Cape Care

Real Opportunities—
Hard Work Required

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This talk rests on almost two decades of work with my fellow-director, Debbie Socolar.

Main Topics

A. Massachusetts health care realities
B. Problems and causes, perceived and real
C. Lessons from the 2005-06 state debate
D. Health care for all—consolidated financing and appropriate delivery
E. Cape Care—resources, challenges, opportunities, next steps

A few Massachusetts health care realities, 2006

	Mass.	U.S.	Mass. vs. U.S.	Mass. Rank
Estimated health spending, 2006	$58.9 billion	$2.2 trillion	--	--
Estimated health spending per week, 2006	$1.1 billion	$41.6 billion	--	--
Estimated health spending/person, 2006	$9,206	$7,256	+ 27%	1
Medicaid % personal health spending, 1998	19.3%	15.7%	+ 23%	4
State Medicaid $ % state-funded budget, 2004	12.2%	12.7%	- 4%	31
Hospital spending/person, 2004	$2,357	$1,639	+ 44%	1
Hospital beds/1,000 people, 2004	2.5	2.8	- 8%	31
Hospital total margin, 2004	4.0%	5.2%	- 23%	40
Hospital surgery/1,000 people, 2004	118	93	+ 26%	10
Hospital outpatient visits/1,000 people, 2004	2,552	1,563	+ 63%	6
Share of patients served in teaching hospitals				1
Patient care MDs/1,000 people, 2002	3.92	2.54	+ 54%	1
Specialist MDs/1,000 people, 2002	2.85	1.73	+ 64%	1
Registered nurses/1,000 people, 2002	11.2	7.8	+ 44%	1
Share of people in HMOs, 2003	38.4%	23.7%	+ 62%	2
Share of people lacking health ins., 2004	11.7%	15.7%	- 25%	36
Income inequality (top fifth/bottom), 1998-2000	10.5	10.0	+ 5%	5

Realities—spending

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Realities – hospitals

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Realities – MDs, RN, insurance

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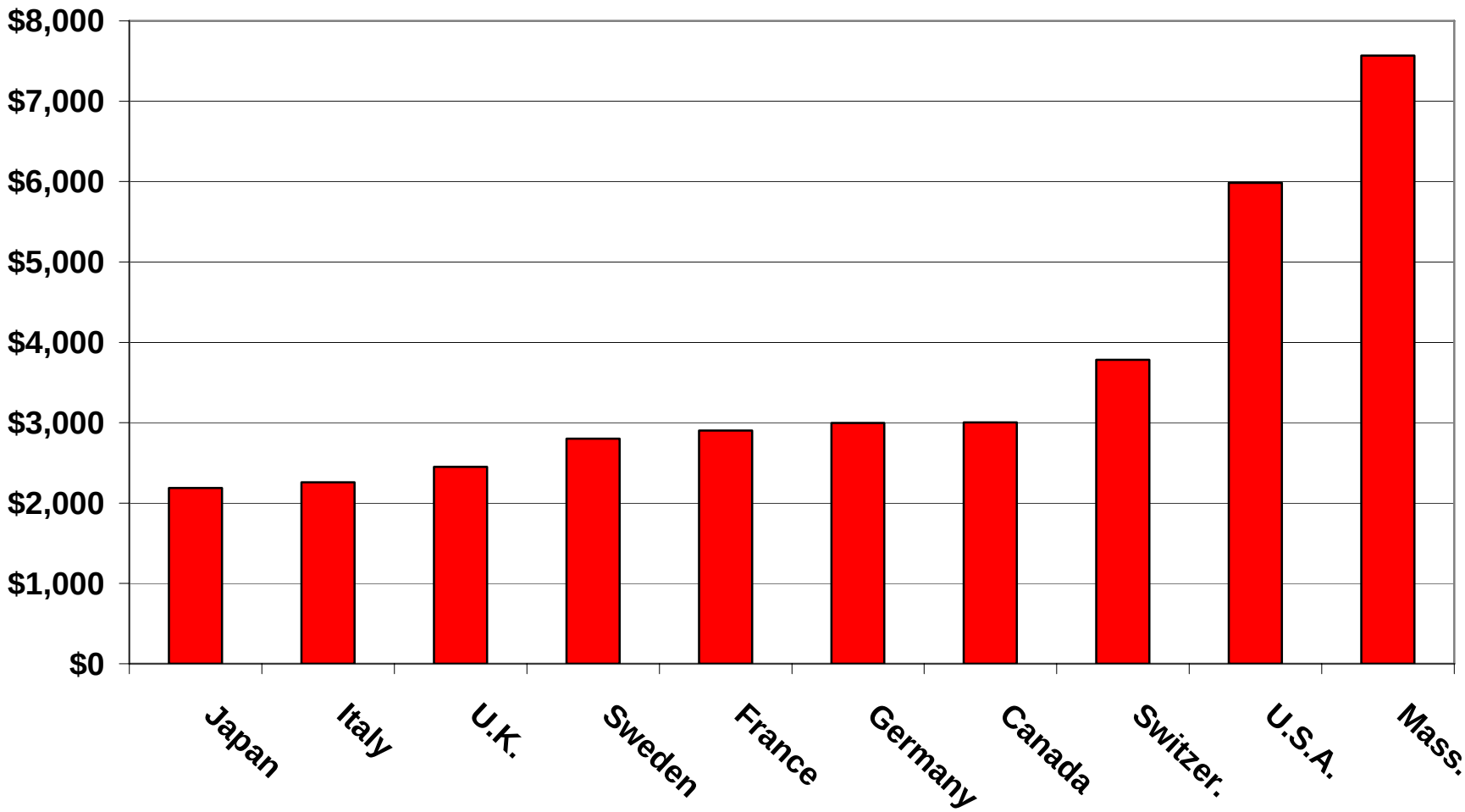
Comments on realities

- The world’s costliest health care
- Premiums soaring
- Relatively few uninsured people, but rising
- Lots of physicians and nurses, state-wide
- Growing dependence on costliest hospitals
- Elaborate and expensive care

Health Spending per Person, Selected Wealthy Nations, 2003



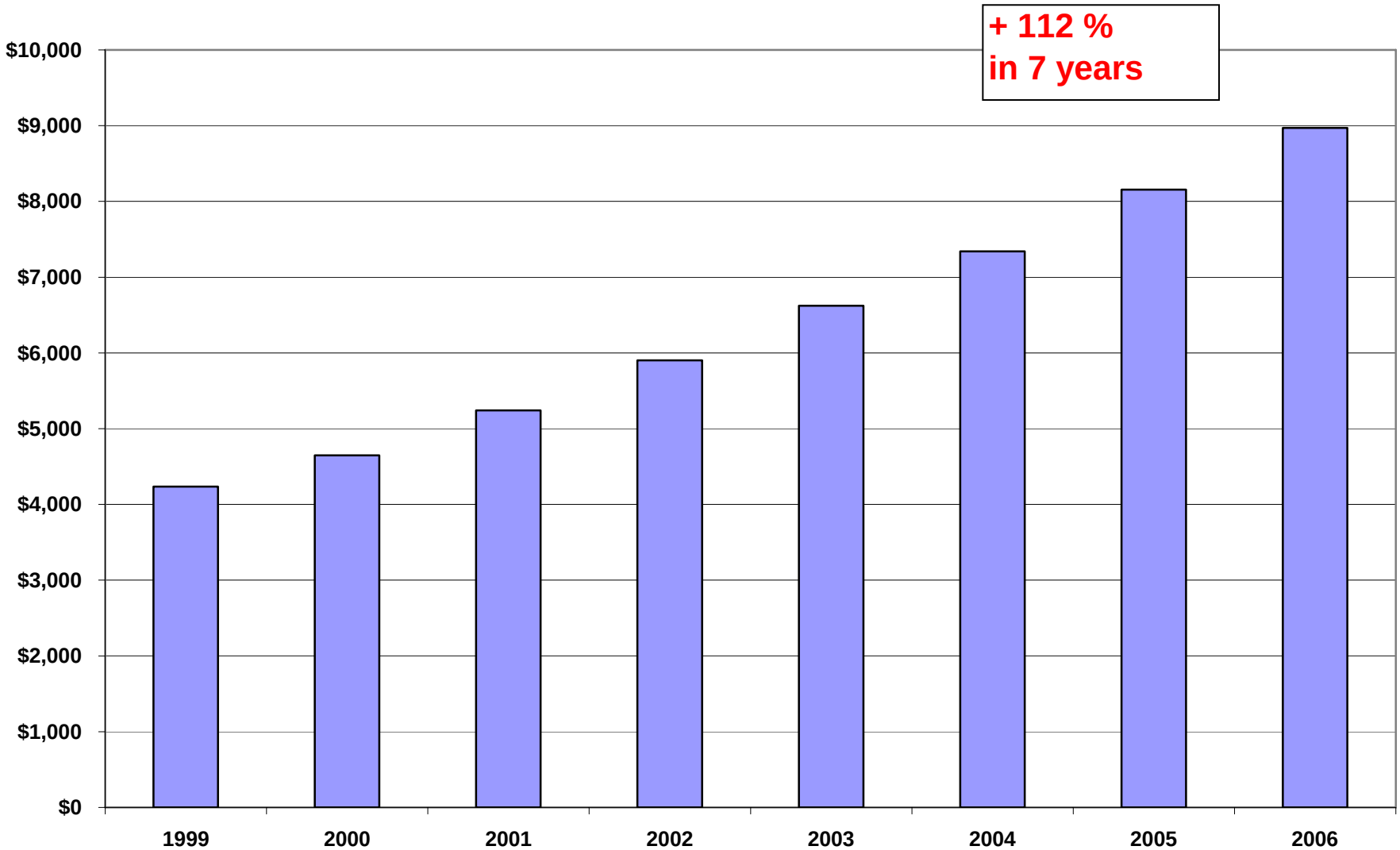
How much would health spending in Massachusetts drop this year if we spent at the

U.S. national average— $15 B (25%)

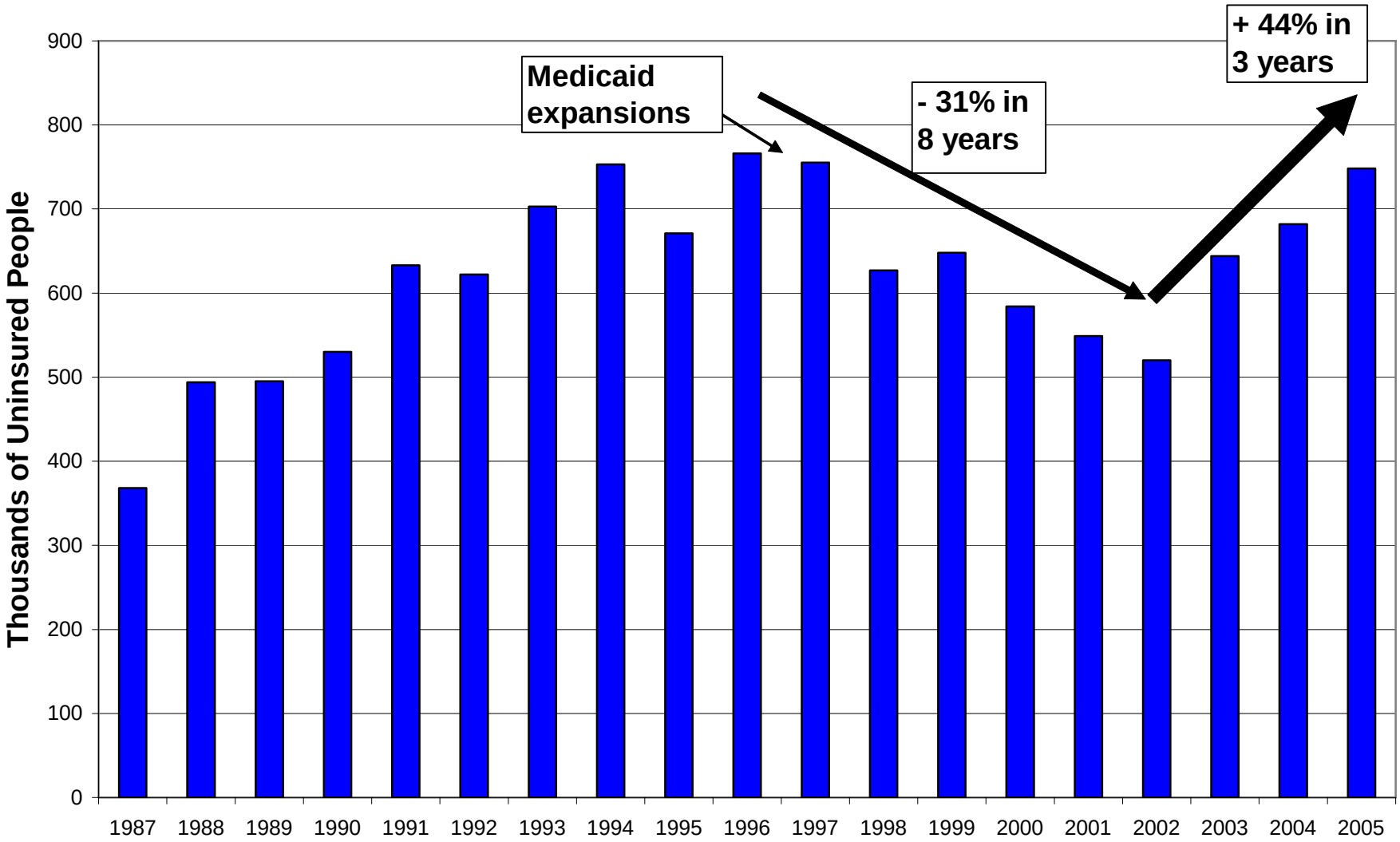
French-German average— $36 B (61%)

U.K.-Italian-Japanese average—$41 B (69%)

