Fixing Our Broken Health Care System Requires Both Incremental and Comprehensive Change

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Good morning!

Health Care Is Broken

Health care is broken. It is rushing toward meltdown. Cost soars. The number of uninsured people moves steadily upward. Quality problems multiply.

Consider payers

- Medicare and Medicaid fight to cut payments, often successfully.
- Private insurance and HMO premiums soar, with one big Boston HMO raising premiums by over 50 percent in the past three years.
- Bigger shares of premiums go to administration, advertising, and profit.
- After the failure of managed care, price competition, and hospital closings to contain costs, no cost control tools that enjoy good political currency are available—except dodging sicker patients, cutting benefits, and increasing out-of-pocket payments. Some employers and economic theoreticians call this "consumer-driven health care." We call it using patients as Kamikaze pilots in a cost control war.
- Massachusetts health spending is $48 billion this year, or $7,500 per person. That's 30 percent above the U.S. average. If we spent at that U.S. average, we'd save about $10 billion this year alone.
- Nationally, health spending is 15 percent of the economy, four times reported defense spending.
- Today's styles of care are not durably affordable, and this will make a mess when baby boomers become serious users of care in the next decade.
- This is not a sustainable business plan.

Coverage

- Dozens of millions are uninsured, dozens of millions of others are underinsured, and 75 million have no prescription drug coverage.
- Soaring costs force many people to drop coverage.

Hospitals

- Half of all Massachusetts hospitals have closed since 1960 and half of all beds have closed since 1980.
- At least a half-dozen remaining hospitals are vulnerable to closing in the next 2-3 years.
- We are one bad flu season away from comprehensive emergency room gridlock, with ambulances circling in the snow.
- Mergers and closings haven't saved money or boosted efficiency.
- Nationally, the more efficient hospitals are actually more likely to close, as are those in black neighborhoods and those with less money in the bank.
- Surviving Massachusetts hospitals are the most costly in the world.
- Massachusetts leads the nation in the share of our patients served in costly teaching hospitals.

- Even though Massachusetts leads the nation in nurses per 1,000 citizens, we find it impossible to adequately staff hospitals today. In a decade or two, as nurses retire, there will be far too few nurses to care for all the aging baby boomers.
- Hospitals' preferred solution to all problems: more money for business as usual.
- This is not a sustainable business plan.

Doctors

- Massachusetts spends much more per person on physicians than the national average.
- Yet our doctors typically earn less than their counterparts nationally.
- That's mainly because we have more doctors per 1,000 people than any other state, an excess that grows every year.
- Most doctors' preferred solution: more money for business as usual.
- This is not a sustainable business plan.

Rx

- Drug spending has been doubling every five-six years.
- U.S. drug prices are the highest in the world, which means that many patients can't afford needed drugs.
- The U.S. now gives drug makers one-half of their world-wide revenue, up from one-third in 1996.
- Drug makers have become chemically dependent on high prices in the U.S. market. That's why they spend so much on marketing and administration.
- Drug maker executives are the most nervous very-well-dressed people in the United States.
- This is not a sustainable business model. Indeed, as the CEO of one of the major drug makers recently said, "We know we're defying gravity."

LTC

- 103 Massachusetts nursing homes have closed just since 1998, or one of six.
- Even though nursing home spending in Massachusetts per older citizen is well above the U.S. average, most nursing homes are losing money.
- Many regions of the state already face a stark shortage of beds.
- Nursing homes ask for more money for business as usual.
- This is not a sustainable business plan.

Why Is Health Care Broken? What are the causes?

Magically imagining that Americans can get more and more care without having to pay for it.

Imagining that we are cradled safely in the invisible hands of the free market.

But we don't have anything close to a free market anywhere in health care, perhaps excepting eyeglasses. Sadly deluded and ideologically challenged free marketeers—Mickey Mouseketeers?—should remember that if you ignore reality, reality can "really bite you on the butt," as my 14-year-old sometimes remarks.

There's a more polite way to say this: Without a free market, and with government paying only occasional and ineffective attention, we have health care anarchy. Anarchy means mistrust, among other things, and mistrust multiplies paperwork, administrative waste.

Indeed, one-half of the health care dollar is wasted on

- administration,
- unnecessary or incompetent care, including defensive medicine,
- excessive prices, and
- outright theft.

So health care waste totals $24 billion in Massachusetts this year, roughly equal to the state budget.

