Health Reform that Matches American Values, Traditions

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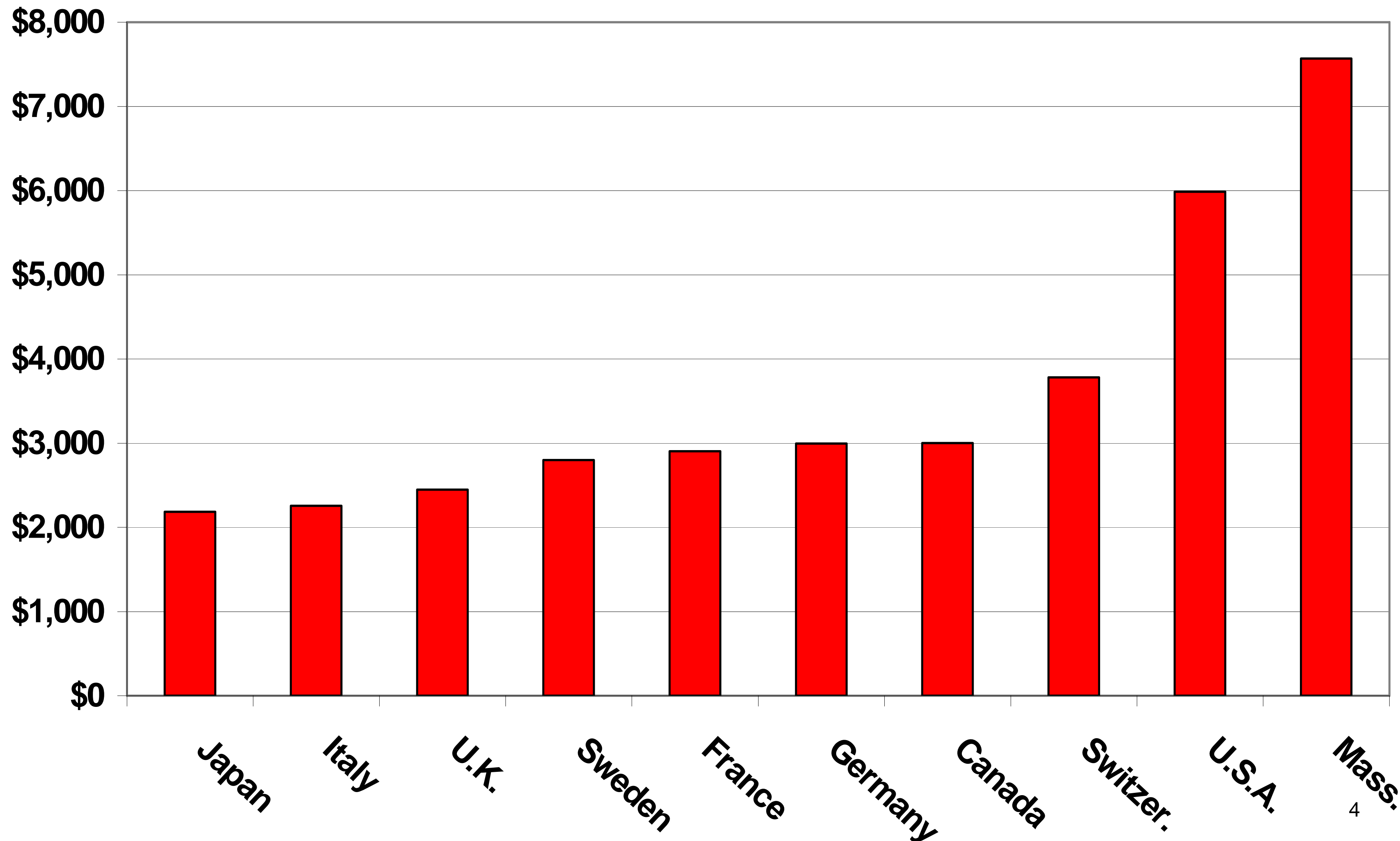
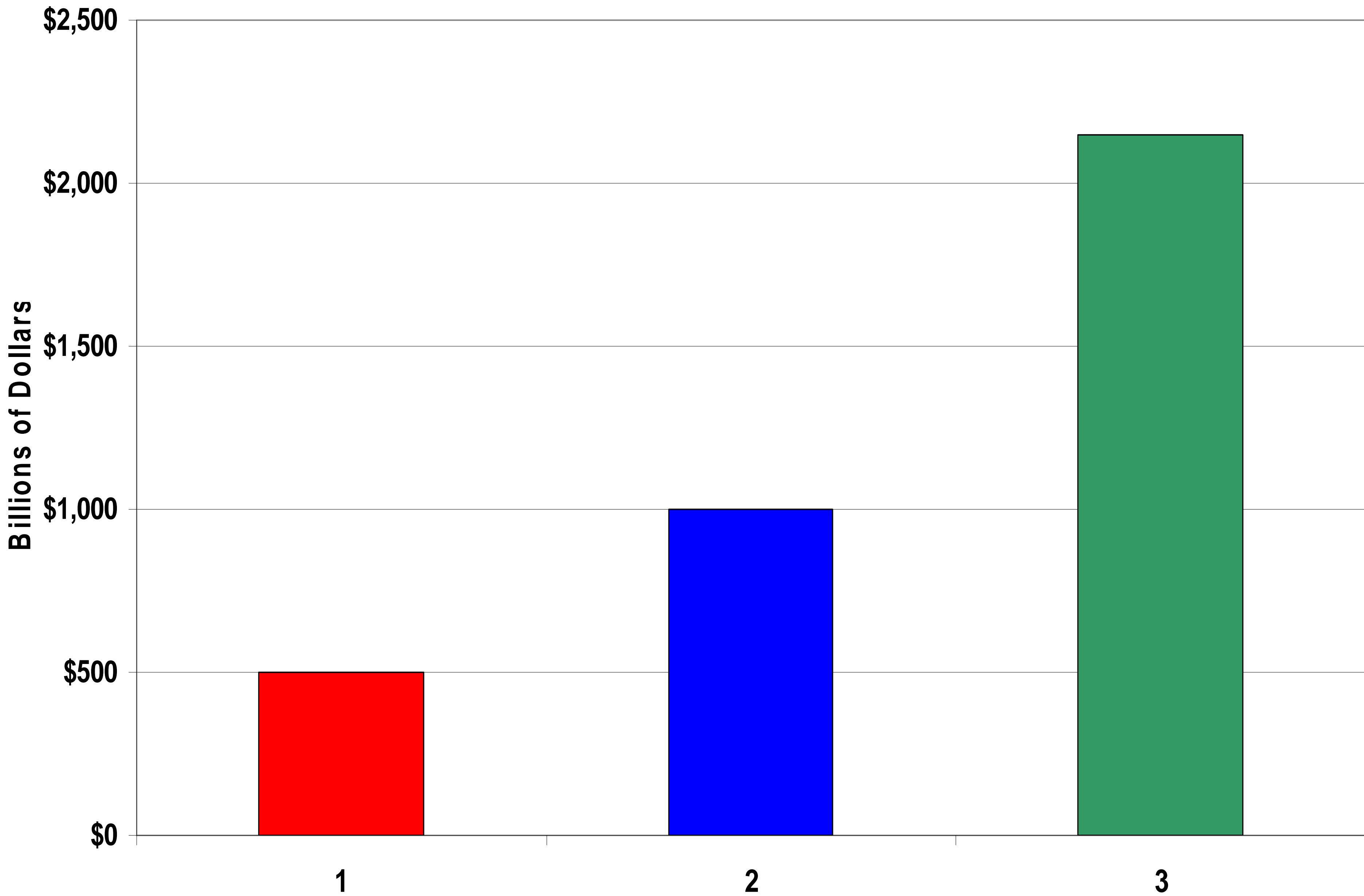
Forces making for change, demanding more value