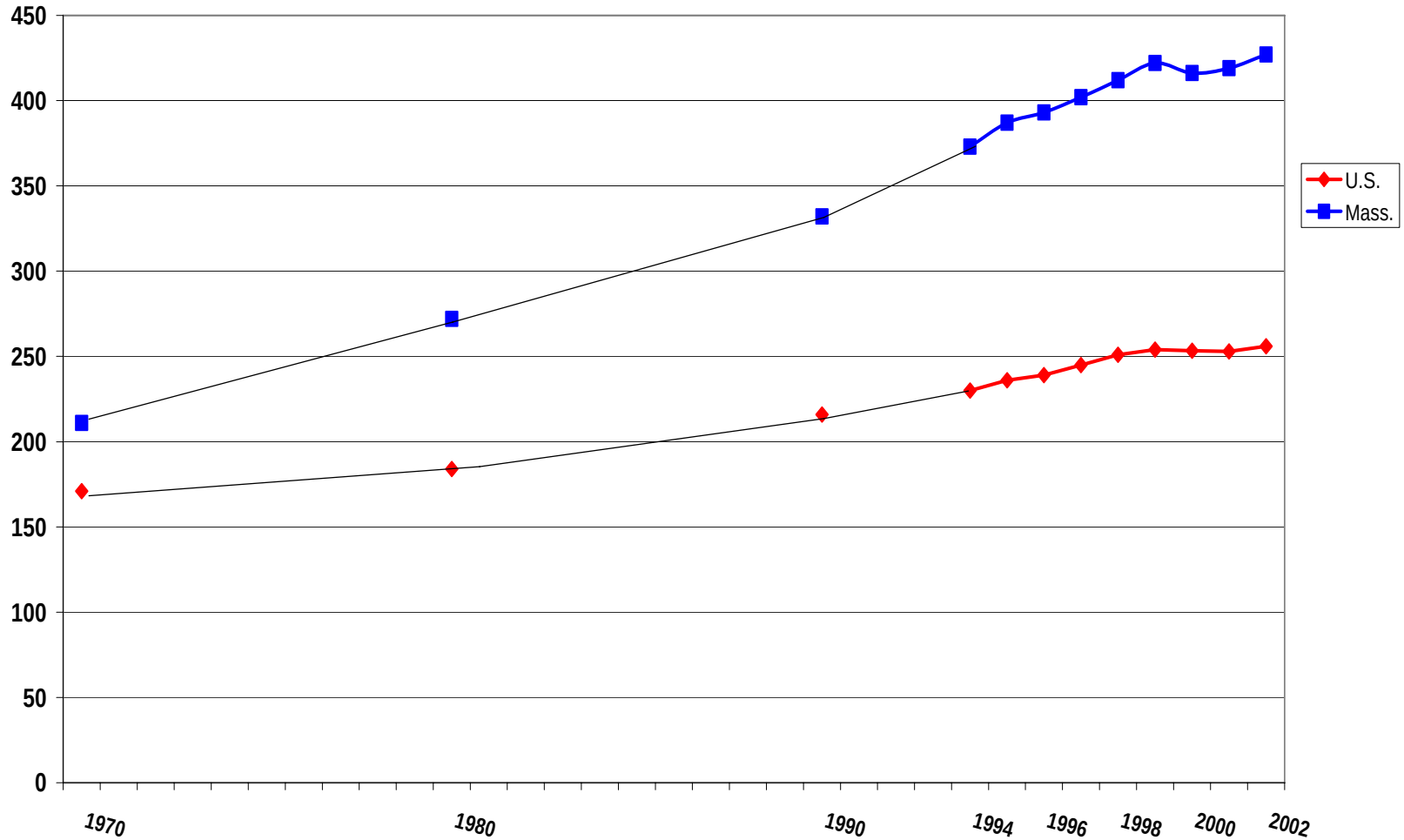
Boston-area Health Care Cost per Employee, 1999-2006



Uninsured People in Massachusetts, 1987 - 2005



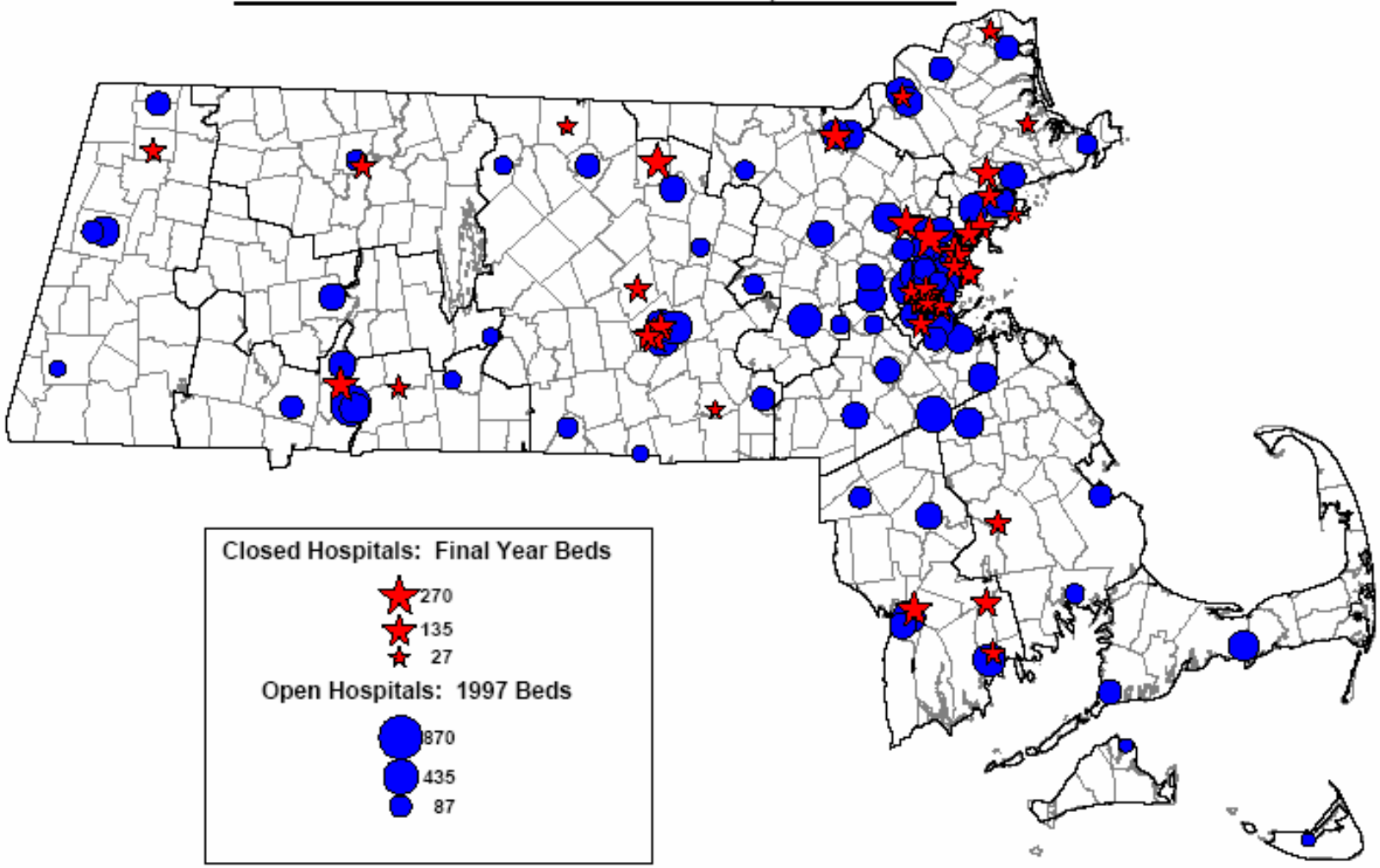
Massachusetts and U.S. Active Non-federal Physicians per 100,000 Residents, 1970 - 2002



Hospital closings

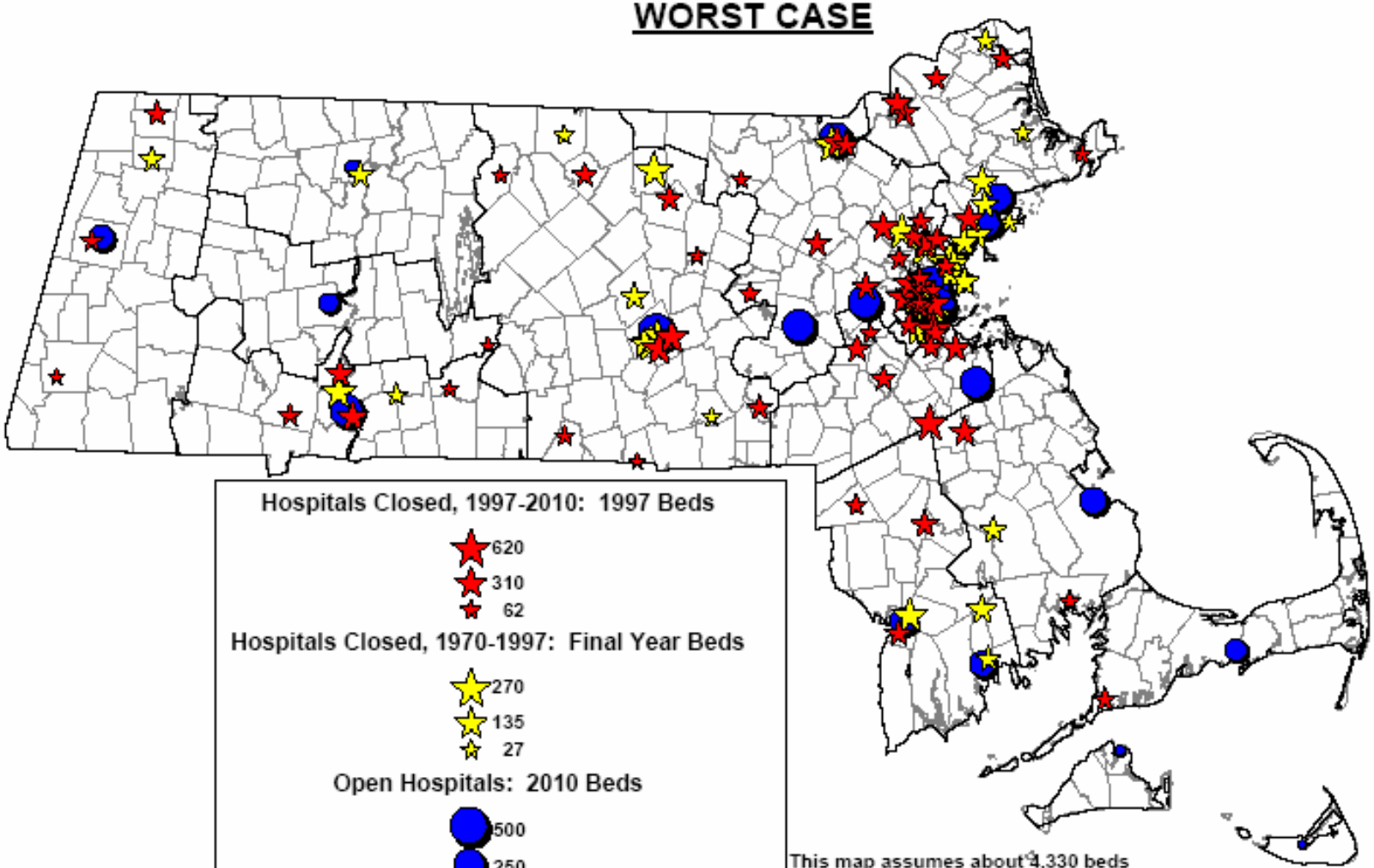
- One-half of Massachusetts hospitals have closed since 1960
  - No teaching hospitals have closed
  - Massachusetts is first in nation in share of patients served in costly teaching hospitals, including many patients who don’t need that level of care
- One-half of hospital beds have been closed since 1980

MAP 1: MASSACHUSETTS HOSPITALS, 1970-1997



25 April 97

MAP 5: MASSACHUSETTS HOSPITALS THAT MIGHT SURVIVE, 1997-2010
WORST CASE



This map assumes about 4,330 beds statewide in 2010 -- reflecting the 1995 experience of certain California HMOs. The map displays illustrative locations that distribute the 4,330 beds in proportion to counties' 1990 share of the statewide bed total.

