Cutting Health Care Costs and Covering Everyone by Negotiating a Political, Financial, Clinical, and Legal Peace Treaty with Doctors

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Summary

U.S. health care is accelerating toward the edge of a cliff. Coverage falls but costs rise rapidly

The presidential campaign has begun earlier than ever. Candidates propose to boost coverage, but most require still higher spending. Multi-row and multi-column comparisons of the proposals proliferate. We've seen them in 1993. And in 1973. What will be different this time?

Caregiver configuration cleaves toward two-class care. Some needed hospitals close and, in many regions, reliance on surviving costly teaching hospitals grows. Too few primary care physicians are being trained. And too many doctors are seduced by financially attractive care that doesn't always coincide with patients' needs.[1]

The current rate of health care spending increases is not sustainable because it crowds out other things that matter, and because the U.S. economy is weak today and unreliable tomorrow.

Since 1972, despite much talk and some action, virtually none of the efforts to contain costs have succeeded. Market competition has failed. Public planning and regulation has failed.

Today, the general absence of functioning markets and functioning public direction helps to explain the growing anarchy in U.S. health care. Too many caregivers and payers pursue their own interests. Consequently, too small a share of care and money are aimed toward meeting patients' needs.

And yet, current spending is, by all reasonable measures, already adequate to finance the care that works for all the people who need it. So there is great reason for optimism.

This paper describes reforms that focus on reshaping the delivery of care. It aims to intimately link coverage for all with cost control, and financing with care delivery. It aims to liberate and oblige physicians to serve all patients and spend money carefully. It seeks to enable doctors to act in accord with their clinical judgment, with their training, with their professionalism and honor, and with the best available evidence on what care works and who needs it.

This paper sketches reforms that are comprehensive, because it's necessary to consider both financing and delivery in order to both contain cost and expand coverage. But the proposed reforms are also mainly bottom-up, avoiding national comprehensive top-down reform that inflicts too many dislocations and requires too much coordination of large-scale decisions.[2] What we offer here is one way to implement the principles we consider vital; others are possible.

A. WHY?

Whereas—

1. The number of uninsured people is rising steadily.

2. Most proposals to cover uninsured people require spending increases that will be hard to enact, are not affordable, and are not needed.

3. Many such proposals purport to solve the problem by stapling plastic insurance cards to people's collars. But much of this insurance would be flimsy, meaning that the reforms would trade lack of insurance for under-insurance. That's progress, but not enough. And condoning that underinsurance encourages the erosion or flimsification of coverage for today's insured people. Indeed, even today, most insured people are seriously underinsured.

4. Neither coverage for all nor cost control can be attained unless both are pursued together. If they are pursued in tandem—and in ways that address the growing malconfigurations of physician supply and of hospital care—current health care spending will be sufficient to finance medical security for all Americans. That should make winning affordable health care the easiest problem to solve—not easy, just easier than all of the others

5. Almost all cost control proposals that are today widely discussed politically are either sideshows or gimmicks that will not work. It is foolish to rely on forcing patients to pay more out-of-pocket or on making patients into consumers by providing better information about price and quality. These arrangements might work for economists who are married to doctors, but will not work for most humans. Also, relying on electronic medical records, or on new overlays of chronic care case management won't do much to contain costs because they are external maneuvers that don't grapple with the core causes of high costs.

6. Today's promotion of ineffective gimmicks is not surprising, since all health care cost controls, competitive and regulatory, that have been attempted during the past four decades have essentially failed. Indeed, competent free market competition and competent government regulations are largely unattainable in health care. The approach described here largely abandons both. Instead, government makes a few decisions—of the very types that government is competent to make. And then, groups of physicians regulate themselves through budgets, professionalism, honorable behavior, and evidence. This is designed as non-market equilibrium-seeking under conditions of universal coverage and cost containment.

7. Past cost controls failed for five main reasons.

- Too few people wanted them to succeed and too many wanted them to fail, so they were often mainly symbolic political posturing.
- Past cost controls were seldom integrated with substantial changes in the actual delivery of care. They did not enable or motivate those who could contain costs to do so.
- In particular, cost controls ignored doctors, marginalized them, or treated them as objects to be manipulated. This was and is unwise, since doctors' decisions essentially control almost 90 percent of health spending
- Cost controls did not address the growing shortage of primary care physicians or the growing malconfiguration of hospitals by location and by specialization.
- Past efforts treated cost control as an objective in itself. But saving money seldom excites or sparks political action. A far better purpose of cost control would be to squeeze out waste or fat that would be transformed to bone and muscle, to visibly win and sustain affordable care for all Americans.

