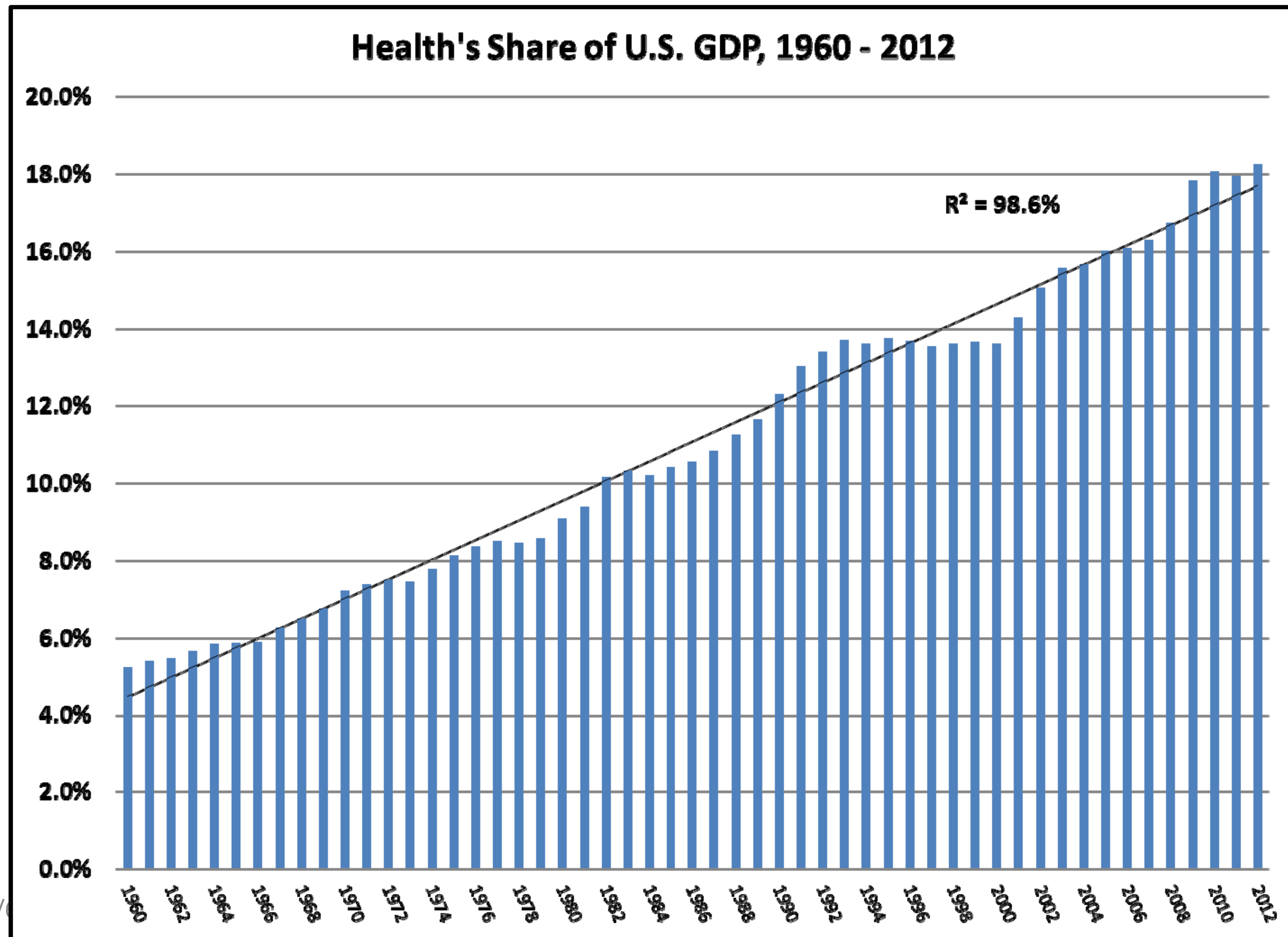
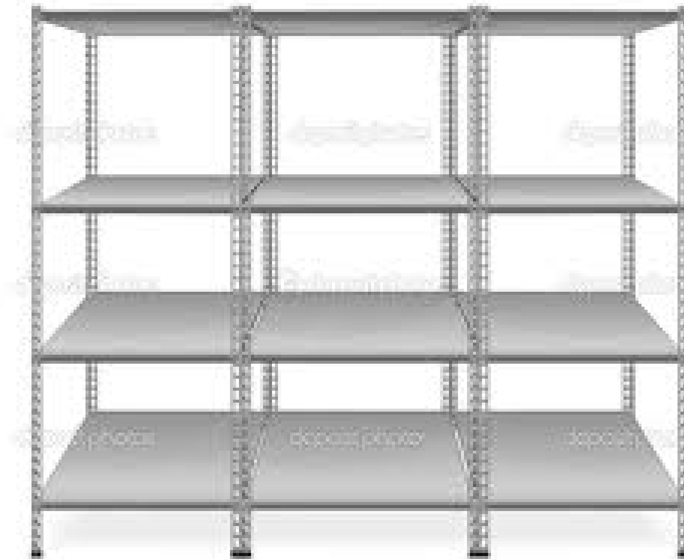
3. Costs under control? Only in *NYT*?