25 April 97

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Conventional causes, solutions -1/2

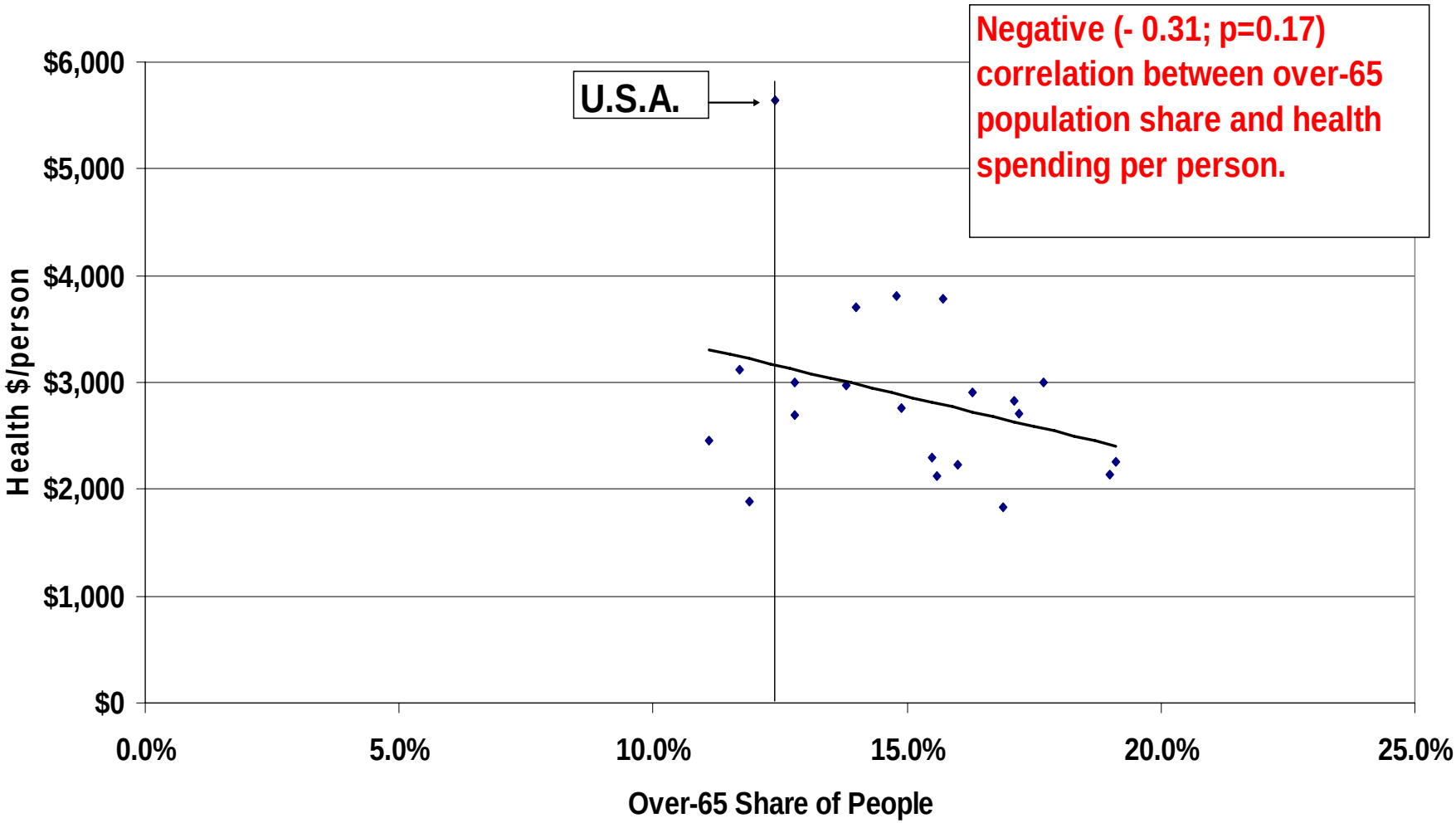
Problem: coverage + access

Causes	Solutions
Spending too low	Spend more, maybe much more
Rising premiums	Unleash market. Offer flimsy insurance
People choose to go bare	Force individual people to buy insurance
Employers don't insure	Force employers to buy insurance
Lack of primary care access	Build health centers

Problem: cost too high (some deny, or say high spending is good for us)

Causes	Solutions
MDs fear being sued	Cap pain and suffering awards
Older people, new technology	?
Higher cost of living	?
Paperwork	Standardize forms, automate
Insurance too comprehensive	Make patients pay more out-of-pocket
Prices too high	Patients learn prices and shop by price

Health Spending and Over-65 Population Share, 21 Wealthy Nations, 2003



Conventional causes, solutions 2/2

Problem: quality, appropriateness

Causes	Solutions
• Uninsured delay care	Force insurance purchase
• Medication errors	Electronic medical records, CPOE
• Evidence lacking, not used	Pay for performance
• Unnecessary care	Cross-examine your doctor

Problem: caregiver financing and configuration

Causes	Solutions
• Hospitals are underpaid	Boost Medicaid rates
• Lack primary + specialist MD	Pay more?
• RN shortage in hospitals	Staffing ratios, train more, pay more

Unconventional causes, solutions 1/2

Problem: coverage + access

Causes	Solutions
• Premiums too costly	Cut costs by cutting waste
• Few nearby caregivers	Reshape hospital, MD location

Problem: cost too high

Causes	Solutions
• No motive to cut cost	Recycle savings to cover everyone
• Over-care of well-paying	Insure everyone equally
• Market can't cut cost safely	Abandon market as cost-cutting tool
• One-half of spending wasted	Cut waste, recycle savings to cover all
• No-one thinks about cost	Negotiate with doctors to care for all with today's huge $s
• Costly caregivers dominate	More primary MDs, community hosps.

Unconventional causes, solutions 2/2

- **Problem: quality, appropriateness**

Causes	Solutions
Defensive medicine	No torts: compensate victims + upgrade skills + weed out bad apples
Financial incentive=over-serve	Pay MDs, hospitals financially neutrally
Uninsured delay care	First-dollar coverage for everyone
Patient mistrust of caregivers	No one benefits by too much/too little care
Evidence doesn't drive care	Compile, share trustworthy evidence

Problem: caregiver financing and configuration

Causes	Solutions
Hospitals closing	Pay all needed hospitals enough if efficient; bolster community hospitals
Primary care MD shortage	Train more, pay more?
Some specialist shortages	Pay hospitals to hire enough

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C. Lessons from Beacon Hill, 2005-06

1. Medicaid waiver sparked action, and shaped it
2. Almost everyone wanted more coverage—if someone else would pay for it
3. Where is the new money going? Coverage? Hospitals? Business as usual?
4. Cost control was ignored—so improving coverage would be costly or shallow—or both
5. Relevant evidence was almost invisible
6. The bill that can pass can't work (to improve coverage), and the bill that could work can't pass—wasn't even debated

1. Threatened loss of $385 million in Medicaid money sparked action

- The coverage debate degenerated into a numbers game, where the flimsiest paper coverage seemed to count as much as real coverage—especially for Romney and Travaglini
- The minimum progress needed to retain the Medicaid money might start looking like the solution.
- Many people will boast about progress.

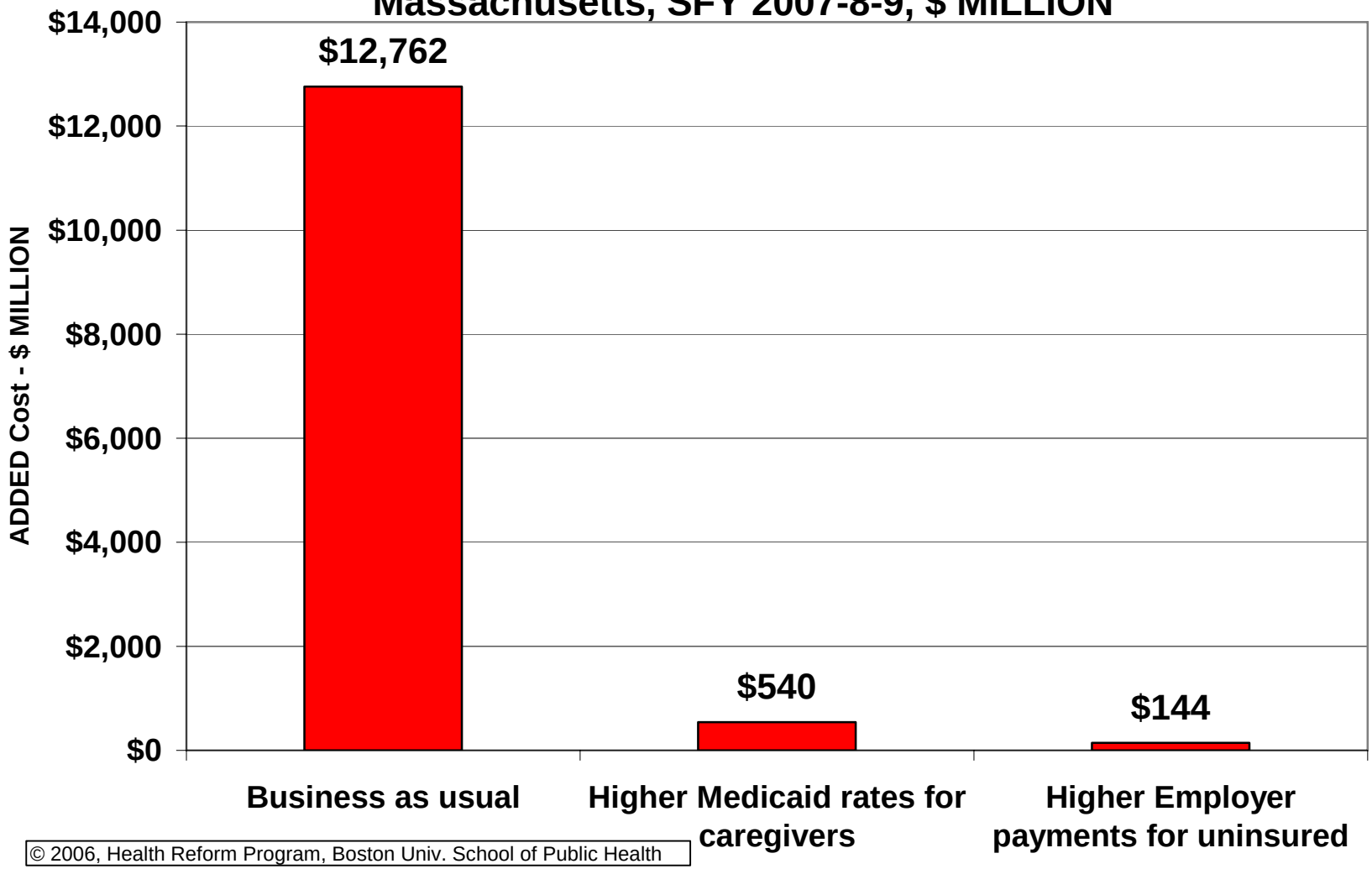
2. Almost everyone wanted more people covered, if someone else would pay

- To subsidize insurance, Romney would use money already spent on uninsured → flimsy policies
- Senate bill would not have covered many people.
- House bill provided more public money and also asked business to pay through an employer mandate, and individuals to pay through their own mandate
- Business said “no” to mandate and asked for more public money. Lobbying, reports, complaints
- Uninsured individuals are not organized to lobby, hire consultants, and protest a bad deal → they’ll pay more

3. Who won?—one measure is added dollars over next three years

- $540 million more from Medicaid for hospitals and other caregivers
- $144 million more from non-insuring employers for citizens who couldn't afford health insurance
- $12.9 billion more from Medicare, Medicaid, and private insurance for higher spending on business as usual (BAU) care—BAU-Wow!

ADDED Cost of Business as Usual, Higher Medicaid Payments to Caregivers, and Employer Payments for Uninsured Workers, Massachusetts, SFY 2007-8-9, $ MILLION



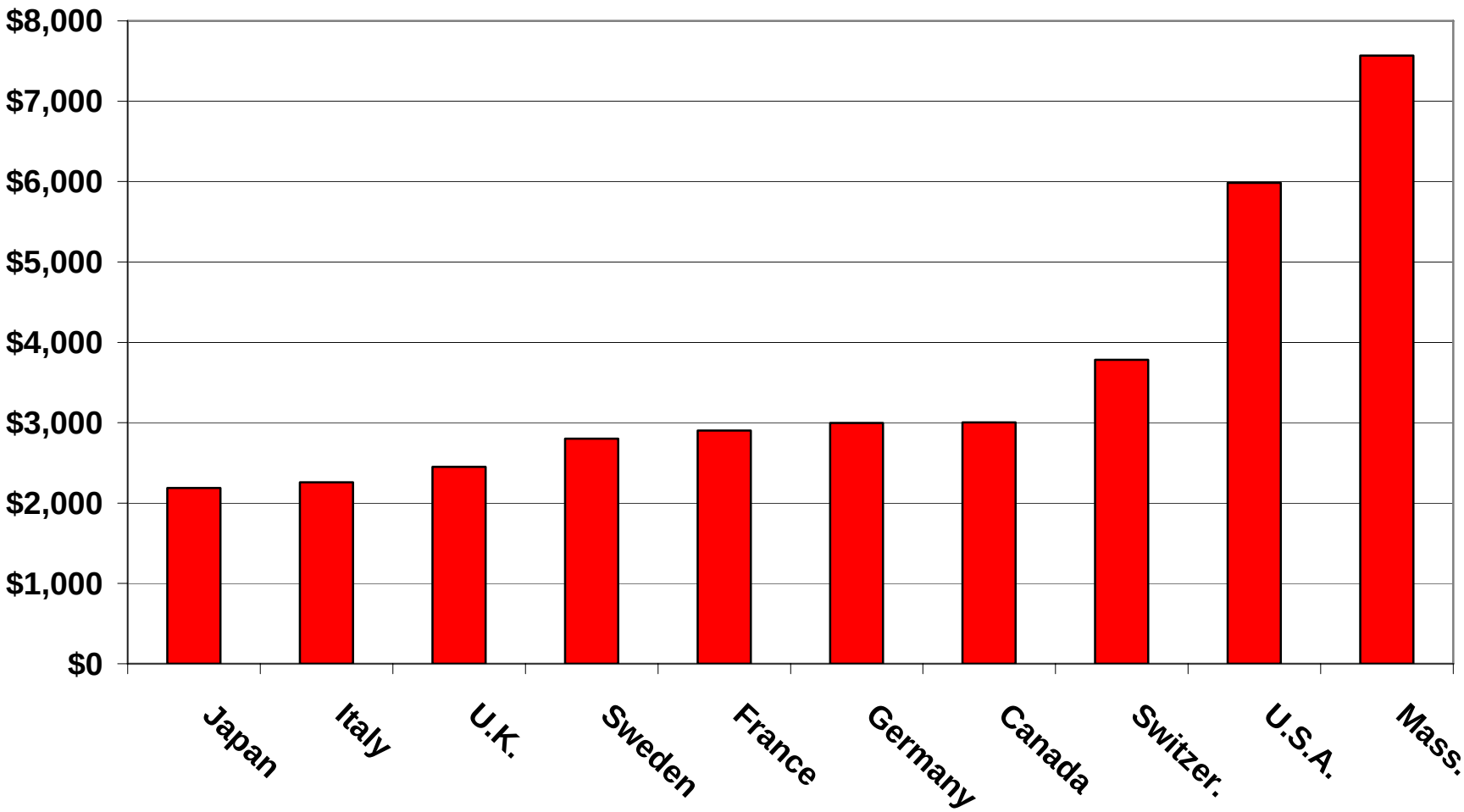
4. Cost control wasn't on anyone's agenda, so improving coverage would have to be costly or shallow