8. Health spending has risen from 13.8 percent of the economy in 2000 to 16.0 percent in 2006, and is projected to rise to 19.6 percent in 2016. This means the dollars spent will nearly double from 2006 to 2016.[3] And this assumes no improvement in coverage.

9. We doubt that Medicare, Medicaid, private employers, and families and individuals will be able to find anywhere near that much money. Higher health care spending is not affordable or sustainable. Indeed, Congressional Budget Office analysts assert that "our country's financial health will in fact be determined primarily by the growth rate of per capita health costs." [4]

10. The U.S. economy is fragile but U.S. health care is financially addicted to higher real spending each year to finance business as usual. Caregivers and payers lack contingency plans to deal with economic decline or disruption, and the resulting substantial drops in real dollars available to finance health spending—drops that are inevitable at the bottom of the next serious recession

11. We are convinced that roughly one-half of health care spending is wasted. This should be an enormous source of optimism

12. Costs can't be safely and seriously controlled unless waste is reduced, and that requires tackling the causes of each of four types of waste. These are unneeded clinical services (stemming from financial incentives to over-serve, defensive medicine, evidence gaps, and malconfigurations of hospitals and doctors), financial paperwork (stemming partly from complexity but mainly from mistrust between payers and doctors and between payers and hospitals), high prices, and theft.

13. Tackling the wasteful financial paperwork arising from today's multi-payer complexity—a major focus of single-payor proposals—would be valuable, but it's a one-time gain. And the morning after chopping administrative waste, we would still confront unsustainable, open-ended increases in clinical spending.

14. Winning health care for all and containing costs requires cutting waste. Cutting waste, in turn, requires deep changes in actually delivering and paying for health care, not shallow changes like boosting patients' out-of-pocket payments. At heart reducing clinical waste requires better decisions by doctors (even though doctors' services are not the main category of clinical waste today). That's because doctors' decisions essentially control some 87 percent of personal health spending. This is the money paid to physicians, along with the dollars expended on hospital care, prescription drugs, long-term care, and other services that require a physician's order.

15. Meaningful delivery reform will not be achieved in the face of doctors' opposition. But if enough doctors support a reform, its prospects for political enactment and successful implementation are substantial.

16. Extracting and recycling waste to cover all Americans requires doctors' enthusiastic participation which, in turn, can be elicited only through bold actions. A dramatic package deal needs to be offered to doctors, patients, and payers—one that will attract the attention of all parties and both liberate and oblige them to adopt solutions that work for all parties and impel all participants to help make it work.

17. Doctors will be able to spend money better after the undesirable financial and legal pressures that now distort doctors' clinical decisions are removed. They will be willing to spend money better if doing so makes them better off professionally and financially.

18. Doctors, like most people, are naturally conservative, and will be more strongly motivated to do what is right for their patients if they, the doctors, themselves benefit along with patients.

19. Crafting this deal will not be easy. Many changes must be made, and these must be coordinated. But the changes are all designed to enable local pilot programs to be launched. While the changes would enable some doctors and patients to try new things, they do not force change on unwilling doctors or patients.

20. The proposal will require testing and tinkering. Those who dislike this idea should develop alternatives. Because business as usual in financing and delivering health care in the United State of America is assuredly doomed.

B. WHAT AND HOW?

We urge designing and negotiating separate peace treaties with doctors, hospitals, and drug makers. The arrangements with doctors are the focus of this afternoon's talk. A peace treaty with physicians can be the foundation for solving many health care cost and coverage problems in the U.S.A.

Cutting waste is essential to financing durably affordable health coverage for all Americans.

And waste can't be cut without reforming the actual delivery of care and payment of caregivers.

These reforms can't be undertaken without the enthusiastic participation of a number of doctors. One reason is that only they can find and excise the waste.

Before sketching some of the specific mechanisms of one set of coordinated reforms in the delivery of health care, we would like to list the main things we would like to do and how we suggest doing them.

The approach described here is intended to achieve clinical, political, financial, legal, and emotional breakthroughs in health care financing and delivery. The peace treaty with physicians would have clinical, financial, legal (malpractice), political, and ethical elements.

It would marry cost controls with and coverage improvements and protections. It would aim to combat both excesses of care and deprivations of care.[5] It would learn from the frustrations associated with past efforts to introduce managed care. It features coordinated incrementalism—it squeezes out fat and recycles it as clinical bone and muscle

To achieve this breakthrough, it's essential to include everything required to liberate, encourage, and oblige doctors to spend finite dollars very carefully for defined groups of people. And also to remove all obstacles that block this liberation.

It seeks to construct self-regulating networks of physicians who are liberated, motivated, and obligated to spend inevitably scarce health care dollars to do as much clinical good as possible.