Shelves of cost control warehouse were bare of new ideas



- So recycle HMO as ACO!
- And boost patients’ out-of-pocket payments so they’ll stop lining up for recreational surgery and instead enlist as kamikaze pilots in cost control war

Market or Government?

	Government?	
Market?	Yes	No
Yes	**A**	**B**
No	**C**	**D**

- Cell A is where we've long been
- Some say, choose either and rely on it exclusively = cell B or cell C
- I'd suggest neither, cell D—Something Different

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Anarchy!

- Absent functioning market or competent government action, anarchy increasingly pervades U.S. health care.
- It's probably not reasonable to expect that <u>either</u> traditional markets or traditional government action can fix most U.S. health care problems
  - Government: weak political support, competence
  - Market: All 6 requirements absent, unattainable

4. The care we get depends on the caregivers we've got—but they are often the wrong types, in the wrong places

PREDICTING THE CHANCE OF URBAN HOSPITAL CLOSING, 1997 - 2003

1990 variable	Slope	Value
Intercept	-0.727639	1
Beds	-0.004452	362.1
Area % black	0.010354	29.1
Area % latino	-0.007471	15.7
Area income/capita	0.000019	$14,852
Hospital total margin	-0.019466	1.3
Hosp. cost/patient (efficiency)	-0.000024	$4,920
Hospital fund balance/patient	-0.000003	$153,739
Predicted probability of closing		8.2%
Values are means for each variable except intercept.		