- Some think that just writing checks will insure people
- Better coverage looks to some like a clean moral issue, while cost control seems like a grubby financial issue
- Cost control isn't simple; can't just write checks or force people to buy coverage
  - nothing's worked so far
- Too complicated to consider coverage + cost
  - few legislators understand health care
- Cost control makes some caregivers angry
  - especially those who fear they'll lose revenue

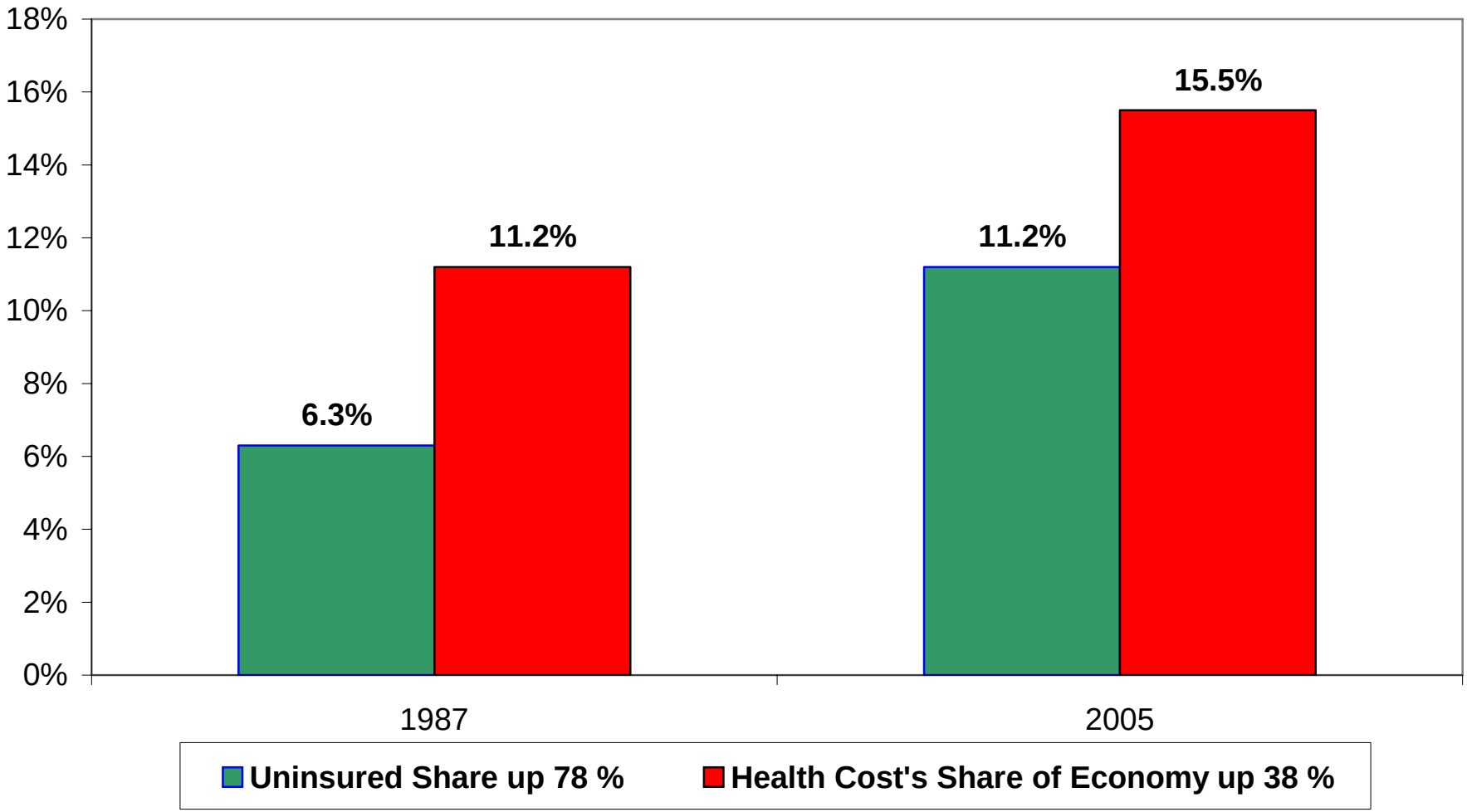
5. Relevant evidence was almost invisible

- World's costliest health care
- Health's rising % of economy + uninsured people's rising % of population
- No effort to slow the rising cost of BAU
- Hospitals plead for higher Medicaid rates, but added the $s go disproportionately to more prosperous hospitals
- State revenues don't grow fast enough to subsidize soaring health costs

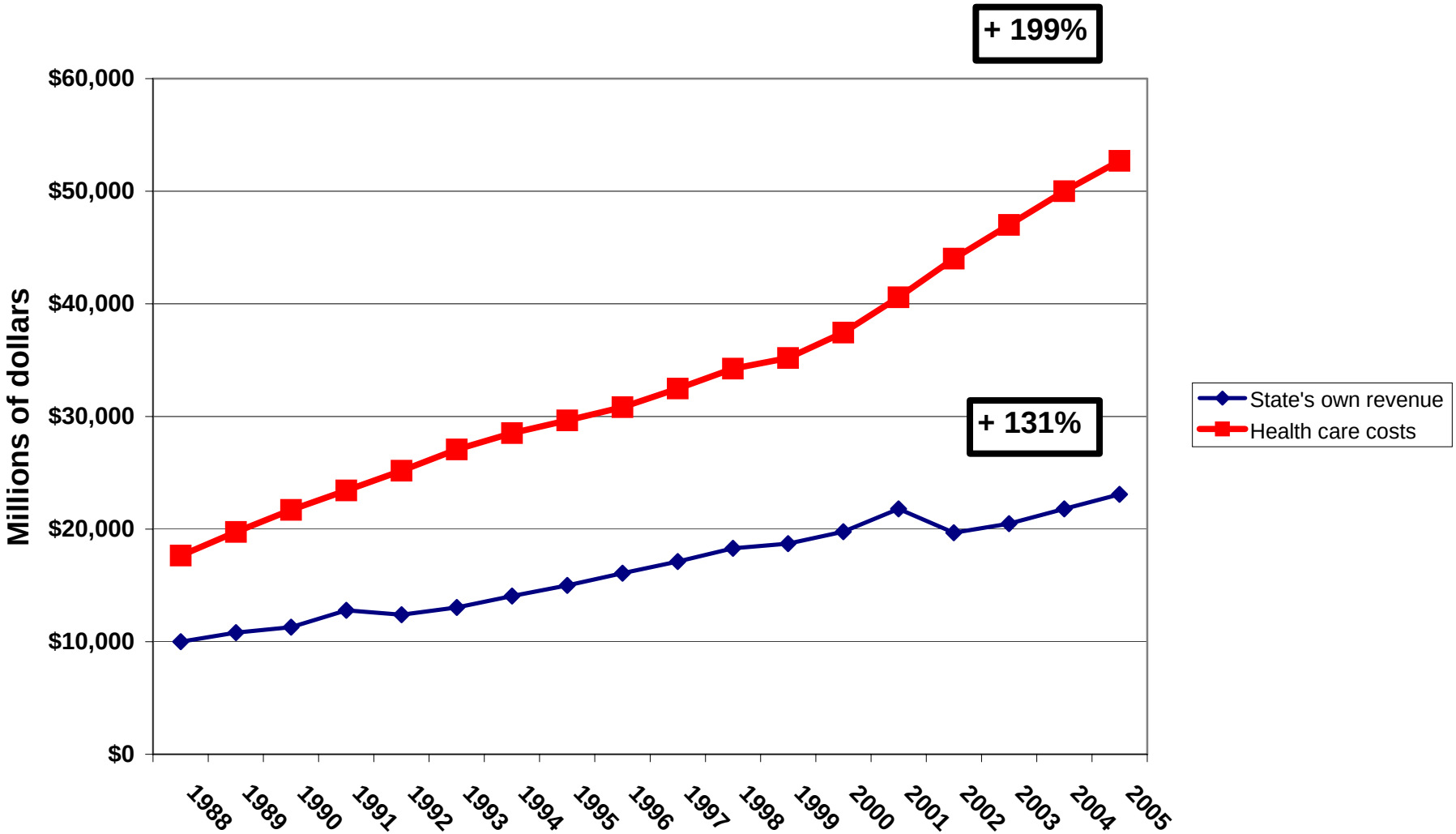
Health Spending per Person, Selected Wealthy Nations, 2003



Health Cost's Share of Massachusetts Economy and Uninsured Share of People, 1987 + 2005



Massachusetts Health Costs Rose Far Faster than State's Own Revenue, 1988 - 2005



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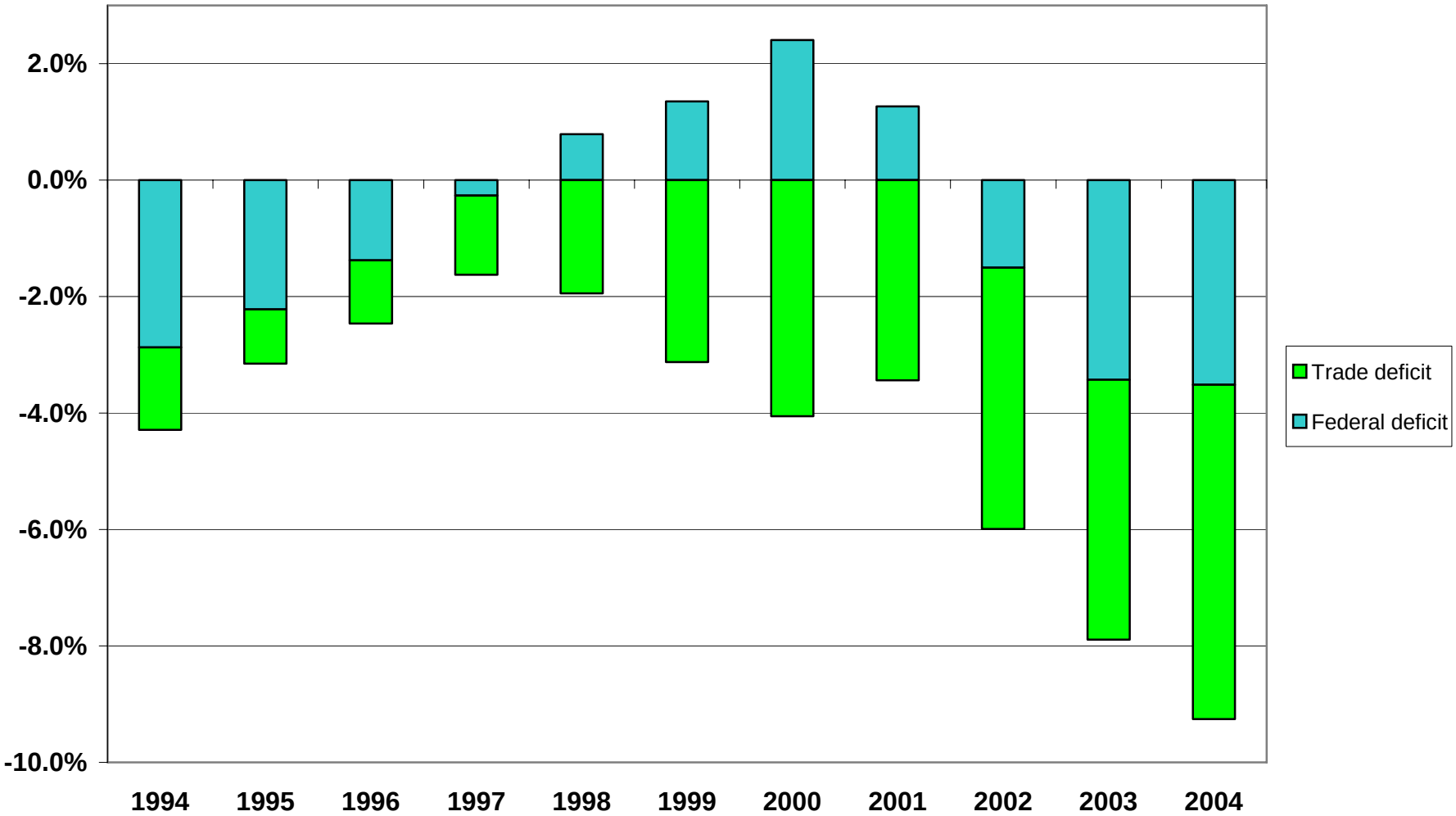
D. Consolidated financing and appropriate delivery

1. Cost control is essential to covering everyone
2. All past cost controls have failed
3. Cost control and coverage = vital allies
4. We spend enough to cover everyone, but one-half of current spending is wasted
5. Consolidating the financing is essential to cutting waste, but it is not enough
6. Needed—honesty, realism, negotiation

1. Cost control is essential to covering everyone

- U.S. economy unstable: trade deficit + federal deficit ~ $1 trillion
- U.S. health care addicted to more money for BAU—regular 5% yearly growth in real health spending—as number of uninsured grows
- Health care will crash through windshield at bottom of next bad recession
- Current spending is enough to care for everyone
- Rising cost of BAU sponges up available dollars

U.S. Federal Budget + Trade Deficits, 1994 - 2004



2. All past cost controls have failed

Market, both wholesale and retail cost controls

- There is no free market in health care, so it can't work to contain cost
- All requirements for market are absent
- Market rhetoric usually becomes smokescreen for
  - Allowing anti-competitive mergers and monopoly
  - Erecting financial barriers between sick people and needed care

Wholesale regulation by government

- Health care is addicted to more money for BAU. Caregivers game regulations
- Public never wanted cost control for its own sake

2. All past cost controls have failed

Failure of market + failure of government

= HEALTH CARE ANARCHY

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

<u>No one is responsible, accountable</u>

2. All past cost controls have failed

Genuine free market requires

a. Lots of small buyers and sellers, so market makes price
b. No artificial influences on supply, demand
c. Easy entry and exit, so no one monopolizes
d. Good information about price and quality
e. Price tracks cost, so low price = low cost
f. Constant suspicion (caveat emptor!)