It seeks to align doctors' and patients' interests as closely as possible.

Reforms would be centered on physicians and how they practice. Doctors' own incomes—especially those of primary care physicians—would be boosted very substantially. (This would make primary care much more attractive to new

physicians, thereby addressing the shortage of primary care doctors—one of the main threats to real access to care for many Americans.) At the same time, today's finance-related paperwork would be largely eliminated.

Mistrust-related paperwork would be eliminated because doctors would be paid in ways that inspire trust. Doctors would be liberated and pressed to deliver care professionally, in light of standards that rest on clinical evidence, and within budgets.

One reason for trust is that all money saved by squeezing out waste would be recycled to insure more people or provide more care to people who are already insured. Fat is converted into bone and muscle.

Professionalism means that doctors are liberated to steer by a clinical compass, not a compass pulled of-course by financial incentives to do more or less than patients really need, or by legal fears that press doctors to do more than patients really need.

The methods of paying doctors that today reward excessive care would be eliminated. Similarly, the legal pressures and fear of malpractice litigation that today engender defensive medicine would be eliminated.

This entails much more than tinkering with methods of paying doctors—much more than moving from fee-for-service payments to more combined units of payment—such as an episode of illness. It entails changing the ways in which doctors decide how to diagnose and treat patients. It entails both details and how they fit together. And it entails the contexts within which decisions are made—such as the role of evidence and what happens to money that is saved by denying unnecessary care.

The reforms described here are furthered by higher incomes for doctors who practice professionally, honorably, affordably, and in patients' best interests. No doctor is exposed to the corrosive corruption and alienation that inevitably follow from making clinical decisions to make money rather than to cure.

These are five of the main elements of the proposed delivery reforms.

- Small groups of primary care physicians would deliver and coordinate care for patients who enrolled voluntarily with them.

    - ✓ We believe that small groups are vital to preserve doctors' independence, sense of control, and comfort with taking on the responsibility of spending money carefully. If groups are larger, doctors will be managed. And we believe that most doctors won't undertake the vital and difficult jobs of

spending money more carefully if they are forced through by management.

- ✓ At the same time, we acknowledge that smaller groups of physicians would need technical assistance and support in managing budgets and coping with risk. Shortly, we describe such supports. Also, we note that the numbers of patients to be covered by these small-seeming groups is actually fairly substantial.

- The groups would receive risk-adjusted capitated payments.

- Doctors would have no financial incentives to under-serve or over-serve.

- Revenue would be divided between two watertight compartments. Physicians would be paid from only one of these, and in financially neutral ways that liberated them to think clinically. They would marshal the dollars in the second budget to pay for other services and do as much good as possible.

- Enrolled patients would waive their right to sue their physicians in exchange for superior protections, and consequently, doctors would cease practicing defensive medicine.

We believe that these and other design features would markedly reduce clinical and administrative waste from the levels prevailing in health care today.

Further, theft would be reduced. One reason is that dollars are visible and finite, and defined groups of patients must be served with those dollars, so that any theft visibly harms patients. No open-ended third party payer absorbs the theft and simply increases premiums or taxes next year. Awareness of this should prompt whistle-blowing to increase.

The reforms outlined here address types of changes that would become vital system-wide even a law that promised to insure all Americans were adopted.

Since sweeping, nationwide reforms face great political obstacles, it's important to recognize that many of the elements of the reforms proposed here could be implemented and tested in pilot programs. The pilots would help inform and make the case for such efforts on a broader scale. We'll describe the model we suggest overall, but at various points will also note some of the issues involved in attempting such pilot efforts.

Twelve Design Elements

a. Enrollment. A cluster of primary care doctors who agree to serve a defined group of patients would be recruited. Suppose that 12-20 physicians agreed, with an average of 1,500 patients, making 18,000 to 30,000 potential patients. The new arrangement could be called a Health Security Care Team (HSCT).

The physicians would bring that share of their potential patients who agreed to the new arrangement. They would be considered enrolled patients. Other, unenrolled patients would be told that they would have to find new primary care physicians within one year.

The HSCTs would give considerable weight to primary care and prevention. For example,

- Each patient would have a primary care physician who could be reached conveniently by telephone or by e-mail.
- Patient out-of-pocket payments would be eliminated whenever possible and kept to nominal levels for most other services.
- Each HSCT would engage in advanced practice, providing same-day appointments with primary care physicians.[6]
- Primary care visits would probably be somewhat longer, on average, than those now prevailing in most regions.
- But primary care physicians' incomes would be substantially higher than those now prevailing.