- Cost—new pressure for control; is more money for business-as-usual possible?
- Coverage—added pressure to cover all; how to pay for it?
- Caregivers—right shape? Right numbers?
- Care—can it be more patient-centered?
- Confidence—medical security is the aim—competent, timely care when needed, but no worries about bill when sick or about losing coverage ever

A. Is anyone surprised?

Health Spending per Person, Selected Wealthy Nations, 2003





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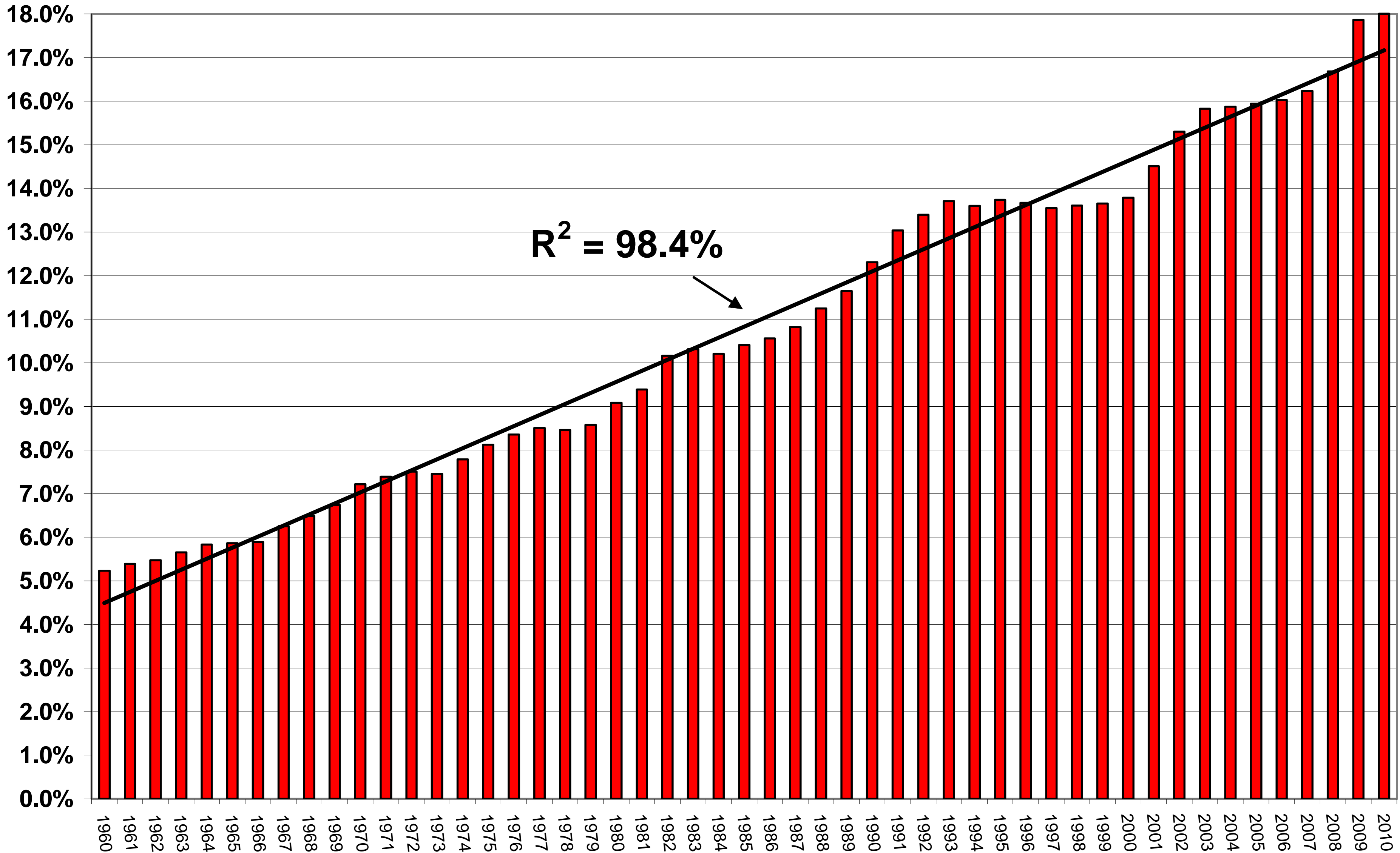
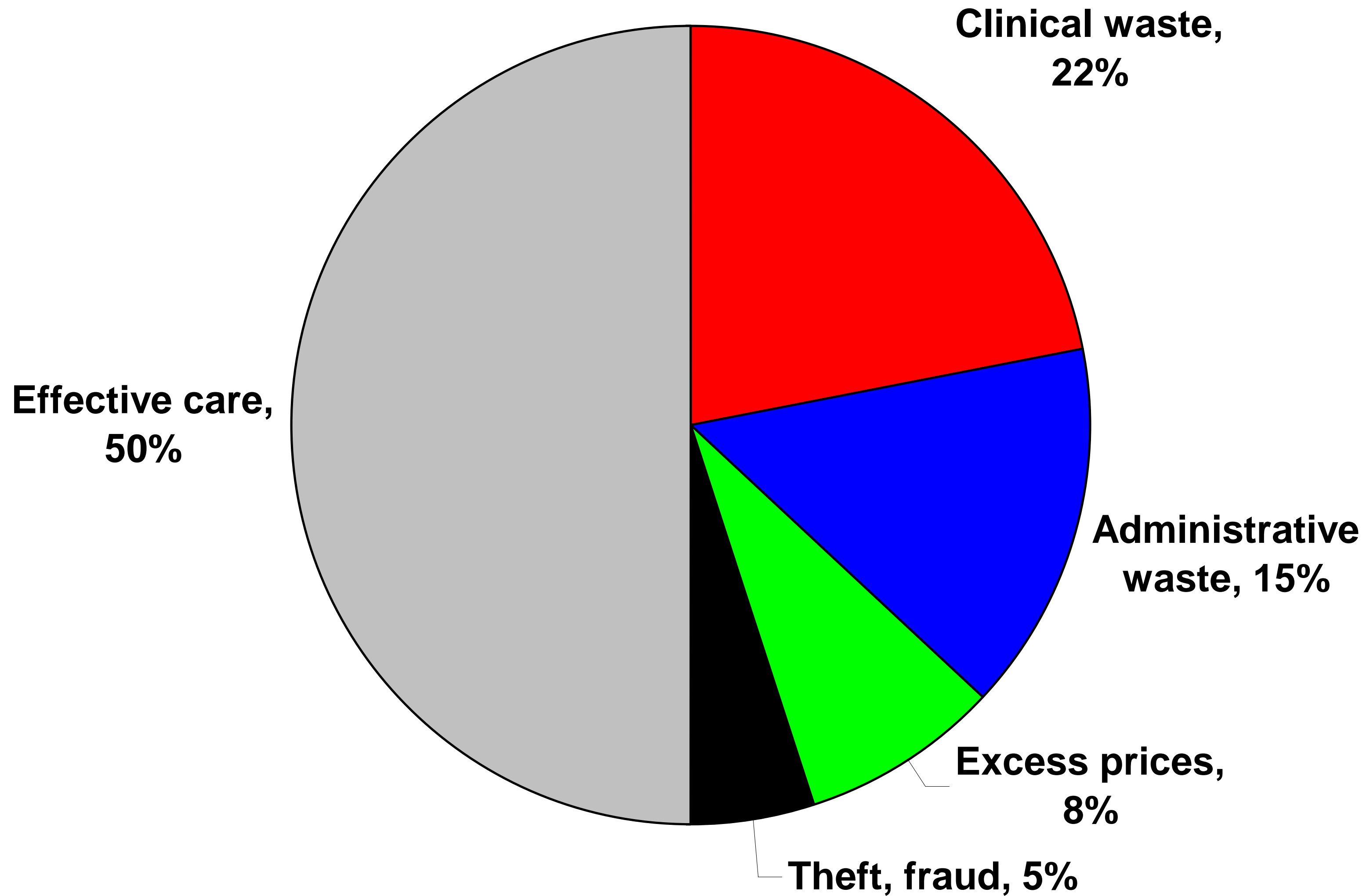