All of these are absent in health care

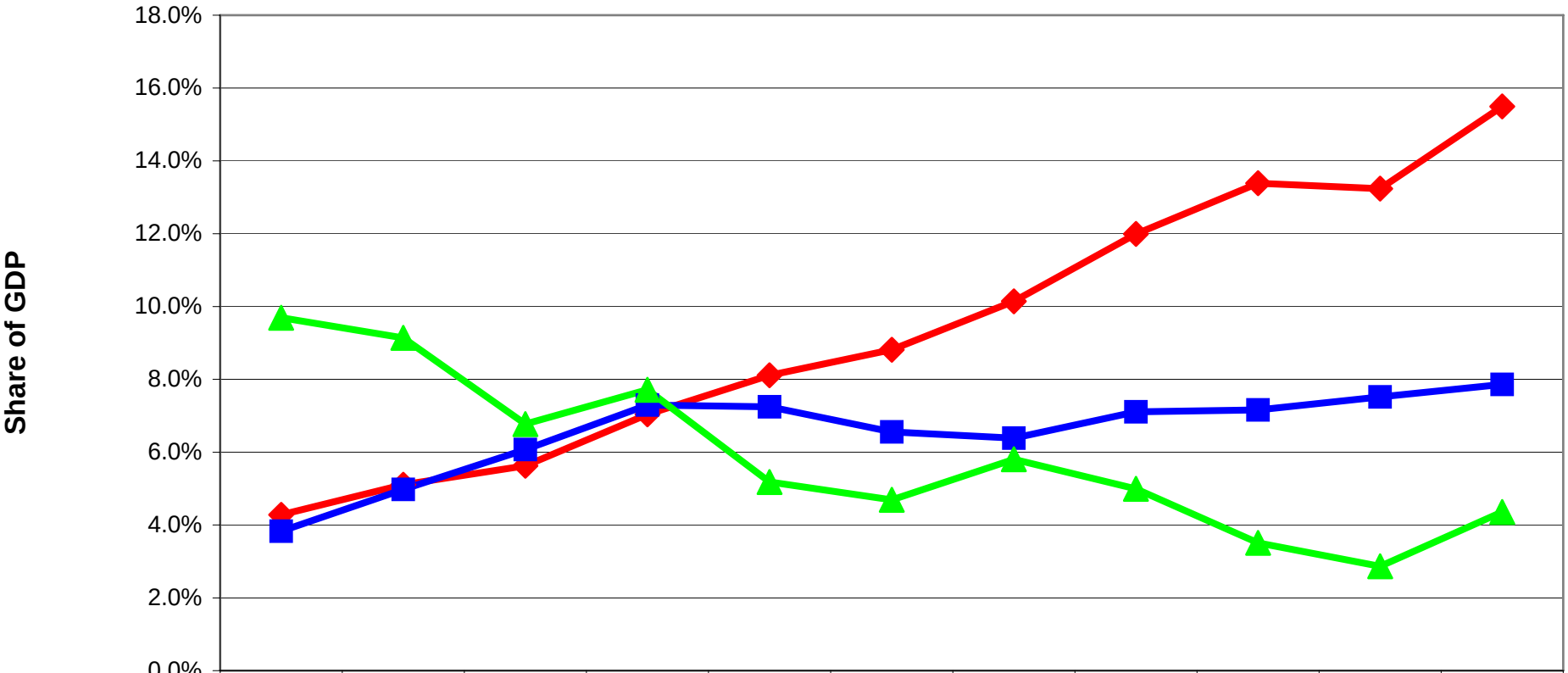
3. Cost control + coverage = allies

- Can't cover everyone unless contain cost
- Can't contain cost without
  - persuasive motive and
  - effective and acceptable means
- Winning durable coverage for all is the motive to contain cost by cutting waste.
- All means of cutting waste must embody recycling of savings to finance care for all.

4. We spend enough to care for everyone

- Compare health, education, and defense
- Compare with other wealthy nations
- ½ of current health spending is wasted

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%	15.5%
Education	3.8%	5.0%	6.1%	7.3%	7.2%	6.6%	6.4%	7.1%	7.2%	7.5%	7.9%
Defense	9.7%	9.1%	6.8%	7.7%	5.2%	4.7%	5.8%	5.0%	3.5%	2.9%	4.4%

Year

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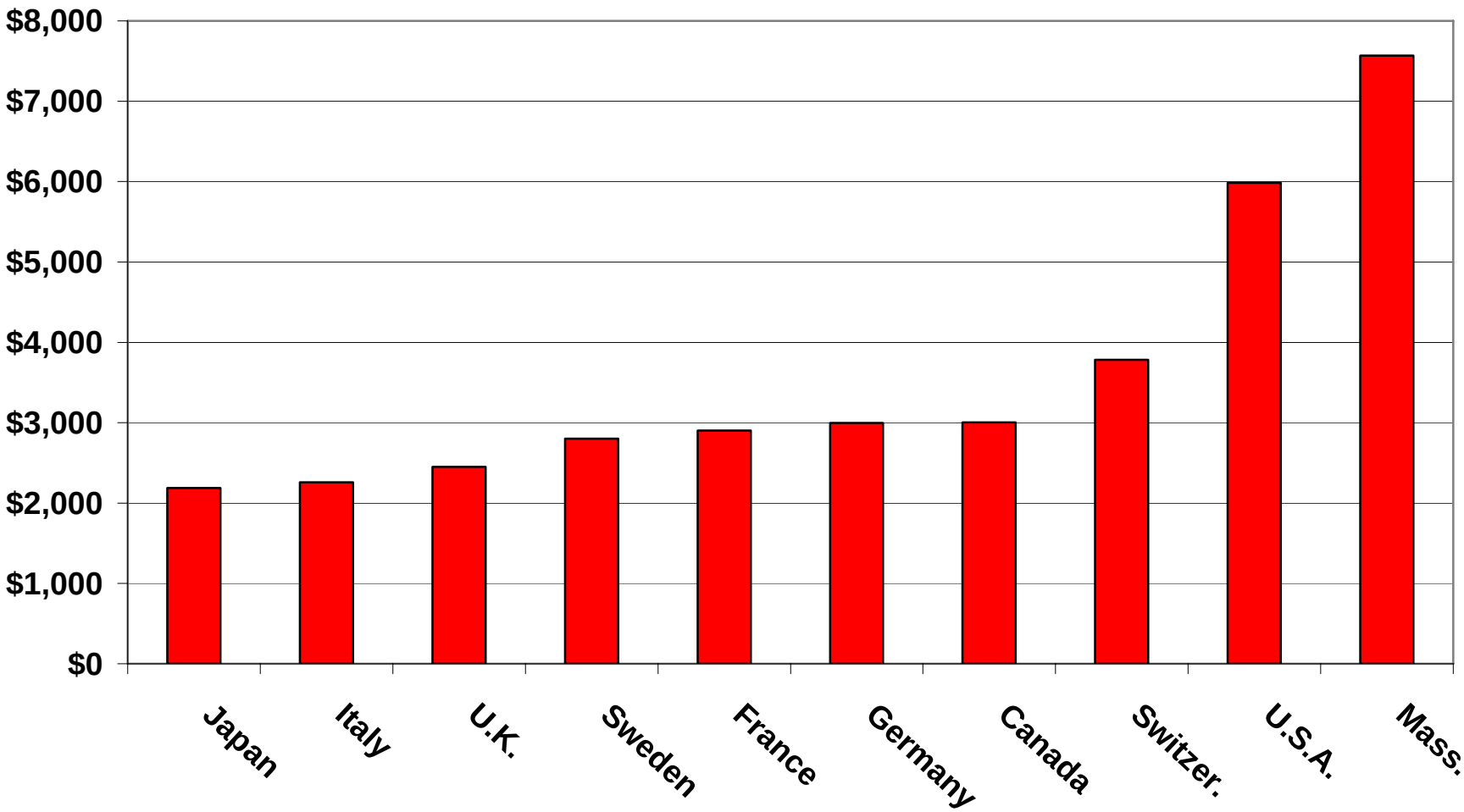
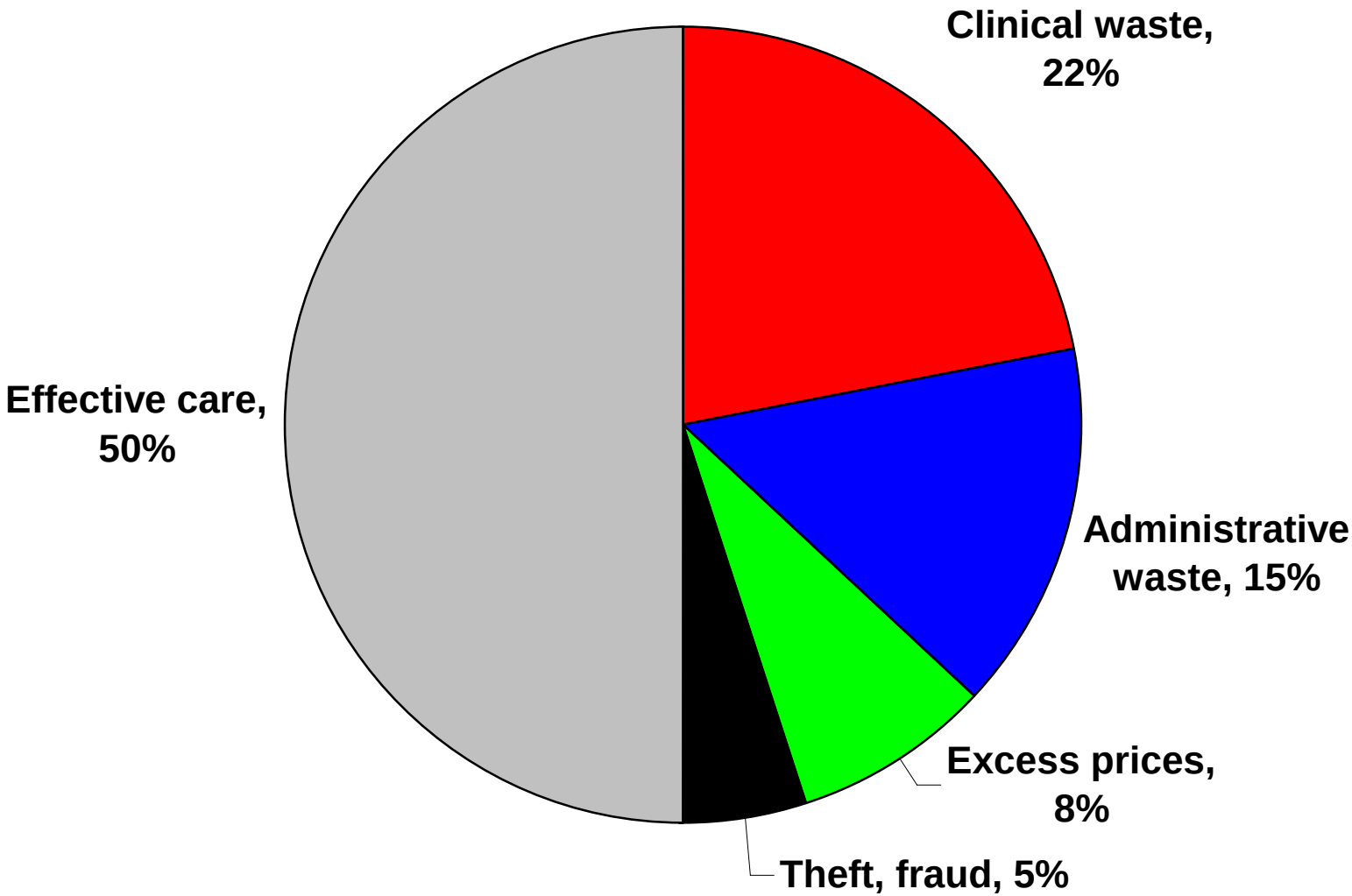


Waste's main causes

1. **Clinical**: unnecessary or incompetent care
   - Piecework payment → financial incentive to do more
   - Too few well-insured patients → they are over-served
   - Fear of being sued → defensive medicine
   - Lack of evidence or failure to use it
   - Weak quality improvement efforts
2. **Administrative**
   - Some: complexity (eligibility, referrals, formularies)
   - More: mistrust between payers and doctors, hospitals
3. **Excess prices**
   - Rx, medical supply, durables, caregiver industry power
4. **Fraud, theft**
   - Light punishment, perception that no-one's hurt

U.S. Health Care Waste, Estimated



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**

(Detail: methods of containing cost)

	Wholesale	Retail
PUBLIC	•Medicare prospective payments to hospitals by the diagnosis •resource-based relative value payments to physicians •certificate of need •reward cost-cutting technologies •boost primary care physicians and community hospitals •prescription drug price controls •cut administrative cost	•squeeze clinical waste through bedside rationing , coupled with end of malpractice system •squeeze administrative waste by improving payer-caregiver trust •develop/disseminate more evidence on what care works, and who needs it •evidence to caregivers on actual cost of each type of care
MARKET	•hospitals compete by price, quality •HMOs compete by price and networks' comprehensiveness •prescription drug insurers compete by price, networks, and formularies	•raise patients' out-of-pocket payments •further de-insure patients by requiring huge out-of-pocket costs + HSAs •give patients better information about need for care and caregivers' price and quality