Before enrolling, potential patients would be asked to signal that they were aware of the methods by which their doctors would be paid, methods for quality assurance, and methods of compensating for harm incurred in the course of medical care.

Transitional financing would protect the incomes of primary care physicians during the early years, when they might see a temporary drop in the size of their patient panels, until new patients signed up with them.

Individuals would enroll. One member of a family might choose to enroll but the others could retain their existing coverage. This makes it unnecessary for the HSCTs to grow very large by including all of the doctors currently used by a given family.

b. Capitation. Each HSCT, a non-profit corporation initially controlled by the cluster of primary care physicians, would receive risk-adjusted capitation payments for each enrolled patient. The capitation would cover the services provided by all physicians themselves, and also the services that physicians essentially control, services typically ordered by physicians. Services not

controlled by physicians—such as dental care or over-the-counter medications—would not be covered by the capitation payments.

c. Financing. Under federal and state law, Medicare, Medicaid, other public programs, and all private insurers would be required to make risk-adjusted capitation payments to the non-profit HSCT on behalf of those of their patients who chose to enroll. The money would follow the patient, as if it were a voucher. The single method of risk-adjustment would be set by national rules. Thus, all payers would pay the same risk-adjusted price for each patient.

Uninsured patients could also enroll. There would be three two sources of financing for uninsured patients. One would be federal or state payments on behalf of newly insured patients. The second would be a share of the savings won by reducing clinical and administrative waste. The third would be federal matching funds equal to at least two dollars for each dollar of savings earmarked for boosting insurance coverage. Together, the recycled savings and the federal match would make the same risk-adjusted payment per patient to the corporation as did other payers.

It is important to assure payment from all payers. Without this, primary care physicians would find it very hard to bring with them into the new arrangement all of their patients who wished to follow their doctors

We are also considering ways of getting started that do not require the federal actions described here.

d. Specialist physicians. The cluster of primary care physicians would identify the specialist physicians with whom they would like to work. Preferably, these specialists could become full-time full members of the physician group—and would then share control of the HSCT. Alternatively, they could work part-time under contract. Primary care physicians would add specialists incrementally in proportion to patient need.

e. Hospitals. The HSCT would admit patients to the hospitals at which its physicians had admitting privileges. The corporation would pay hospitals by Medicare DRGs. It needs to be resolved whether DME and IME add-ons would be included. In time, all hospitals might be given flexible budgets, and all payers—including the corporation—would pay hospitals accordingly. Each HSCT would pay drug makers, nursing homes, and other caregivers at standardized rates—thereby avoiding the burden of negotiating rates individually.

f. Two budgets, each in its own watertight compartment. The capitation payments are divided between two budgets.

- One is used exclusively to pay physicians, both primary care physicians and specialist physicians who are full-time and therefore full members of the group. (This does mean that the allocation of dollars between the first and second budget would need to change over time and would probably differ among HSCTs)

- The second is used exclusively to pay for the hospital care, medications, long-term care, durable medical equipment, and other services that require a doctor's order or approval. Payments to non-group specialist physicians would also be made from the second budget.

g. Methods of paying doctors. Physicians would know how much money was in the first budget, and the methods by which they were paid from that budget. We expect that most participating physicians would choose to be paid by salary, with moderate bonuses for competence, experience, kindness, and productivity.

The primary care physicians and full member specialists would decide the method of compensating physicians. Lists of approved and prohibited methods of compensation would be created and adhered to. Again, financial incentives to give more care or less care would be banned. All of the money in the physician budget must be used to pay full time physicians. None of the money in the second budget may be used to pay full time physicians.

(A persisting question is whether the first budget would cover doctors' gross incomes, including practice costs, or their net incomes. In other words, would doctors continue to practice in their own offices, employ their own administrative staff/managers, nurses, techs, clerks, and other workers? In this event, doctors would need to be paid for all of their office costs. Or, alternatively, would the group provide all of these services to each physician, who would function solely as a clinician, and not as a business owner, supervisor, or manager of a practice? We lean toward the second method, where physicians today are in private practice, but transition to this method would probably take time.)

h. Doctors manage budgets without financial risk. Doctors get (from Budget 1) or spend (from Budget 2) all of the money available, and no more than the money available. They would face no financial incentives or temptations to spend more or less than the sums budgeted. The primary care physicians and full-time specialists would not be at risk financially for either budget. The money in the first budget is used only and entirely to pay them.

Similarly, no physicians would be at risk financially for the second budget. It is expected that this entire budget would be spent each year, with no over-run. On one hand, there is no shortage of illnesses to diagnose or treat. And if some of the money is not spent, it is not divided up among the full-time physicians. Rather, it remains in the second budget and is carried over to the next year. On the other hand, it is not possible to spend money that is not in the budget.

i. Doctors' obligations. Using the money available in the two budgets, physicians would be obliged to provide the most appropriate and effective care to all enrolled patients. Together, doctors could allot the available dollars as they saw fit, but no one doctor could have a blank check.