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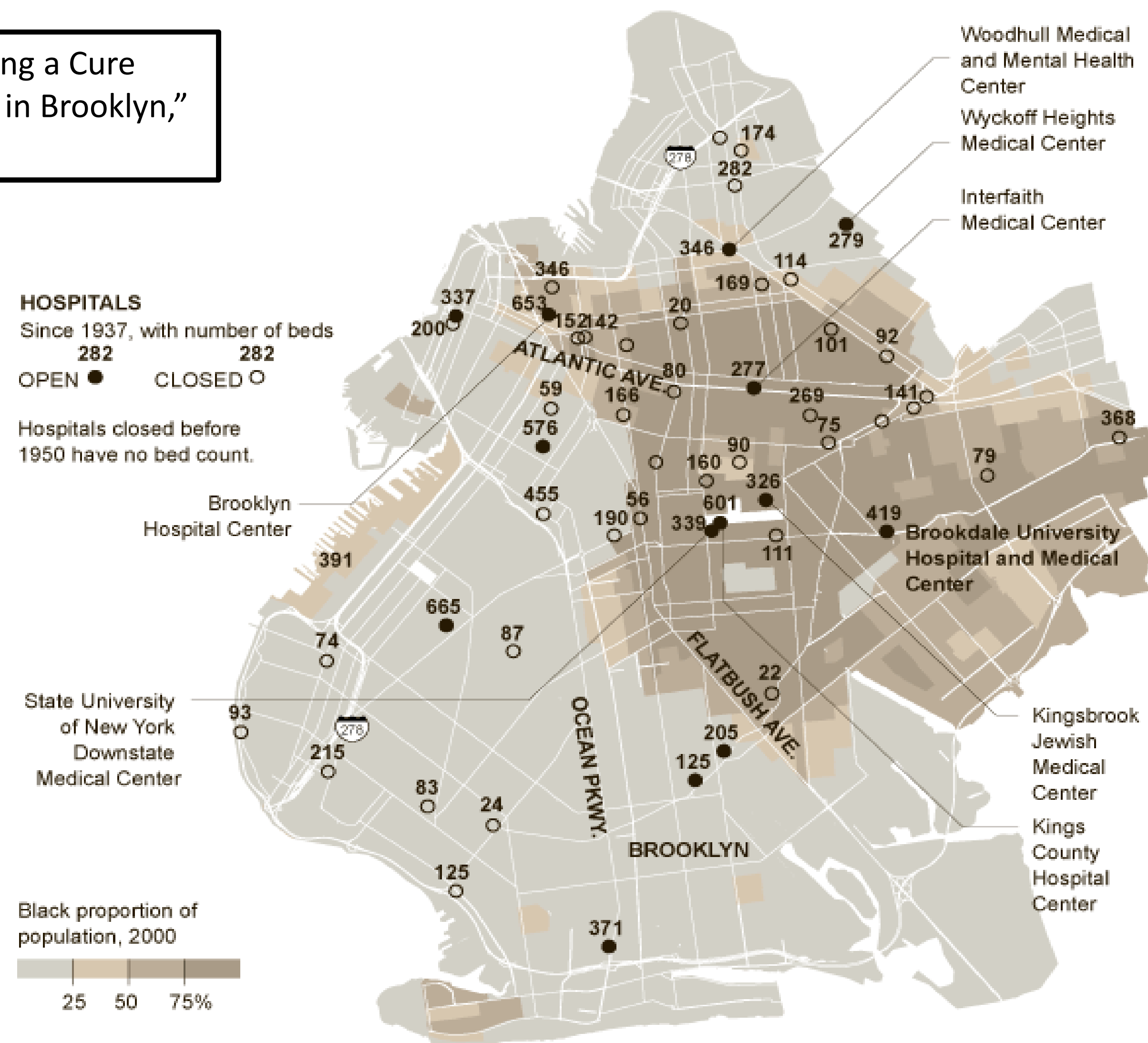