5. Consolidated financing—essential but not enough

- Two ways to consolidate financing
- Some savings from consolidation alone
- Most waste persists
- What's needed to cut remaining waste?
- A few means of cutting remaining waste

Two ways to consolidate financing

a. Pay for all care from taxes, federal, state, local (would double federal income tax)
b. Pool existing revenues in trust fund (reservoir), and modify revenue mix
   - Medicare + Medicaid
   - Freeze and maintain effort by employers/ employees (in current dollars/person)
   - Slash out-of-pocket costs by raising taxes to fill gaps
   - Spending increases financed only by new taxes on income, payroll, sales, property, or other

Some saving by consolidating financing + covering everyone

Savings won by cutting administrative waste stemming from complexity

- If everyone's covered, cost of certifying eligibility plummets
- If everyone has same benefits, no wasteful checks of referral requirements, formularies
- If one payer, need only one set of forms

And if everyone's covered → more paying customers → no need to over-serve well-insured

Most waste persists

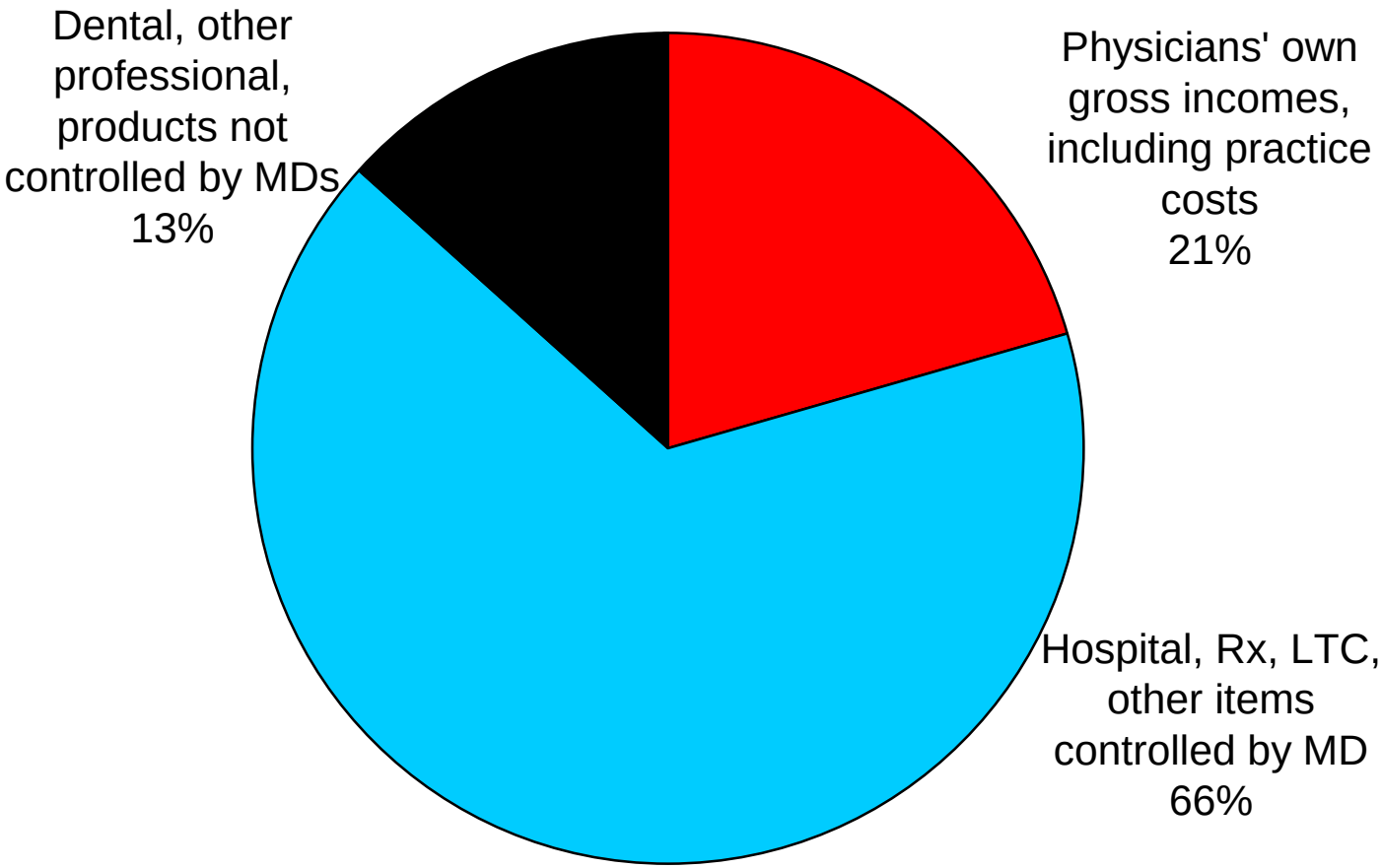
Consolidated financing makes it easy to cap revenue and cover all, but doesn't address waste caused by

- Hospitals', doctors', others' financial incentive to give more care
- Paperwork stemming from payer-caregiver mistrust
- Absence of limits on spending (cost of care) if caregivers play "chicken" with budget
- Lack of need to make trade-offs, spend carefully
- Actual organization and delivery of care
- Causes of defensive medicine
- Excess prices
- Inability to cut theft, fraud

How to trim the remaining waste?

- Recognize that doctors essentially control 87%
- Doctors' support vital to win patients' votes
- Negotiate a peace treaty with doctors, one that
  - End to threat of malpractice suits
  - Ends paperwork stemming from mistrust
  - Liberates them to use evidence to care for all
  - In exchange for doctors' agreement to care for everyone well, staying within budgets (containing much more money than is available today) weeding out waste patient-by-patient

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



Doctors Control > 87% of Personal Health Spending

Personal Health Spending, 2006, $ BILLION	Spending	% MD control	MD-controlled Spending
Hospital Care	$663	100%	$663
Physician and Clinical Services	$463	100%	$463
Dental Services	$94	0%	$0
Other Professional Care	$60	40%	$24
Nursing Home Care	$128	90%	$115
Home Health Care	$53	80%	$42
Prescription Drugs	$219	100%	$219
Other Non-durable Medical Products	$34	25%	$9
Durable Medical Equipment	$25	80%	$20
Other Personal Health Care	$63	50%	$32
Total Personal Health Spending, 2006	$1,802	>87%	$1,587

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 save money required to keep the ER open, not to make a profit
b. Acknowledge that pathology is remorseless but resources are finite
c. Acknowledge need to spend carefully
d. Pay doctors in ways that allow us to trust them to spend the money carefully
   - ✓ Doctors get about 20 cents on health dollar but keep only 8 cents—how they garner the 8 cents is a key to everything else

A few more means to cut waste

e. End malpractice litigation. Substitute
   - ✓ evidence-based care,
   - ✓ compensation for victims of harm,
   - ✓ education and weeding-out of error-prone or dangerous clinicians

f. Regional budgets

g. Three watertight compartments
   - ✓ One for physicians' 20 cents/8 cents
   - ✓ One for the other 67 cents doctors control (inpatient care, medications, nursing home care, others)
   - ✓ One for dental care, public health, capital projects, other activities

Saving money and recycling it – 1/3

- 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 salaries or fee-for-service, in light of competence, effort, kindness
- Doctors marshal the money for hospitals, labs, meds, long-term care.
- Primary care and specialist physicians set standards of care, using evidence, to cover everyone with the money that's available.

Saving money and recycling it – 2/3

- Why would doctors do these things?
  - Clinical-financial-legal-political-ethical peace treaty
  - More money for care + more insured patients → generous MD incomes are protected, not threatened
  - BAU is doomed
  - Doctors can do their jobs better because have clinical freedom to care for all, using evidence
  - No fear of being sued and no mountains of paperwork
- Patients trust physicians' motives + decisions
  - Knowing that MDs can't benefit financially from giving more care or less, patients are more likely to trust doctors to give the right care (even if less than previously), knowing that savings are recycled to finance more care

Saving money and recycling it – 3/3

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

Main Topics

A. Massachusetts health care realities
B. Problems and causes, perceived and real
C. Lessons from the 2005-06 state debate
D. Health care for all—consolidated financing and appropriate delivery
E. Cape Care—resources, challenges, opportunities, next steps