Health Share of U.S. GDP, 1960-2010, 20 March 09 edition
R^2 = 98.4%
18.0%
17.0%
16.0%
15.0%
14.0%
13.0%
12.0%
11.0%
10.0%
9.0%
8.0%
7.0%
6.0%
5.0%
4.0%
3.0%
2.0%
1.0%
0.0%
1960 1961 1962 1963 1964 1965 1966 1967 1968 1969 1970 1971 1972 1973 1974 1975 1976 1977 1978 1979 1980 1981 1982 1983 1984 1985 1986 1987 1988 1989 1990 1991 1992 1993 1994 1995 1996 1997 1998 1999 2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010

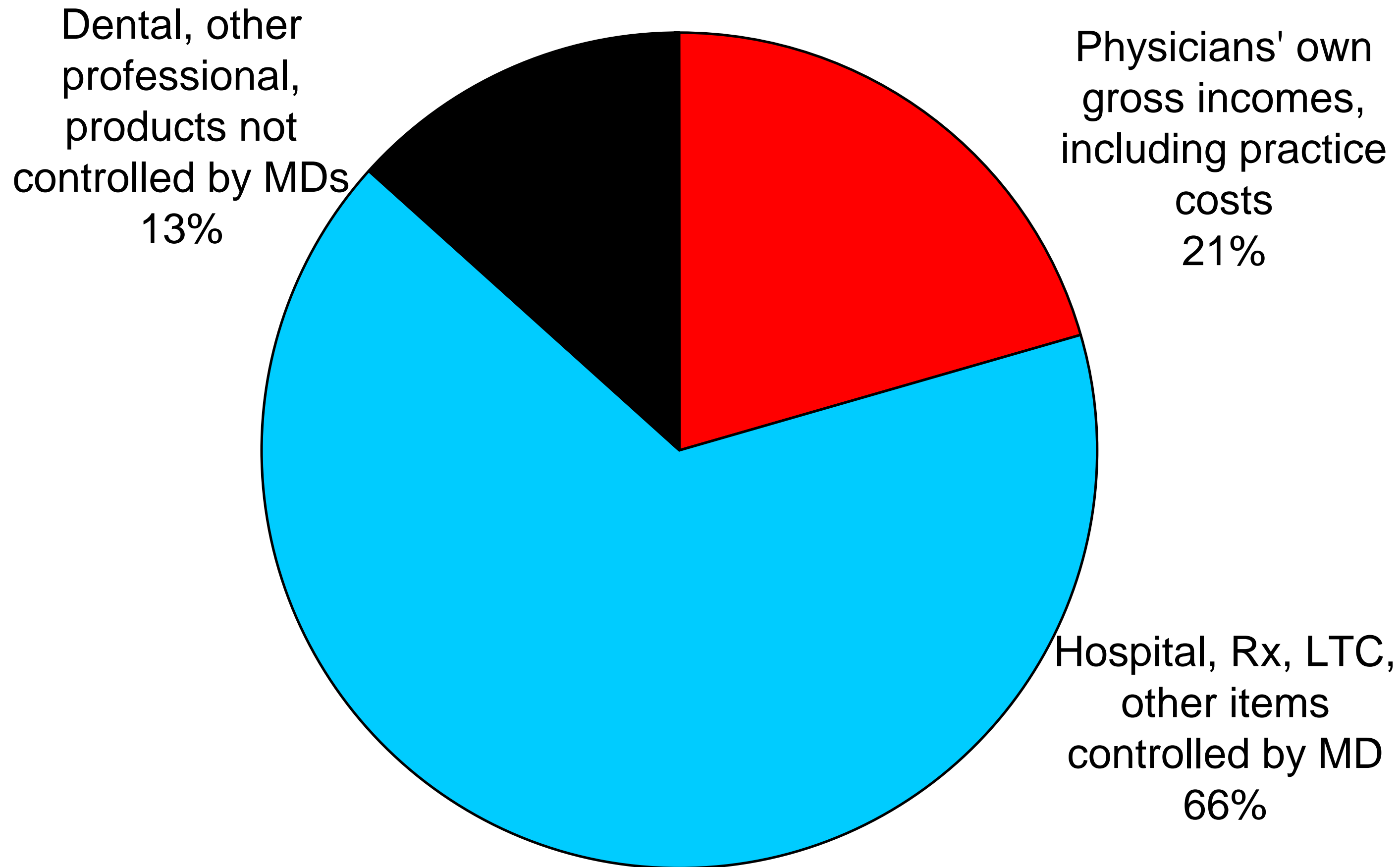