The sight of this much waste should at once horrify and inspire us. Horrify because so many people suffer and die for lack of needed care amidst such waste—we say that "***squander causes squalor***." Try saying that fast three times. Seeing this waste should inspire us because all that money is right there.

Some Political Considerations

Politically, today, what will pass won't work and what can work can't pass.

All caregivers want more money for themselves. All payers want to spend less money. No one is thinking about the good of the whole health care enterprise.

Most politicians—today's company conspicuously excepted—don't like to think hard about problems before they become crises. What else is new? But a deep crisis with 100 million uninsured people and no money will be the worst time to fix health care.

What would we do then? Whatever we tried, it probably wouldn't work unless we designed and tested in advance new ways to cover everyone and save money.

The challenge then is to dig our wells before we are thirsty. Congressman Tierney had a great health care bill to do just this—it would grant states substantial sums to plan and conduct tests of methods to cover everyone.

Similarly, states could be liberated to work as Justice Brandeis's laboratories of democracy—as Gov. Dukakis intended here with his 1988 health care for all law.

Toward Some Real Solutions

Single payer is great, but let's be honest and acknowledge it is only the broad framework of a solution. It sparks many good questions, but does not pretend to answer most of them. It is like deciding to invade France by putting eight divisions ashore at Normandy on one day in the spring of 1944. But this one big decision does not tell us how to get the troops ashore or how they will proceed to defeat the enemy in the months ahead.

Single payor aims to

- Put a limit on spending.
- Cover everyone.
- Squeeze out administrative waste.

And then what?

If single payer does buy us time by quickly squeezing administrative waste, then the underlying annual cost increases still persist. This is like taking a few steps down or back on the up-escalator. The upward movement soon carries us to high and unaffordable costs.

Single payer alone does not tell us how to answer most of the big questions.

- Paying hospitals and doctors fairly and adequately, and with the right incentives.

- How to persuade, encourage, and oblige doctors to carefully spend the 75 percent of the health care dollar that they get or control?

- How to squeeze out the clinical waste—the unnecessary surgery, tests, or drugs; the defensive medicine; and the incompetent care—that is probably the single largest source of waste?

- How to lower excessive drug prices and other unnecessarily high prices?

- How to reduce theft of vital health care dollars?

- And more.

Each of these questions deserves detailed answers that are feasible to implement—medically, financially, ethically, politically, and administratively feasible.

Do We Need Incremental or Comprehensive Change?

We need both a smart and politically acceptable overall strategy and incredible attention to the details that make the strategy work.

This means adding a heart, a brain, other vital organs, and muscles to the skeleton of single payer reform.

Here are 10 of the main steps forward--

1. A new name for single payer, the nation's dumbest political slogan since "Nixon - Agnew, Leaders America Can Trust." Single payer. Single, in a nation that hates monopolies, and payer, in a nation that wants to think about what it can get, not what it has to pay. How about substituting "Health Care for All" or "Medical Security" or "Medicare for All"?

2. Enact Health Care for All legislation.

3. Entitle all residents to the full range of needed health care services.

4. Cap revenue, dollars available to be spent on health care. Assemble in one reservoir the streams of money that today finance health care. Medicare, Medicaid, and money that now pays for private insurance would all flow into a new Medical Security Trust Fund. Retain employer-employee premiums but freeze them in current dollars, not adjusted for inflation.

Employer-employee checks would be paid not to insurance companies but to the new Health Security Trust Fund. This maintenance of effort makes it unnecessary to raise taxes immediately to replace private insurance money. That temporarily retains much unfairness, but this is steadily phased out by a combination of declines in the real cost of insurance and a new tax assessed on employers not providing insurance. (By contrast, replacing private insurance would require, nationally, doubling the federal income tax. There's a powerful bumper sticker in that, but not for us.)

Instead, raise taxes by a much smaller sum, by just enough to replace most of today's out-of-pocket spending. This makes it much easier for everyone to seek the care they need, and also makes it much easier to cut administrative waste. This tax might be a payroll tax, which is much fairer than today's incredibly

regressive insurance financing. The newly capped employer-employee payments would be credited against the tax, so the tax would be phased in gradually to affect only those not yet providing insurance. New revenue to cover higher costs could be raised only be raising taxes, an effective brake on spending. Over time, the job-based premiums drop steadily in importance.