E. Cape Care

1. Resources
2. Challenges
3. Opportunities
4. Next steps

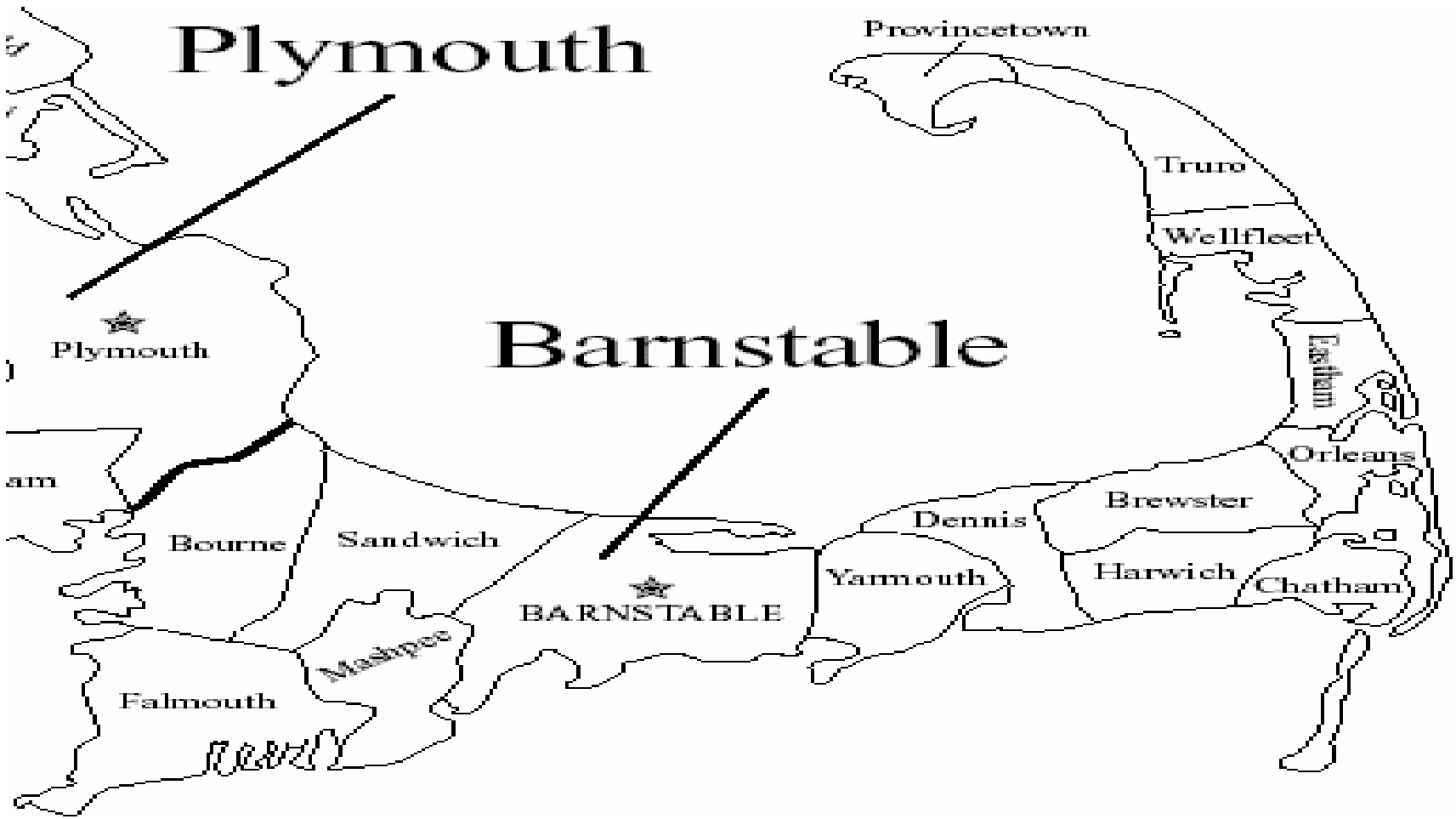
1. Resources

- Money, potentially
- One hospital network
- Geographic limits

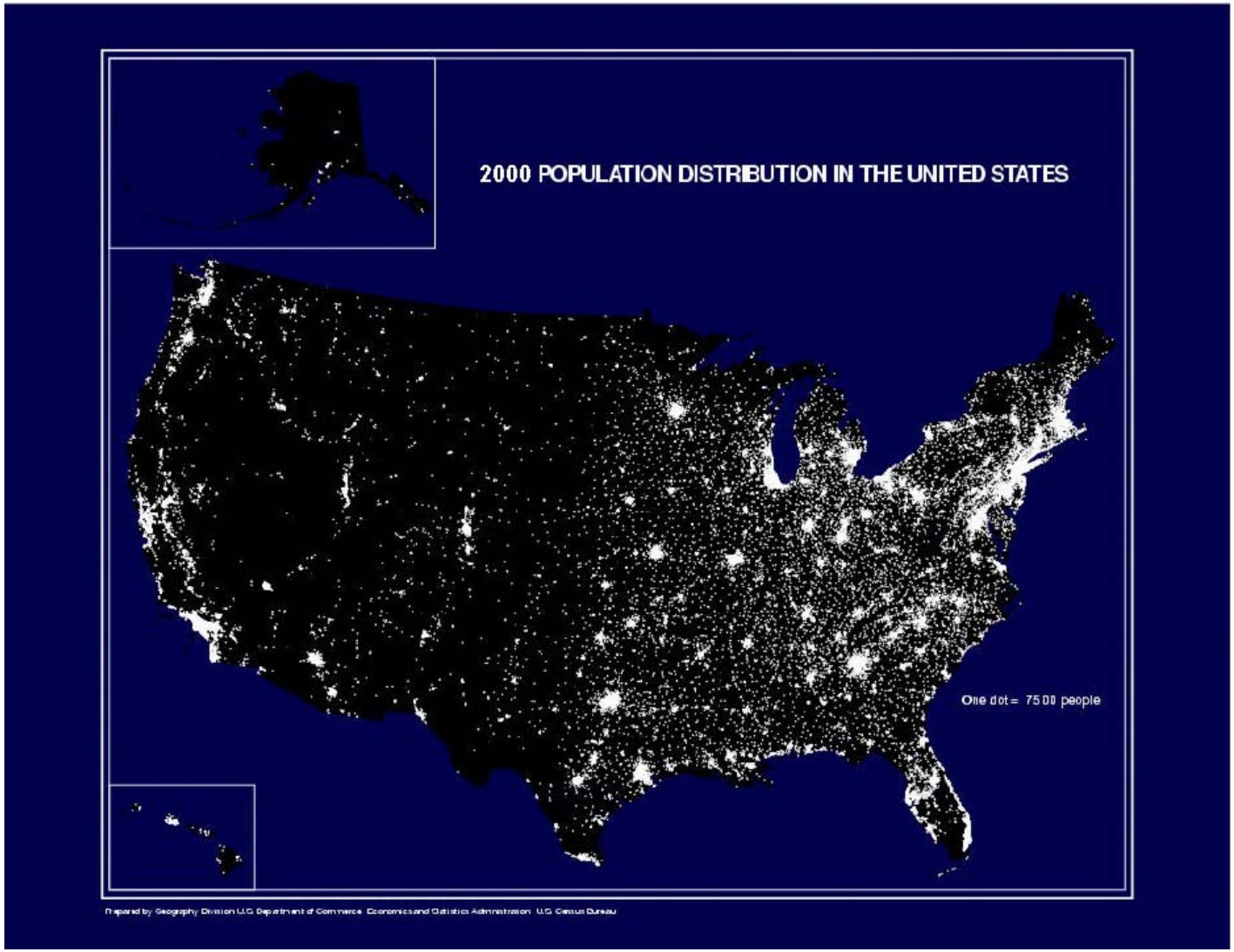
Money

- 225,000 people in Barnstable County
- 2006 Mass. health spending = $9,200/person
- 225,000 * $9,200 = **$2.1 billion this year**
  - Enough to care for people who live in Barnstable County
- A reasonable estimate
  - Total could be higher, with more older people
  - Might be lower, with less use of costly teaching hospitals
  - Less research here
  - What share could be pooled in reservoir?

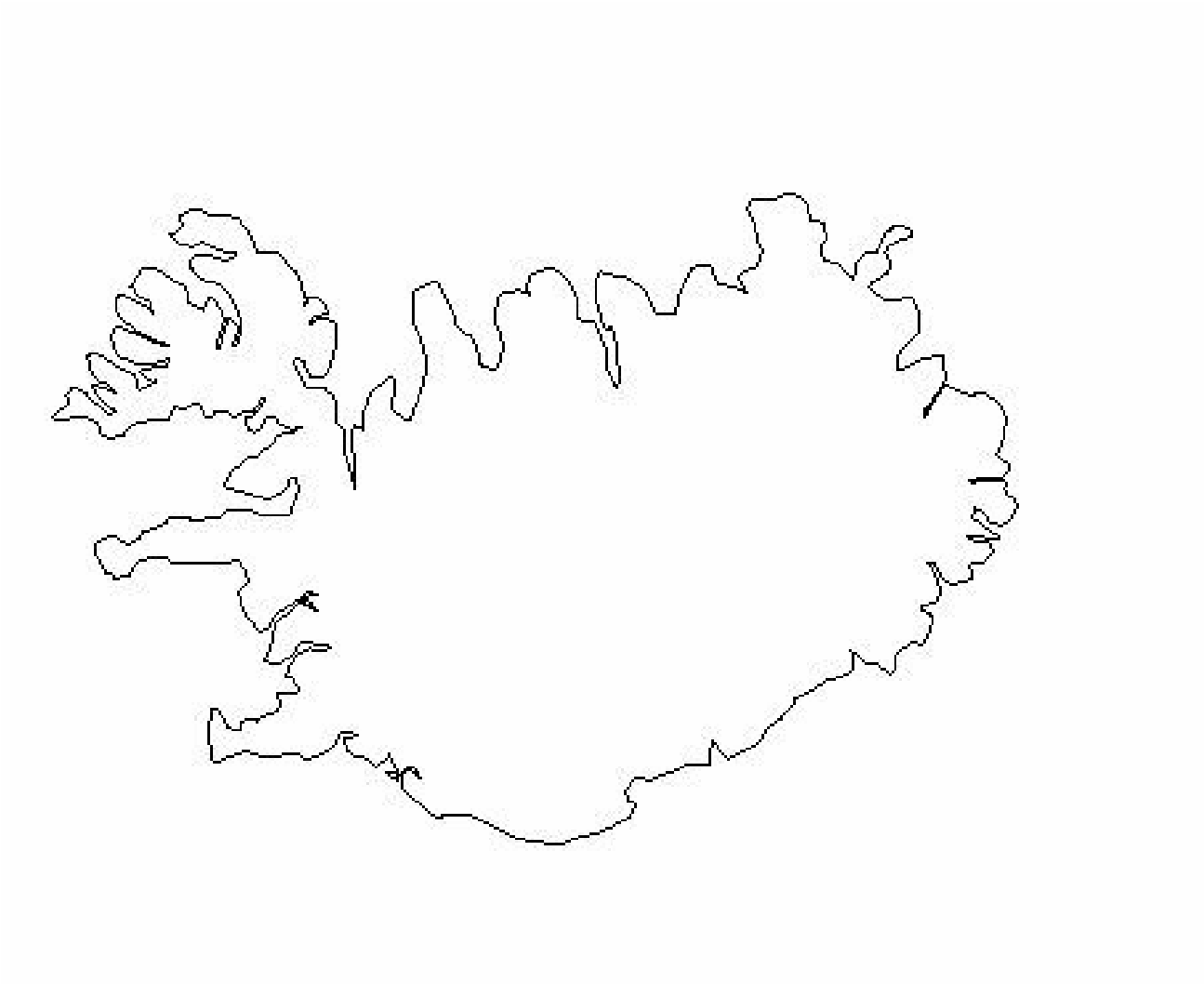
Health spending in Barnstable County, 2006 = $2.1 billion



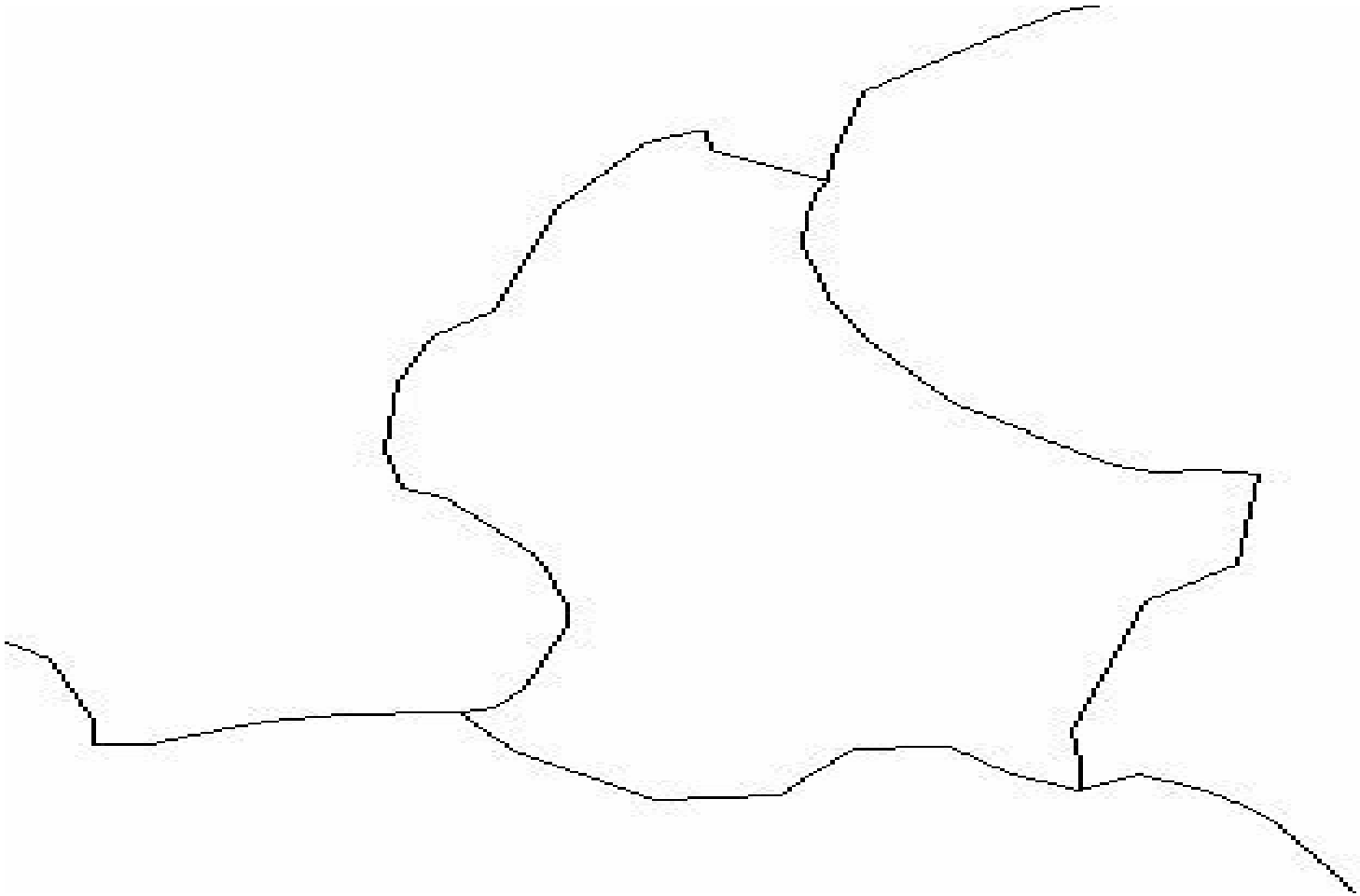
Barnstable County in perspective



$2.1 billion is double Iceland's health spending (population 40 % greater than Cape's)



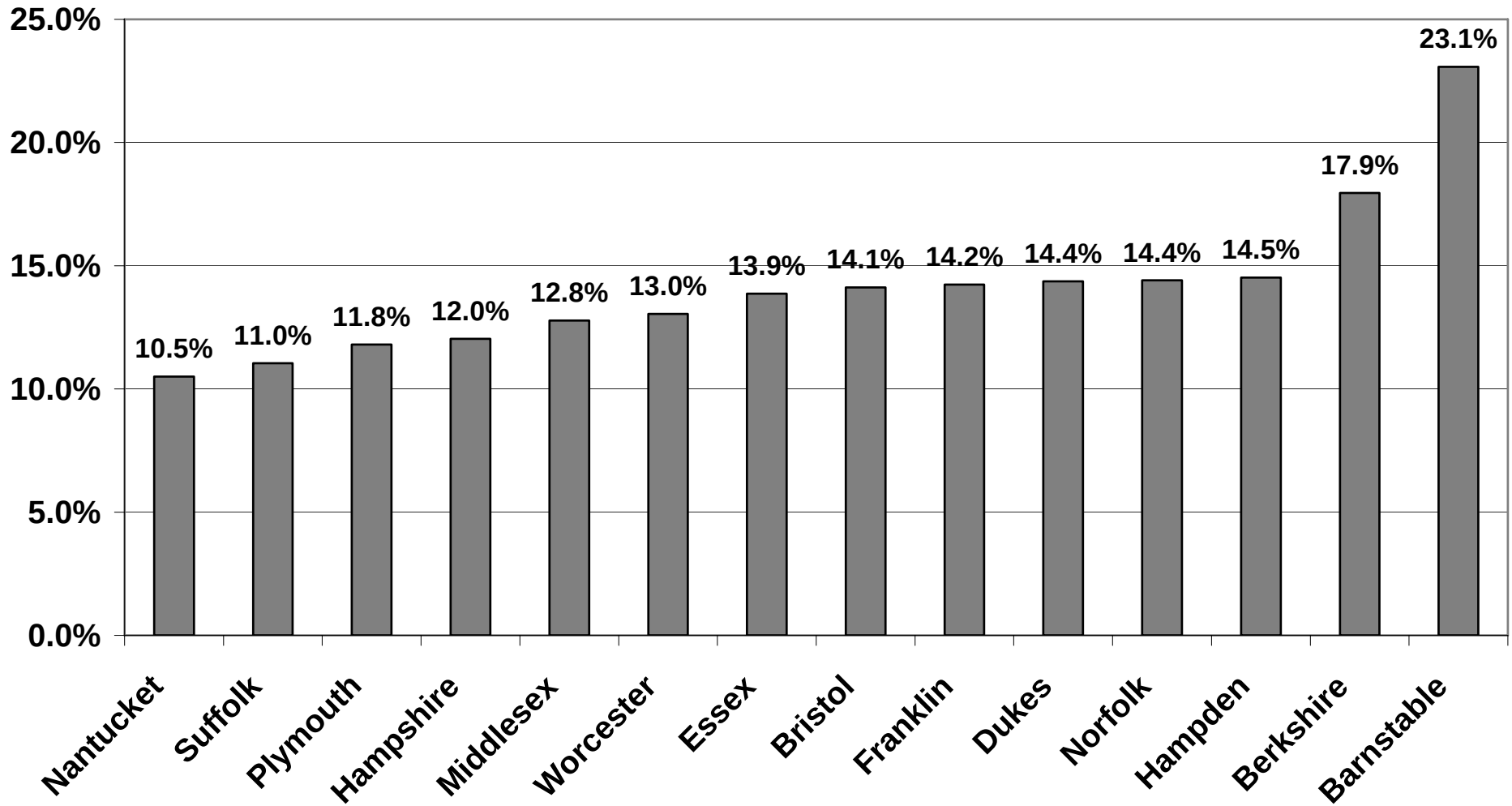
$2.1 billion exceeds Luxembourg's spending (its population is double Cape's)



2. Challenges

- Older population
- Insurance coverage
- Some caregiver shortages possible
- Caregivers march to different drummers
- Current payment rules, Medicare, Medicaid
- Time and space
  - Seasonal population flows—care for non-residents and part-time workers
  - Off-Cape people get care on Cape; Cape residents get care off-Cape
- Traffic, travel times

Share of People 65+, Massachusetts Counties, 2000



Insurance coverage

- Nationally,
  - 1 in 6 have no health insurance
  - 1 in 4 have no Rx insurance
  - About 1 in 2 has no dental insurance
  - Few people have adequate mental health insurance
  - Under 15 percent have any long-term care insurance
- Barnstable County
  - 7.8% of people under age 65 uninsured in 2004 versus 8.3 percent statewide
  - Source is state survey

Some caregiver shortages

- Primary care physicians?
- Some specialist physicians?
- Nurses?
- Nursing home care?
- Home care?
- Dental?
- Mental health?
- Others?