When dollars are finite, care can't be infinite, so doctors would need to weigh choices and make trade-offs. Joseph White calls this "professionalism within a budget." [7] Within their two budgets, doctors would be liberated to decide the ways to do as much clinical good as possible.

j. Clinical standards. To assure adherence to best practices, reasonable consistency of care, and avoidance of inappropriate care, doctors would weigh the available evidence and set standards of care. They would probably adopt a number of clinical protocols. National support centers might generate model standards, but each group could choose to modify those standards.

k. Quality assurance. Today's malpractice litigation resembles a drunk person at a party who tries to sit between two chairs and falls on the floor. Malpractice litigation does a terrible job of identifying, re-educating, and—if necessary—weeding out dangerous doctors. It does a terrible job of compensating victims of medical harm. And fear of lawsuits spurs defensive medicine, generating vast clinical waste—and insidious harm as unneeded services siphon off funds needed for people now underserved.

So we need a different approach. First, as a condition of enrollment, patients will be asked to sign a waiver of their right to sue a member physician for malpractice. Along with paying doctors in financially neutral ways, this step is vital to freeing doctors from the pressures that now prompt unnecessary care.

Several steps will be taken to assure quality and appropriateness of care.

- Only knowledgeable and skilled physicians who are respected by their colleagues will be invited to join.
- Just as patients will be asked to waive their right to sue for malpractice as a condition of enrollment, doctors will be asked to agree to practice in accord with best evidence and standards, to identify their own errors of judgment or

practice, and to allow careful peer monitoring of their methods of diagnosing and treating patients.
- Physicians will reserve time for daily discussion of possible quality/appropriateness problems.

l. Compensating for harm incurred in the course of medical care. Today, patients sue doctors to recover damages for three things: costs of medical care, lost earnings, and pain and suffering.

- In the new arrangement described here, all of members' medical costs will be covered. The group will purchase insurance to cover costs of care for members who leave the group.
- Lost earnings would be covered by a parallel insurance policy, purchased by the group, along with Social Security Disability Income and Supplementary Security Income protections.
- Fair compensation for pain and suffering is clearly more difficult to determine.

The capitated group will contract with an independent group that has developed fair, impartial, and professional procedures to evaluate and pay claims for each of the three types of damages. Here again, systematic support would be provided. Several such independent groups might be financed to develop these procedures and to perform these functions for HSCTs and their patients.

C. WHAT'S DIFFERENT ABOUT THIS APPROACH?

1. What are the main differences between this approach and business as usual or traditional managed care?

All Health Security Care Teams are non-profit.

There are no financial incentives to overserve or underserve. No one makes more money when patients get more care or less care.

Doctors act as professionals, and as fiduciaries for patients, not as businesspeople.

Doctors are not at financial risk, but they can't spend more than they have in the two budgets.

All savings are plowed back into better patient care.

Most administrative waste is eliminated since both complexity and mistrust are markedly reduced. Complexity stems from needs to determine if a patient is insured, what services are covered and at what payment rates, what referrals or other administrative approvals might be required, which medications are covered, and the like. Mistrust stems from various methods of payment that give physicians (and, comparably, hospitals) financial incentives to provide more care, less care, or care of certain types. Insurers and other payers often question or disallow some bills submitted by doctors. Doctors then seek ways to secure payments. This bland description does not begin to capture the skill, energy, and emotion in submitting or paying bills.

A great deal of clinical waste is eliminated since financial incentives to do more and defensive medicine pressures to do more are both eliminated.

a. Doctors, not patients. This approach differs from the consumer-directed skin-in-the-game fantasies of free market mystics.[8] Doctors—people with actual degrees in medicine—are responsible for making the decisions about how to diagnose and treat, not patients or "consumers." Patients are not incited to doubt and mistrust their physicians.

b. Not competition among HMOs. This approach differs from past and current he models of competing managed care organizations, even the most benign and best-designed of those models (such as Alain Enthoven's).

- All HSCTs are non-profit and physicians are financially neutral.