U.S. Health Care Waste, Estimated



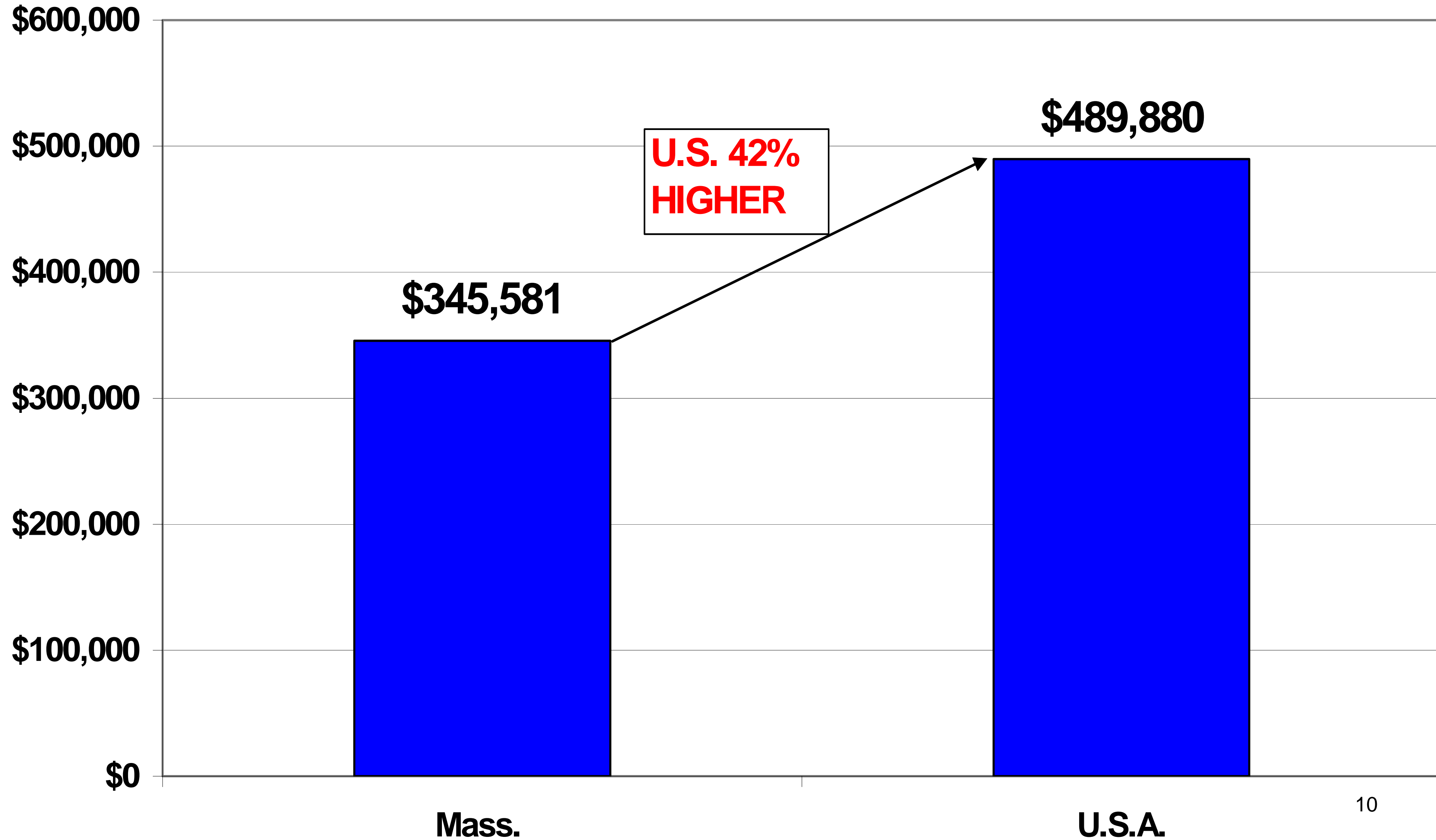
Causes of waste

- Clinical
  - Financial incentives to do more
  - Defensive medicine
  - Lack of knowledge or failure to use it
  - Mismatches between caregiver capacity and patient need
- Paperwork
  - Mistrust, doctor-payer, hospital-payer
  - Complexity of forms, formularies, rules, networks
- High prices of meds, equipment, some incomes
- Theft
  - Belief that more money replaces what’s stolen
  - Weak punishment