Caregivers march to different drummers

Motivations include

- Caring for patients well—competence, kindness, availability
- Professional pride in doing a good job
- Some physicians integrated with others, but some are more independent-minded
  - Coordinating and cooperating closely with other caregivers
  - Entrepreneurial

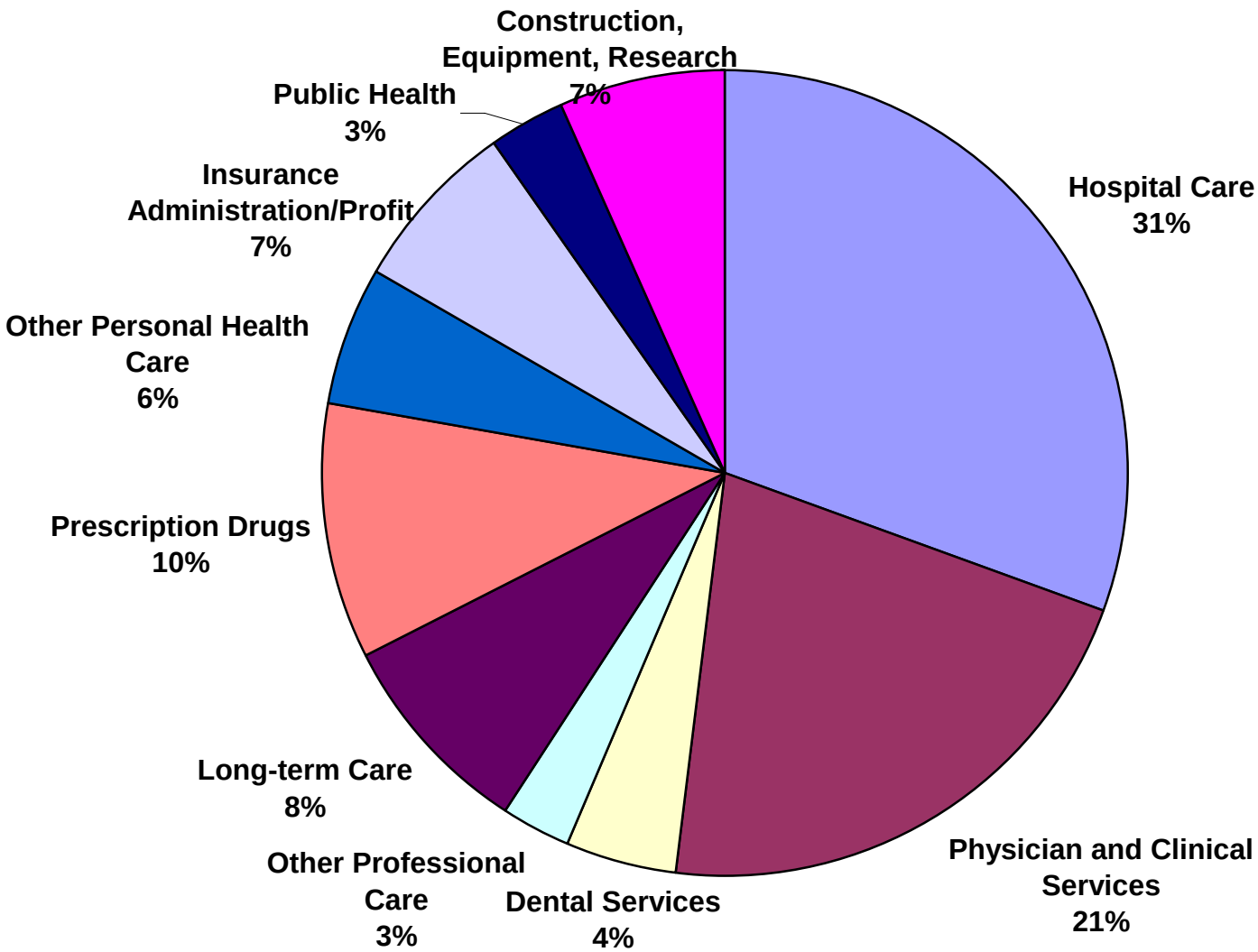
Where the money goes—
All Health Spending by 2006, U.S.A.

Category	$ billion	share of health $
Personal health care	$1,802	83%
Public health activity	67	3%
Insurance administration, profit	151	7%
Research	45	2%
Structures and equipment	98	5%
Health care total	$2,164	100%

Where the money goes—
Personal Health Spending,
2006, U.S.A.

Category	$ billion	share of health $
Hospital care	**$663**	**31%**
Physician + related services	**463**	**21%**
Nursing home + home health	**181**	**8%**
Prescription drugs	**219**	**10%**
All other personal health care	**276**	**13%**
Personal health care subtotal	**$1,802**	**83%**

Spending the Health Dollar, 2006



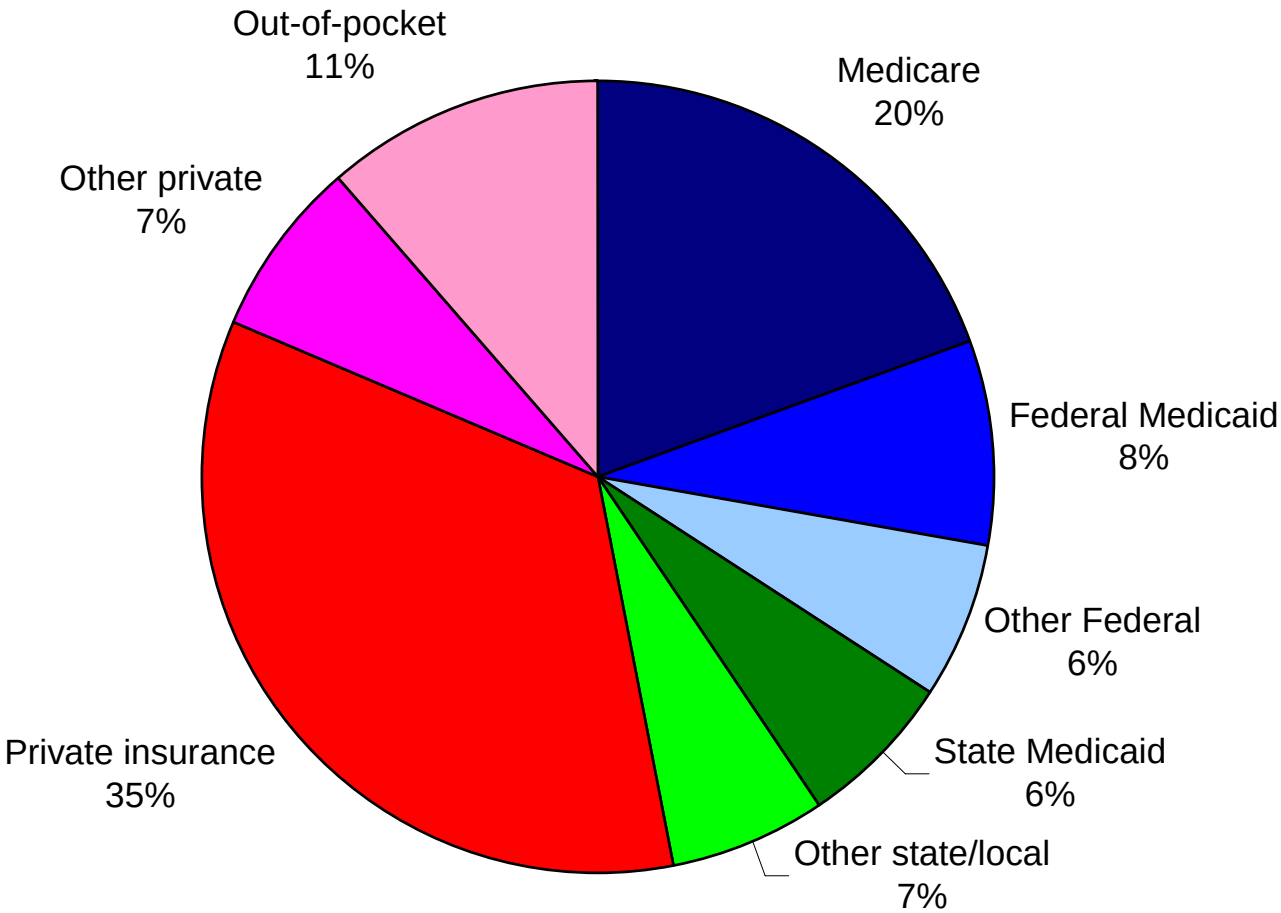
3. Opportunities

- National or state health care crisis might spark demand for reform, but what would we do then?
  - Now is time to learn how to cut waste, pay for care, and organize delivery of care
  - States need to be able to experiment
    - Rep. Tierney has proposed federal $s to let states try ways to cover more and cut cost
    - Sens. Bingaman + Voinovich will file bill to allow parts of states to experiment also
- We already spend enough to finance the care that works for the people who need it.

Sources of U.S. health dollars,
2006, $ Billion

Medicare	$420	19.4%
Federal Medicaid	$184	8.5%
Other Federal	$138	6.4%
State Medicaid	$136	6.3%
Other state/local	$143	6.6%
Private insurance	$745	34.4%
Other private	$157	7.3%
Out-of-pocket	$246	11.4%
Total	$2,164	100.0%

Sources of U.S. Health Dollars, 2006



4. Next Steps—ready for 20 Jan. 2009

Politics

Money

Organization and delivery of care

Benefit design

Quality

Legal

Next steps - politics

- Single payer – good idea, weak political support
  - Promises to save a lot by cutting paperwork but many people are nervous
  - How much will it really save? Will I lose care?
- Capping revenue is not same as capping spending on care
- How to enlist support from doctors, hospitals, dentists, nurses, health care workers, others?
- Political negotiations are essential
- BAU is no longer an option
- No villains

Next steps - money

- Seek waivers to pool the money
  - Medicare - Medicaid – ERISA (if needed)
  - How to require employer/employee maintenance of effort without violating Mass. constitution
- Who will hold the three budgets?
- What happens if we're heading for exceeding the budgets?
- Design payment methods
  - physician
  - hospital
- Seek lower Rx prices
- Special financing vehicles to cut premiums, out-of-pocket
  - County sales tax?
  - Payroll/income tax?
  - Tax property to finance health insurance for seasonal workers? (Inter-town differences)

Next steps - delivery

Organization and delivery of care

- One structure to provide care or several competing ones?
- Benefits?
- A primary care physician for each Cape resident
- Plan LTC, mental health, dental, other
- Delivery innovations (such as time banking to help people with long-term disabilities)
- Who will administer the budgets?

Next steps - benefit design

- What services covered, excluded?
  - All care that works, depending on need and budget?
- Who decides if a covered service is needed?
- Patient appeals, ability to sue if don't get care they want?
- Out-of-area coverage

Next steps - quality

- Enact new harm compensation/physician safety methods
- Physician and other professional groups compile and share best clinical practices
- Collect and monitor quality data, with feedback

Next steps - legal

- Governance
- Enact and defend new ways to compensate for harm / improve safety of physician care
- Mechanisms to assure that savings are recycled to improve care
- Tough anti-theft/fraud provisions
- Anti-trust waivers
- What arrangements for caregivers who remain outside the care network?
- Would patients be allowed to buy supplementary insurance or spend own money to get more care or get an appointment or operation sooner?

Checklist of practical very next steps

- Develop the work plan + committees
- Continue to identify supporters/opponents
- Identify legal issues and how to address them
- What implementation steps can be taken right away?
  - Physicians identify ways to weed out wasted care—where's the low-hanging fruit?
  - Any existing ways to capture and recycle savings?
  - Cape-wide discussions of problems/solutions
  - Assess care delivery capacity, shortages
  - Measure current spending, financing sources
  - Identify minimum elements essential to cover all and contain cost

Why? To attain medical security

- Medical security is not a promise of immortality.
- It is honest, grounded confidence that
  1. We will get competent and timely care from clinicians and institutions who know and care about us
  2. Without worry about the bill when we are sick, or fear of bankruptcy
  3. And without worry about losing insurance coverage ever, in good times and bad

How? Better spend what we've got

- Health care = easiest problem to solve
- Not easy, just easier than all of the others
  - Were it easy, we'd have done it long ago
  - And, inside health care, Rx is very easy to fix while long-term care and mental health are hard
- While easiest, it's complicated, multi-faceted
- It's headed toward meltdown
- We can stop this
- We can protect our health, our finances, and our caregivers
- If we work together

Why? 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
  - Health care will crash during next bad recession → insecurity
- Political
  - Spending more money to finance less care for fewer people is a recipe for political fury
  - Local and state governments are feeling the crisis well before Washington

One hand for yourself and one for the ship