- These and other approaches mean that no one—investor, owner, manager, or physician—will be able to pursue profits by withholding health care.
- And the HSCTs would not compete by price. Instead, they would sign up members. Members would choose whether to follow their primary care physicians into the new arrangements. HSCTs with reputations for quality might attract more patients.
- The HSCTs would be fairly small. They would combine financing and delivery.
- If some HSCTs with reputations for quality were to grow to sizes that made it hard for physicians to know and trust one another personally, thereby impeding smooth decision-making, the HSCTs might divide.

c. Avoid broad networks. All members will enroll as individuals, not as families. This makes it possible for each person—each member of a family—to identify a HSCT that includes as many of their own current physicians as possible. This should markedly reduce the pressure on HSCTs to enlarge their panels to include most or all of the physicians in a community.

2. No seriously, isn't this proposal just Managed Care: The Sequel—The Rebirth of the Undead?

Weren't you paying attention from the 1970s through the 1990s, when prepaid group practices, health maintenance organizations, and managed care were over-sold, over-marketed, discredited, and ultimately despised? Doctors and patients hated the financial incentives to give less care, and the private regulatory micro-management by the HMOs.

Many patients feared denial of needed care at the behest of greedy stockholders. Many came to worry that HMOs and doctors made more money when patients got less care. And doctors weren't in charge. They were regulated by managers; they did not regulate themselves.

In the HSCT plan described here, there are no opportunities to make money by giving less care. Doctors are financially neutral. The only reason one patient gets less is so another patient can get more.

And these clusters of caregivers are all non-profit. No one earns a profit when patients get less care. So they are much less likely to be sued successfully for denial of marginal care that turned out to be possibly useful or even vital.

And these organizations don't compete by price. They all charge the same risk-adjusted price, and they must all offer the same services.

3. Why would doctors agree voluntarily—even enthusiastically—to sign on to this arrangement?

What's in the HSCT for doctors?

First, they get higher incomes. In effect, doctors—especially primary care doctors—would receive as added income a share of the administrative waste that formerly plagued them. That share would be included in each HSCT's budget for paying physicians.

It is noteworthy that, from 1970 to 2000, gross revenue for all physicians in private practice, adjusted for inflation as measured by the consumer price index, rose by 62 percent. But doctors' net incomes rose by only 23 percent. That's because doctors' practice expenses rose by 129 percent. As a result, doctors' net incomes as a share of gross incomes fell from 63 percent in 1970 to 48 percent in 2000. (Malpractice premiums grew even faster, but constituted only 7.5 percent of expenses in 2000.)[9]

Today, physicians' fees are being squeezed. Growing numbers of doctors seek to protect their incomes by acquiring profitable equipment or facilities (and winning legal and profitable opportunities for self-referral).[10] Doctors have opportunities to make money that don't do as much as might be desired to deliver needed and affordable care to all patients.

Second, it seems that most physicians have fairly strong autonomy needs and don't like to be managed.[11] Therefore, In this approach, physicians win power, control, and responsibility—no one manages doctors; instead, they manage themselves.

Spending money carefully is a new professional challenge, one for which few physicians have been trained. But they can obtain support in the forms of a) evidence on comparative costs and efficacy of various treatments, compiled into clinical guidelines, and b) help in managing their finite budgets over time and across patients.

Third, physicians win better working conditions. Primary care physicians are freed from today's pointless burden of fighting over billing and payment, eligibility verification, and the like.

Primary care physicians also enjoy longer visits with patients. They have more time to spend with patients and might have fewer patients on their panels. (Higher incomes and improved professional lives will attract more physicians to primary care—perhaps enough to offset the greater number of insured patients.)

They are liberated to act professionally and honorably in their patients' interests. They do not fear being sued for malpractice.

4. Can doctors do these things on their own?

Technical, managerial, and financial support—

Start-up funds until reach break-even membership numbers
Technical assistance with budgeting
Technical assistance with clinical standards
Technical assistance with governance, decision-making, equity monitoring, and inter-physician relationships.

5. How to assure equity of care—fair treatment of patients and absence of discrimination?

Monitoring the equity of clinical standards and the equity of actual clinical decisions is an important support function. It is useful to promote both vertical and horizontal equity.

Vertical equity would require that more care is given to patients who are more severely ill and to patients whose problems are most amenable to treatment, other things equal.

Horizontal equity would require that patients with similar problems are treated similarly, regardless of income, race, occupation, or similar factors.

6. What are the main threats the financial stability of the HSCTs?

Each HSCT would be responsible for delivering or paying for needed health services. It would function as an insurer, though with certain reinsurance protections in place of reserves. It would finance emergency out-of-area coverage.

For several systematic reasons, the risk-adjusted capitation payments might prove inadequate.

- The risk-adjustment method might have been unreliable or invalid in important respects.

- The physicians simply failed to live within their budget owing to bad management, unrealistically costly clinical standards, or simple recklessness or inexperience.

If the risk-adjustment method were shown to generate inadequate revenue because it was unreliable or invalid, added payments should be provided.