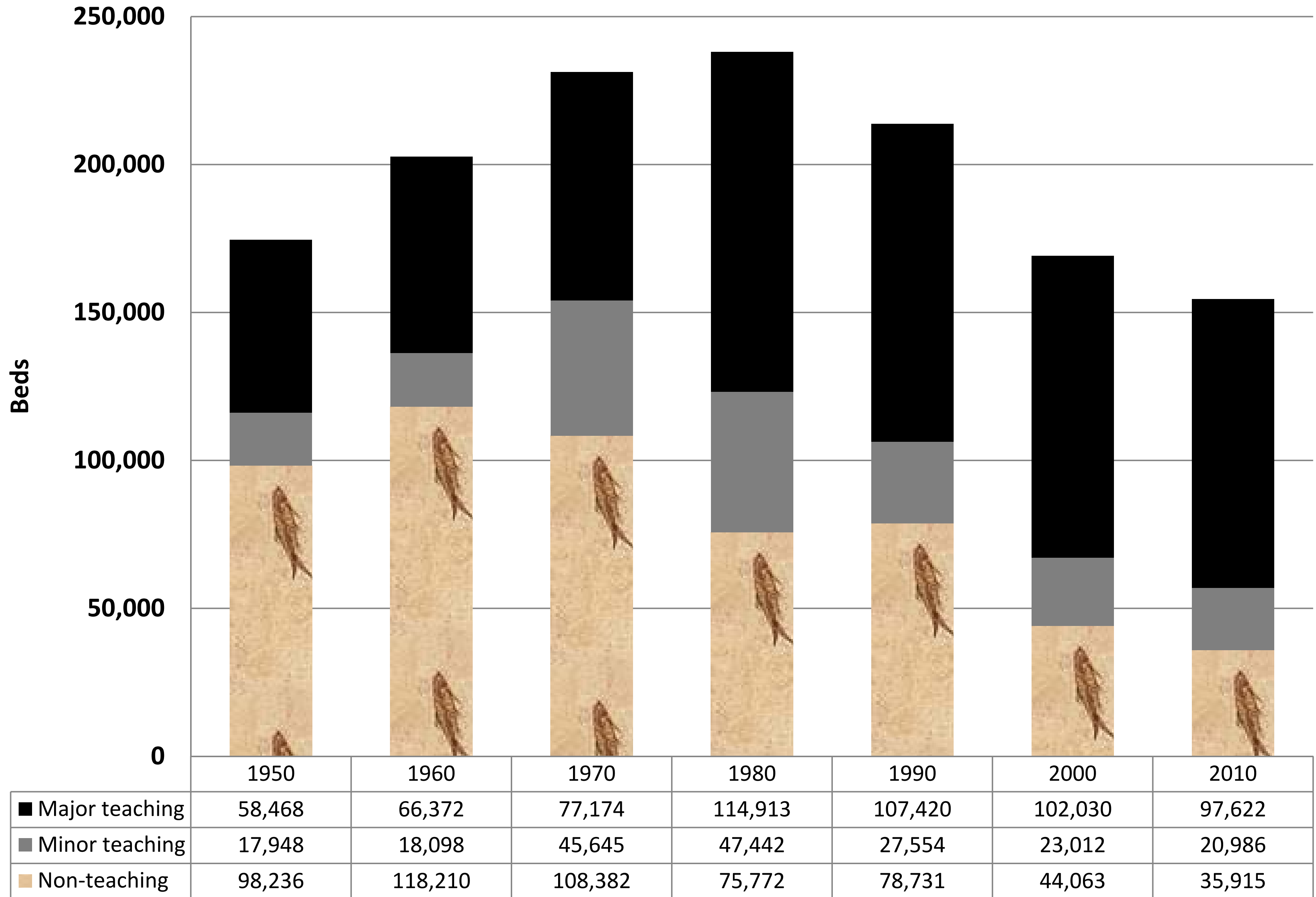
Surviving hospitals often not those we need—or can afford