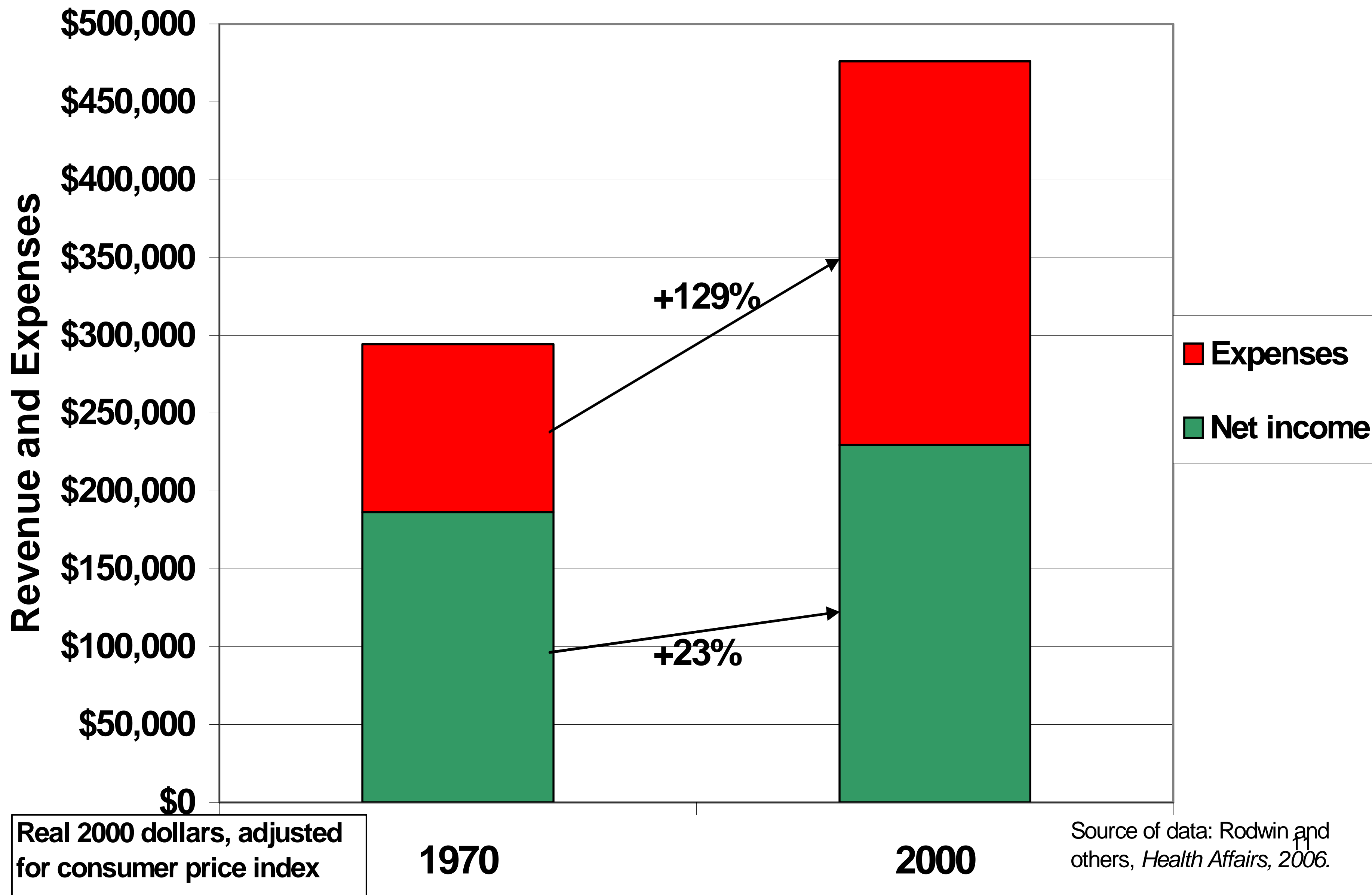
PHYSICIANS RECEIVE OR CONTROL 87% OF U.S. PERSONAL HEALTH SPENDING, 2005

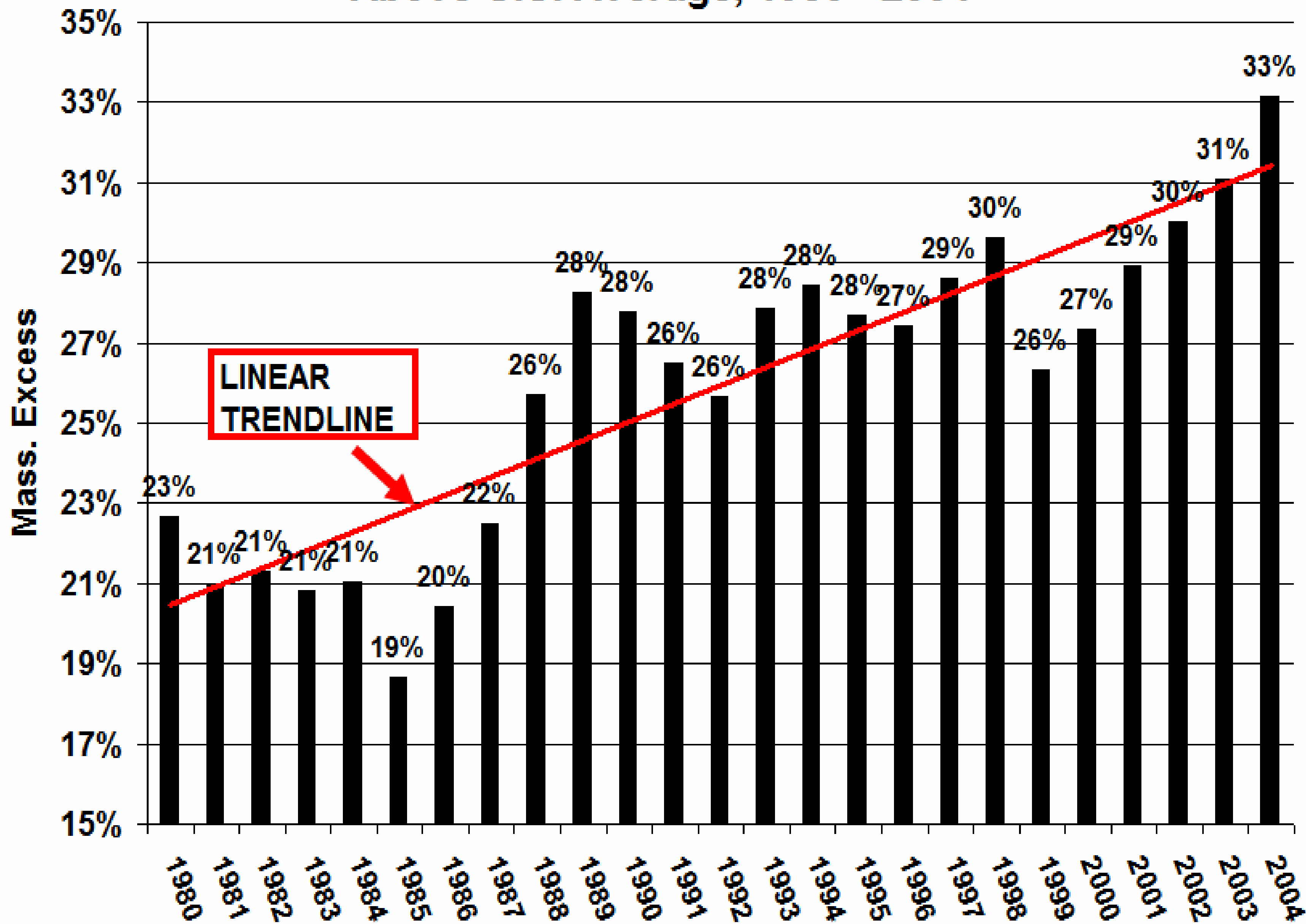


Estimated Gross Income per Physician, Massachusetts and U.S., 2002



U.S. Physician Net Revenue and Expenses, 1970 + 2000




Excess Massachusetts Personal Health Cost per Person, Above U.S. Average, 1980 - 2004
Mass. Excess
35%
33%
31%
29%
27%
25%
23%
21%
19%
17%
15%
LINEAR TRENDLINE
23%
21%
21%
21%
21%
19%
20%
22%
26%
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2004

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

20.0%
18.0%
16.0%
14.0%
12.0%
10.0%
8.0%
6.0%
4.0%
2.0%
0.0%

6.3%
11.2%
11.2%
17.6%

Uninsured Share of People Up 78 %

Health Cost's Share of Economy Up 59 %

B. Surprised about what?

- Failure to cover everyone
- Failure to contain cost
- Failure to identify and protect all needed hospitals
- Failure to train and pay enough primary care physicians

No villains – just decade after decade of unfortunate accidents (?)

- 1945 – 1970: strong economy—what better to spend more money on than health care?
- → 25 years of blank check medicine→ financial addiction to more money for business as usual
- 1972 – 2009: almost four decades of failed cost controls, market and regulatory

Why does US spend so much more? Why have cost controls failed?

- Much money flows through invisible underground aqueducts→ little pressure to spend less (elsewhere, neurons are linked)
- No top-down political consensus among employers, unions, government, hospitals, and doctors that $X is all we can afford
- Assertion that constraining revenue means rationing (deny valuable care; wave bloody shirt)
- Cost controls have had little effective political support—why?

Cost control: Why little political support?

- Seldom any tangible benefit offered (abstract good-government, so savings trickle invisibly to payers)
- Caregivers deeply want more money
- Hospitals, doctors, drug makers are volume-driven, because TR rises with volume much faster than TC
- Obsession with formulas
  - DRG, RBRVS, formularies
  - Invitation to mistrust, gaming, complexity, administrative waste
  - Formulas manifest weak political support but don't substitute