The more serious question concerns physician unwillingness or inability to make clinical decisions that live under the budget. There are several possible reasons for this, and responses for each.

For example, suppose that—out of ignorance, unwillingness to accept budget limits, elimination of financial risk to doctors who over-spend Budget 2, or group adoption of clinical standards that were simply affordable, doctors spent in excess of available funds during the first two months of the fiscal year. They would be told to cut back. (Who would tell them to do so? This is clearly a matter for physician self-governance and budget monitoring, but who would confront whom? With what authority?) Better information could be provided. Clinical standards could be modified to match available dollars. If a physician failed to adhere to budgets that the physician group as a whole supported, that physician could be expelled from the HSCT.

We are optimistic that, by cutting clinical and administrative waste, the HSCT arrangement would provide financing that is generous by today's standards. If so, the problem of over-spending the budget should be markedly reduced.

The risk-adjusted capitation payments might prove inadequate for a number of random reasons also. These include epidemics, economic recessions (which undermine health), and unpredictably high numbers of very costly patients. HSCTs would purchase stop-loss insurance coverage on individual patients and comprehensive reinsurance as well. A state- or federally-financed or –chartered national reinsurance trust fund should be established to help cope with these.

7. Why would patients agree voluntarily to sign on to an arrangement that ended blank check medicine along with their right to sue for malpractice?

First, what's so great about the right to sue for malpractice? Today, only a very small share of patients who believe that they have been hurt in ways that may well result from malpractice actually sue their doctors.

Some patients will be attracted by the possibility of compensation without having to go to court to prove fault.

Some patients may prefer that their physicians provided needed care, not care spurred by anxiety to guard against being sued.

Some patients may recognize that ending financial and legal distortions will liberate their doctors to identify and provide the care that actually works—and that this would expose patients to fewer risky diagnostic and therapeutic procedures. Doctors would have sought to set clinical guidelines that allocated inevitably scarce dollars to do as much good as possible.

Still other patients might appreciate that ending malpractice is essential to reducing the costs of defensive medicine, which would help substantially in sustaining affordable care for all Americans.

Also, patients who signed on to the HSCTs would win more comprehensive coverage, improved access to their primary care physician, and lower out-of-pocket barriers to seeking needed care.

8. Who'd object to this approach?

Physicians and others who believe that a doctor's sole duty is to the patient he/she is caring for currently—with no social responsibility to use scarce dollars as carefully as possible—would object to this approach.

That's because this approach entails making trade-offs among patients. One patient might be denied potentially beneficial care in order to leave money in Budget 2 to finance care that would be of greater benefit to another patient. Doctors would design and implement the clinical standards that would essentially guide which patients received which services under which circumstances. It is likely that physicians would enjoy some flexibility in departing from the clinical guidelines, but that flexibility would not approach the that required to allow doctors to give as much care as they thought might be beneficial to each successive patient they treated.

There is considerable risk that some procedure-oriented specialist physicians would oppose the HSCT proposal, especially those working outside the HSCTs who are paid fees for seeing HSCT patients.

Some such physicians might fear loss of income owing to weeding out unnecessary care. They might be offered reassurance that the HSCTs' efforts to recycle administrative and clinical waste should liberate a net increase in dollars to finance payments to specialists. In particular, when all Americans are insured against the costs of health care, specialists would have more paying customers.

Today's insurance companies and some of today's HMOs and PPOs would probably oppose HSCTs because insurers' roles would fade away. Others, though, might find opportunities to recast themselves as providers of technical support services to the HSCTs.

9. Other risks

Would primary care physicians try to bring only selected patients into the new HSCTs? Would they try to cream their younger, healthier, middle-income, or more interesting patients—and avoid patients with chronic illness or patients who are less interesting or of lower incomes?

Physicians would have no reason to cream patients on financial grounds since their capitation payments would be risk-adjusted.

If a disproportionate number of primary care physicians were to enter HSCTs in a given region, it is possible that patients who remain outside the HSCTs would suffer a graver shortage of primary care physicians. That's because the HSCTs would feature fewer patients per FTE primary care physician and longer visits.

Would the quality protections be adequate? What if a cluster of not-very-good physicians tried to form their own HSCT, relatively free from observation by sounder colleagues? How would their patients be protected?

10. How to get started?

The approach described above rests on federal law authorizing Medicare, Medicaid, and private third-party payers to make capitated payments to the new HSCTs.

We think that such legislation is reasonable and could be passed by Congress and signed by the president within the next five years. It might be one of the provisions of broader legislation designed to enable states to experiment with different methods of expanding coverage while containing costs.