Nina Bernstein, "Seeking a Cure for Troubled Hospitals in Brooklyn," *NY Times*, 9 Nov. 12





	1950	1960	1970	1980	1990	2000	2010
Major teaching	58,468	66,372	77,174	114,913	107,420	102,030	97,622
Minor teaching	17,948	18,098	45,645	47,442	27,554	23,012	20,986
Non-teaching	98,236	118,210	108,382	75,772	78,731	44,063	35,915

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PCPs/1,000 people in 29 rich democracies, 2009

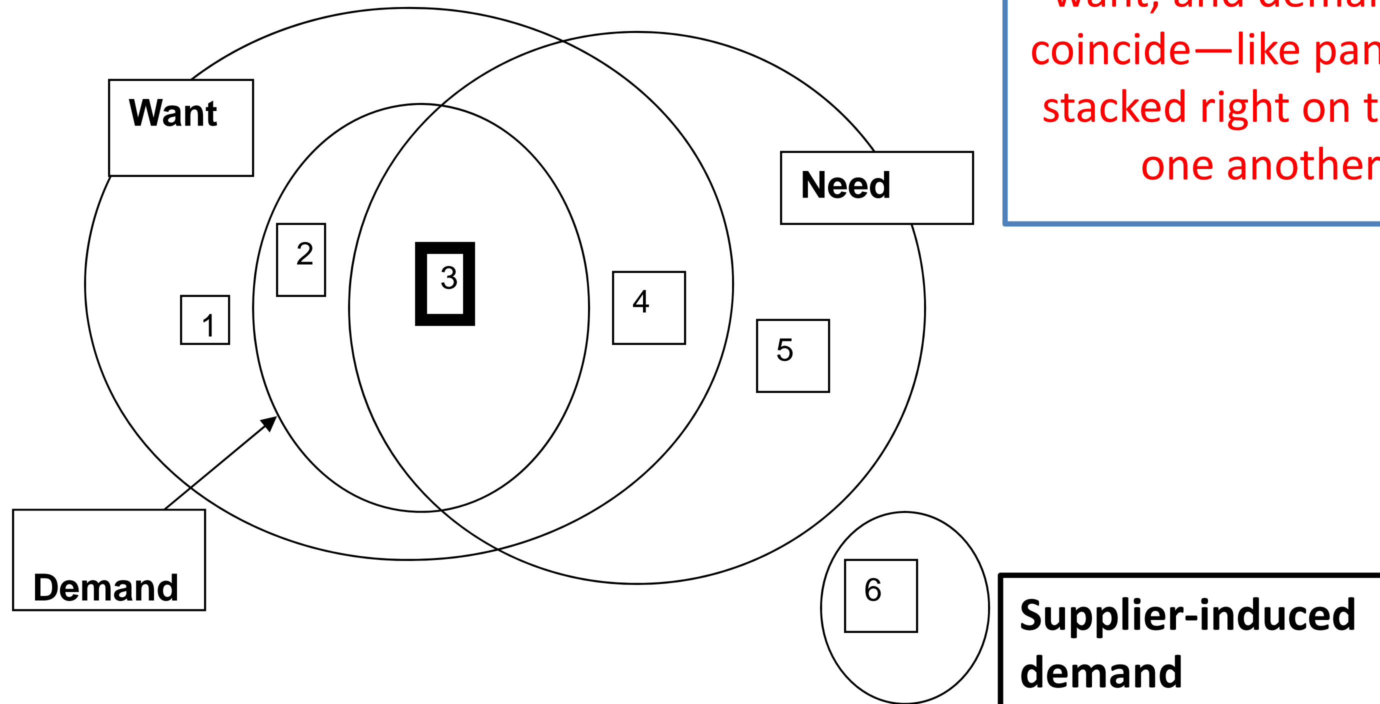
	All physicians	PCPs
Median, 29 OECD nations	3.2	1.6
U.S.A.	2.4	0.8

→ The U.S.A. has half as many PCPs/thousand citizens as the median OECD nation.

Note: 1/3 of US physicians are PCPs (HUS 2010); OECD nations' mean PCP share seems to be close to 50%

Source: OECD Health Statistics, Frequently requested data, http://www.oecd.org/document/16/0,3746,en_2649_33929_2085200_1_1_1_1,00.html

5. Initial want, need, demand – not to scale



Ideally, we'd like need, want, and demand to coincide—like pancakes stacked right on top of one another

1. Wanted, but not demanded or needed.
2. Wanted and demanded, but not needed.
3. Wanted, needed, and demanded. ***Yes!***
4. Wanted and needed, but not demanded.
5. Needed, but not wanted or demanded.
6. Supplier-induced demand—neither wanted nor needed, but demanded.