5. After capping revenue, cap costs, lest we bankrupt ourselves with cost that exceeds revenue.

Once all the money is in one place, it constitutes this year's budget for health care, the amount of money that is available to spend. Everyone must be served with this money.

How to live within this budget? Spend it carefully.

How to spend it carefully? How to take care of everyone? How to make the trade-offs that weed out clinical waste?

Some once thought that managed care would mechanically manage cost through better primary care and prevention, and ending fee-for-service's financial incentives to over-serve, and by restricting referrals to specialists.

But there are no mechanical or top-down ways to limit cost. The only way is a combination of top-down arrangements, like a budget that actually caps revenue, and a bottom-up arrangement, centrally involving physicians, that contains cost.

Doctors already know where most of the waste is, though they do need better information on what diagnostic procedures and therapies work, and on which patients need them.

The biggest management challenge in health care is to devise ways of bringing groups of doctors together with patients, under a budget, and obliging and encouraging and rewarding the doctors for taking good care of all patients under that budget. If doctors don't manage costs, someone else would have to do it for them, and they would then complain about unfair market forces or about micromanagement by non-clinical "bean counters."

"Professionalism within a budget" is a way to liberate clinicians to think clinically, not financially, and to take control of the enormous but inevitably limited resources available to care for us all.

In no sense will health care for all liberate physicians to return to the carefree days of the 1950s when each doctor could do what he/she wished, without regard to its affordability.

Instead, each doctor would read Garrett Hardin's "The Tragedy of the Commons" at least monthly. They would be reminded that pathology is remorseless but that resources are finite, and to give care accordingly.

6. Paying doctors. Individual doctors should be paid in financially neutral ways—that is, so their decisions about what care to give don't affect their own incomes. Then, they have no incentive to under-serve or over-serve. This cuts the need for paperwork and regulatory oversight because it is inherently more trustworthy.

It's vital to place the 20 cents on the health care dollar that doctors receive in one watertight compartment. This is the total income available to physicians. It should be divided among doctors in proportion to their competence, energy, and kindness. We need to think through good ways to do this. Salary with good management is one option, though not one most doctors yet like.

The other 55 or so cents on the health care dollar that doctors control—money for hospitals, prescriptions, nursing homes, and the like—would be put in a second watertight compartment. Doctors would spend it, and they must spend all of it each year, and they cannot benefit by how it is spent. They could not be tempted to scrimp on care to boost their own incomes.

7. If we don't decide where we are trying to go, we will probably not get there. We could make "medical security" the goal—confidence that when we are ill, we will get the care we need from competent and kind clinicians and institutions.

We won't get everything that might conceivably benefit us, but that's OK. Why? Because much marginal care is of little use, and we will know that if we do not get something, it is withheld not to make money for someone, but to liberate dollars to provide care to someone who needs it more.

8. Paying hospitals. All needed hospitals should be identified, and each needed hospital must then be guaranteed enough money to remain solvent and provide high-quality care to each patient, as long as it is operated efficiently. Hospitals should have budgets that vary with volume and with case mix, so they are not financially tempted to serve more patients or fewer, or patients with simpler or esoteric problems.

9. Paying drug makers. Massachusetts would negotiate a peace treaty with the world's drug makers. We pay them a certain pre-set sum that is sufficient to sustain their profits and abilities to finance research and, in return, they agree to fill all prescriptions written by Massachusetts physicians. This requires a huge price cut, which is offset by much higher volume, probably a one-third increase in

annual prescriptions. The additional cost of this approach is tiny, because once the drug makers do the research and build the factories, the added cost of making more pills is no more than five cents on the retail dollar. If we don't do this, filling that big rise in prescriptions will be unaffordable—and would also bestow huge windfall profits on the drug makers—as any bill this Congress passes would do.

10. <u>One hand for yourself and one for the ship</u>. Finally, how to get here? Doctors, hospitals, drug makers, and other parties will gradually appreciate that more money for themselves for business as usual is not sustainable. All parties will learn to behave like sailors on the old sailing ships. Recall a ship like the U.S.S. *Constitution* in Boston Harbor. Its mainmast is 220 feet (67meters) tall. In storms, when the ship was rolling through 90 degrees of arc, from left to right, and also pitching up and down, in total darkness, and in rain, sailors would have to climb rope ladders and edge out over yardarms, with their feet on a swaying footrope, to furl or reef sails. They did this with a simple slogan in mind: "One hand for yourself and one hand for the ship."