- "Faith-based cost controls"—prevention, EHRs, case management for chronically ill.
- Doctors control almost 90% of personal health spending but have been squeezed, manipulated, or ignored—rarely involved as partners in cost control.

Strong rhetoric but weak action

- Market competition! Government regulation!
- Neither works in health care, → anarchy
- Talk that cost control is essential politically
  - but nothing has worked, so we regularly rely on more revenue to balance the books
- Talk that increased primary care supply and medical homes are essential
  - but nearly nothing real has been done
- Talk that stabilizing needed hospitals/ERs is essential
  - but nearly nothing has been done
- Talk that units of payment have to change
  - but will they be changed, and why will that help?

That’s why we need to do things differently—here’s an illustration

- Dramatic health care peace treaty
- Squeeze the wasted 50%, capture, recycle
- Assure revenue to finance high-quality, appropriate care at each needed hospital
- Attract best physicians to primary care
- Get research and marketing costs out of drugs’ prices
- Free up resources for long-term care

Peace treaty's key principles

1. Since neither free market competition nor traditional government action work to contain cost in health care, we need a substitute to achieve homeostasis, equilibrium.
2. Integrate payment reform with delivery reform
3. Integrate coverage for all with cost control
4. Doctors and patients adopt reforms voluntarily
5. Incremental, narrow but deep reforms with top-down (money follows patient) and bottom-up elements (care networks are formed locally)
6. Sustain all needed caregivers

Peace treaty's key principles

7. Negotiate a deal with doctors, one that liberates, motivates, and obliges them to spend carefully, squeeze out clinical waste
8. Doctors should steer by clinical compasses, not legal or financial ones
9. But dollars are finite: "professionalism within a budget"
10. Only motive to deny care or save money should be to spend it better → trust → slash payment-related paperwork
11. Move to 300,000 FTE primary doctors (panel size drops from 2,000-2,500 to 1,000 per primary)
12. Reform must bootstrap its own political support. If enough doctors support a reform, it will pass