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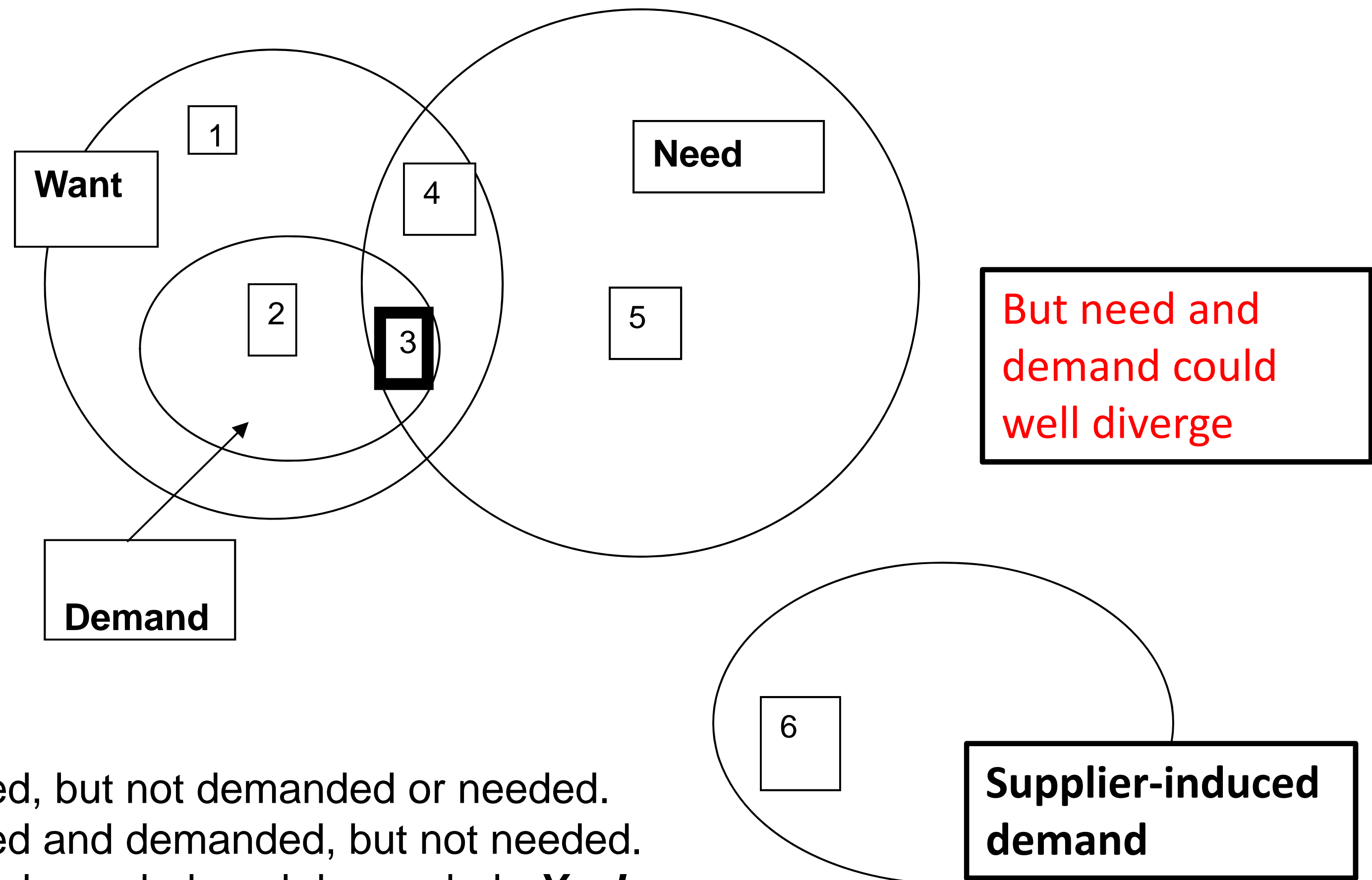
Growing unmet need and supplier-induced demand —not to scale



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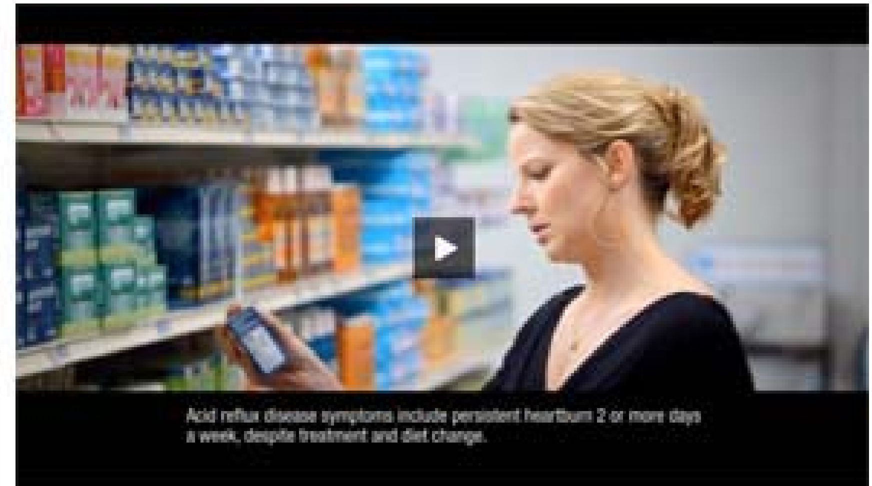
6. Mistrust-complexity death spiral