Alternatively, states, reformed HMOs, and others could pilot many of these approaches. One alternative would be to finance newly-trained primary care physicians to launch HSCT practices. They would not face the obstacle of persuading many or most of their patients to follow them to the new model of

care. But they would probably lack the clinical experience required to develop and follow clinical guidelines and weed out unnecessary care.

In passing

The treaties with hospitals and drug makers would pay each hospital and each drug maker by a flexible budget. These budgets allot revenues that vary from year to year in line with the real marginal costs of changes in volumes of care or patient case mix/severity of illness.

Flexible budgets make it impossible to become more profitable by manipulating volume or case mix. As such, they are generally more trustworthy than other methods of payment.

Each needed hospital would be assured revenue adequate to finance appropriate volumes of high-quality care as long as the institution is operated efficiently.

For drug makers, the flexible budgets would apply to existing products only and would protect return on revenue at something like the average return prevailing over the past five years. New products would be financed by contracts awarding drug makers prizes in exchange for patent rights.

Other constraints, obstacles, questions to answer

- Right doctors in right places—huge amount of work required
- No real role for traditional insurers—but they could perhaps be contracted to provide T.A. in budget management to doctors
- Need for technical support with budget management, weighing and adopting clinical guidelines
- Team building among doctors
- Budget management under doctors' control
- Governance—role of payers, patients in decision-making?
- Population mobility
- Risk-adjusting and fairness
- Border-crossing
- Protect against end-of-period shortfalls
- Large employer opposition to loss of control
- Pooling multiple funding stream
- If try in small scale, little information pooling for improving clinical decision-making, organization, delivery, financing
- Out-of-area care while vacationing and the like. As with localized HMOs today (including Medicare advantage HMOs and also FFS plans, what happens when a patient travels far from home in the U.S.?

NOTES

[1] Hoangmai H. Pham and Paul B. Ginsburg, "Unhealthy Trends: The Future of Physician Services," *Health Affairs*, Vol. 26, No. 6 (November/December 2007), pp. 1586-1598.

[2] For aspects of this, please see the valuable discussion in Jonathan Oberlander, "Learning from Failure in Health Care Reform," *New England Journal of Medicine*, Vol. 357, No. 17 (25 October 2007), pp. 1677-1679.

[3] Aaron Catlin, Cathy Cowan, Stephen Heffler, and others, "National Health Spending in 2005: The Slowdown Continues," *Health Affairs*, Vol. 26, No. 1 (January/February 2007), pp. 142-153; and Office of the Actuary, Centers for Medicare and Medicaid Services, *National Health Expenditure Projections, 2006-2016*, http://www.cms.hhs.gov/NationalHealthExpendData/downloads/proj2006.pdf.

[4] Peter R. Orzag and Philip Ellis, "The Challenge of Rising Health Costs—A View from the Congressional Budget Office," *New England Journal of Medicine*, Vol. 357, No. 18 (1 November 2007), pp. 1793-1795.

[5] Alain Enthoven and Richard Kronick, "A Consumer-choice Health Plan for the 1990s," *New England Journal of Medicine*, Vol. 320 (5 January 1989), pp. 29-37.

[6] Mark Murray and Donald M. Berwick, "Advanced Access: Reducing Waiting and Delays in Primary Care," *Journal of the American Medical Association*, Vol. 289, No. 8 (26 February 2003), pp. 1035-1040.

[7] Joseph White, "Markets, Budgets, and Health Care Cost Control," *Health Affairs*, Vol. 13, No. 3 (fall 1993), pp. 44-57.

[8] Patricia Neuman, Juliette Cubanski, Katherine A. Desmond, and Thomas H. Rice, "How Much 'Skin in the Game' Do Medicare Beneficiaries Have? The Increasing Financial Burden of Health Care Spending, 1997-2003," *Health Affairs*, Vol. 1692-1701.

[9] Authors' calculations from data compiled by Marc A. Rodwin, Hak J. Chang, and Jeffrey Clausen, "Malpractice Premiums and Physicians' Income: Perceptions of a Crisis Conflict with Empirical Evidence," *Health Affairs*, Vol. 25, No. 3 (May/June 2006), pp. 750-758.

[10] Hoangmai H. Pham and Paul B. Ginsburg, "Unhealthy Trends: The Future of Physician Services," *Health Affairs*, Vol. 26, No. 6 (November/December 2007), pp. 1586-1598.

[11] See, for example, Jeff C. Goldsmith, "Driving the Nitroglycerin Truck," *Healthcare Forum Journal*, March 1993; also, on professionals more broadly, see Charles Handy, "The New Equation," *Hospitals and Health Networks*, 5 August 1995, pp. 34-36.