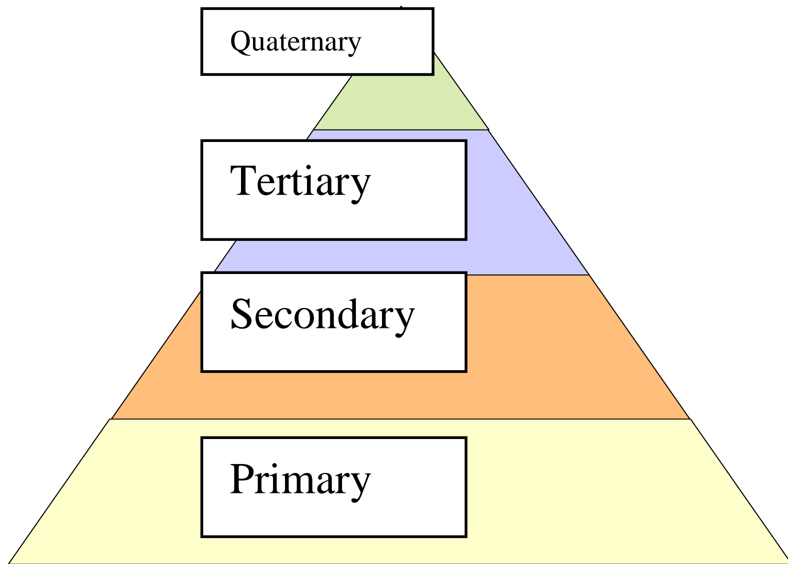
Peace treaty's key background

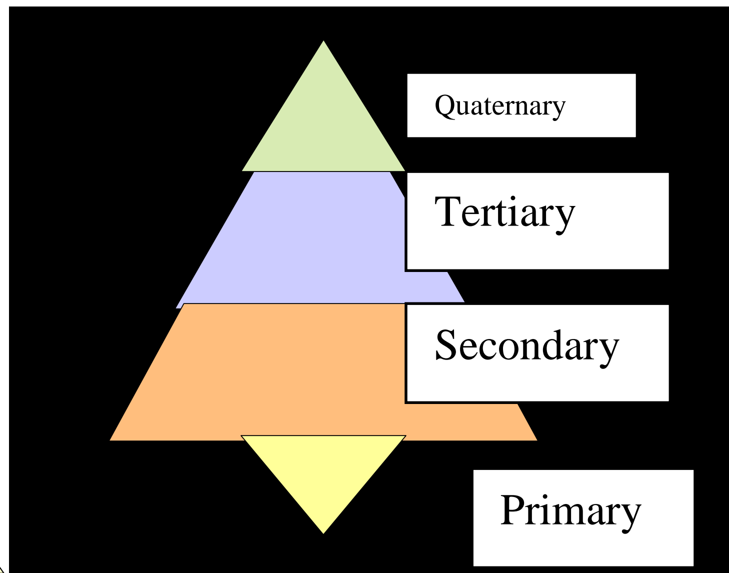
- Real primary care essential to coverage, cost containment, and patient-centered care
- U.S.A. has about ½ as many primary care MDs/1,000 as the other wealthy nations
- Debt/tuition relief not commensurate with problem
  - Average physician debt now above $150K
  - That's < 1 year's net income differential between primary care and high-paying specialties
- Only much higher incomes will attract more MDs to primary care

The inverted primary care pyramid

Chart X: the traditional health care pyramid, resting on a broad and solid primary care base.

Chart Y: Today's inverted primary care pyramid, in which growing pressure and disruption are imposed on primary care doctors by health care delivery and financing.





Peace treaty key provisions—a package deal for physicians

1. End financial incentives to do more—cease to pay primaries by FFS
2. End defensive medicine—patients voluntarily waive right to sue (replace with no-fault compensation + separate MD quality assurance)
3. End payment-related paperwork
4. Full risk-adjusted capitation to primary care groups
   - 20 MDs → 20K patients @$8K = $160M/year in Mass.

Peace treaty key <u>provisions</u>—a package deal for physicians

5. Clinical, managerial, conflict resolution, decision support, financial, IT, monitoring support for groups
6. Establish three budgets, in separate water-tight compartments
   - One to pay primaries—base target income = $250K (=$75B = 2.9 percent of U.S. health spending, a rise from about $45B today)
   - One to pay specialists—no cuts in incomes
   - One to pay for all the labs, imaging, surgery, meds, LTC they authorize

→ No party has financial incentive to do more or less

True to American values, traditions

- Health care suffers dearth of innovation
  - Or, at least, a near-dearth experience
- Tinkering, empiricism—not ideology
- Smallness—no one gets too big to fail
- If free market can't work in health care, what can?
- Facilitate bottom-up, integrated efforts, and see what works

What can liberate innovators?

1. Voluntary
2. Small
3. Integrate finance and delivery
4. Bottom-up and top-down
5. Let doctors, as fiduciary professionals, try different things
6. Let patients follow their doctors, voluntarily waiving right to sue
7. Let risk-adjusted money follow patients
8. Easier Medicare, Medicaid, ERISA waivers
9. Standardize one-price payments to hospitals (as Maryland), and to drug-makers
10. Standardize benefits
11. Standardize patient rights, protections
12. Weather helm: trustworthy self-regulation
    - Provide for financial neutrality, so money saved is used to finance more care that's needed

One hand for yourself and one for the ship