- Wrong people think about money, at wrong time, in wrong way
- Financial incentives to over- or under-treat various patients boost payer/patient mistrust of hospitals, doctors
- High OOPs for patients told to shop by price and quality
  - But can't measure either very well
  - And real question isn't price or quality, but whether the care's needed—and how many of us have gone to medical school?
- Endless data collection but too little time to use it to improve care
- Miscast actors
  - Too many economists playing politicians
  - Too many politicians playing economists
  - Too many patients told to play doctors
  - Too many doctors playing MBAs (or violinists)

Nexium's Doctor-playing-violinist commercial



Impetus to change

1. Citizens rebel against OOPs, debt, ER waits, PCP shortage, impossible burden of shopping price and quality
2. Doctors angered by tight income, rising costs, more documentation, less autonomy
3. Hospitals besieged by payment cuts, ER and inpatient capacity constraints, financial incentives that don't match clinical needs
4. Payers hate being blamed for inability to contain cost
5. Unable to craft national solution, Congress liberates states to experiment

6. Dean Vernon Wormer:

“Fat, drunk, and stupid is no way to go through life, son.”

- Isn’t $2.8T/nation and $9K/American enough to finance medical security?
- At minimum, can’t we stop bankrupting people?

7. Realistic remedies - key elements

- Promote clinical and financial medical security
- Shave peaks of excess → fill valleys of under-care
- Equilibrium that doesn't depend on markets, incentives, or traditional government action
  - Everyone's covered; only nominal out-of-pocket costs
  - Revert to old-fashioned primary care
  - Protection for all needed hospitals
  - Hospital budgets and physician fee schedules/salaries
  - Financially neutral payment methods
  - Liberate and demand honor, professionalism, and fiduciary duty

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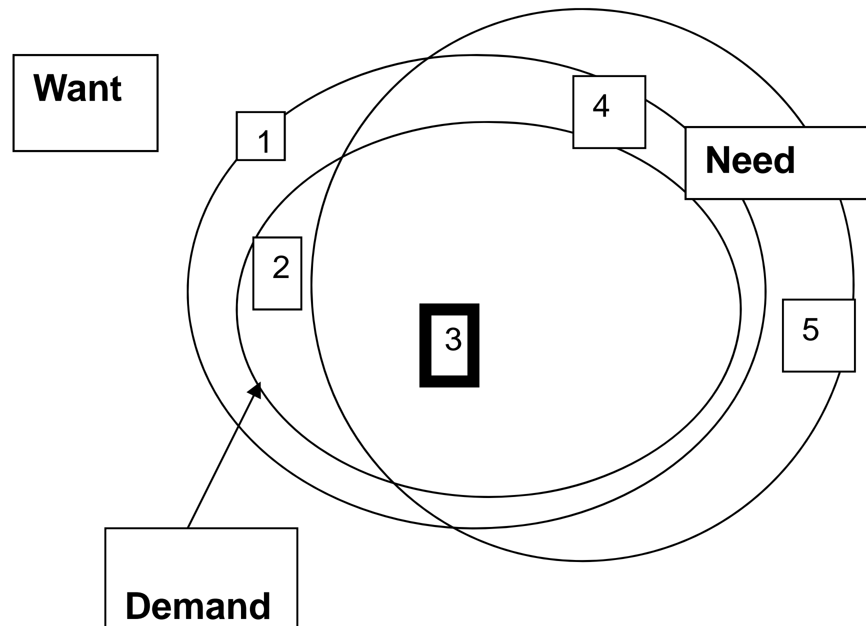
Specific remedies

- Identify and financially stabilize all needed hospitals + ERs
- Rebuild primary care by markedly boosting incomes, training many more PCPs, cutting panel size to 1,000
- Boost all doctors' net incomes by slashing administrative costs of practice
- Negotiate peace treaty with doctors that recognizes their control over almost 90% of health spending
  - Doctors commit to providing appropriate care and cure to 310M Americans, with dollars already available
  - In exchange for fair and stable incomes, paperwork cuts, end of malpractice suits, professional autonomy

Want, need, demand better aligned



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A good motto

"One hand for yourself and one for the ship"