Shaping Affordable Health Care for All Patients and Caregivers

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Structure

A. Foundations

B. Massachusetts Excursion—a real world

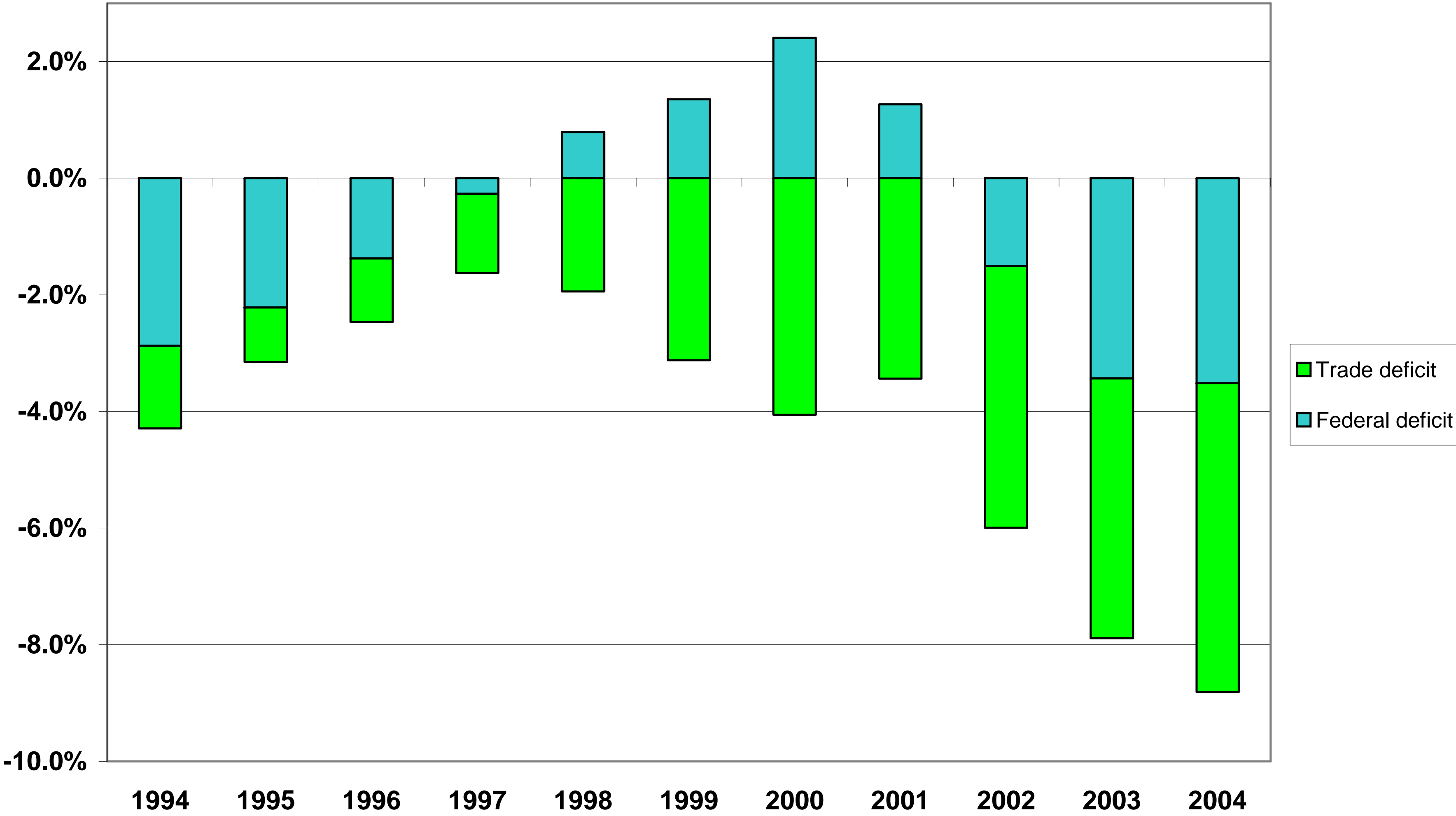
C. Problems, Causes, and Possible Solutions

D. How to Move Forward?

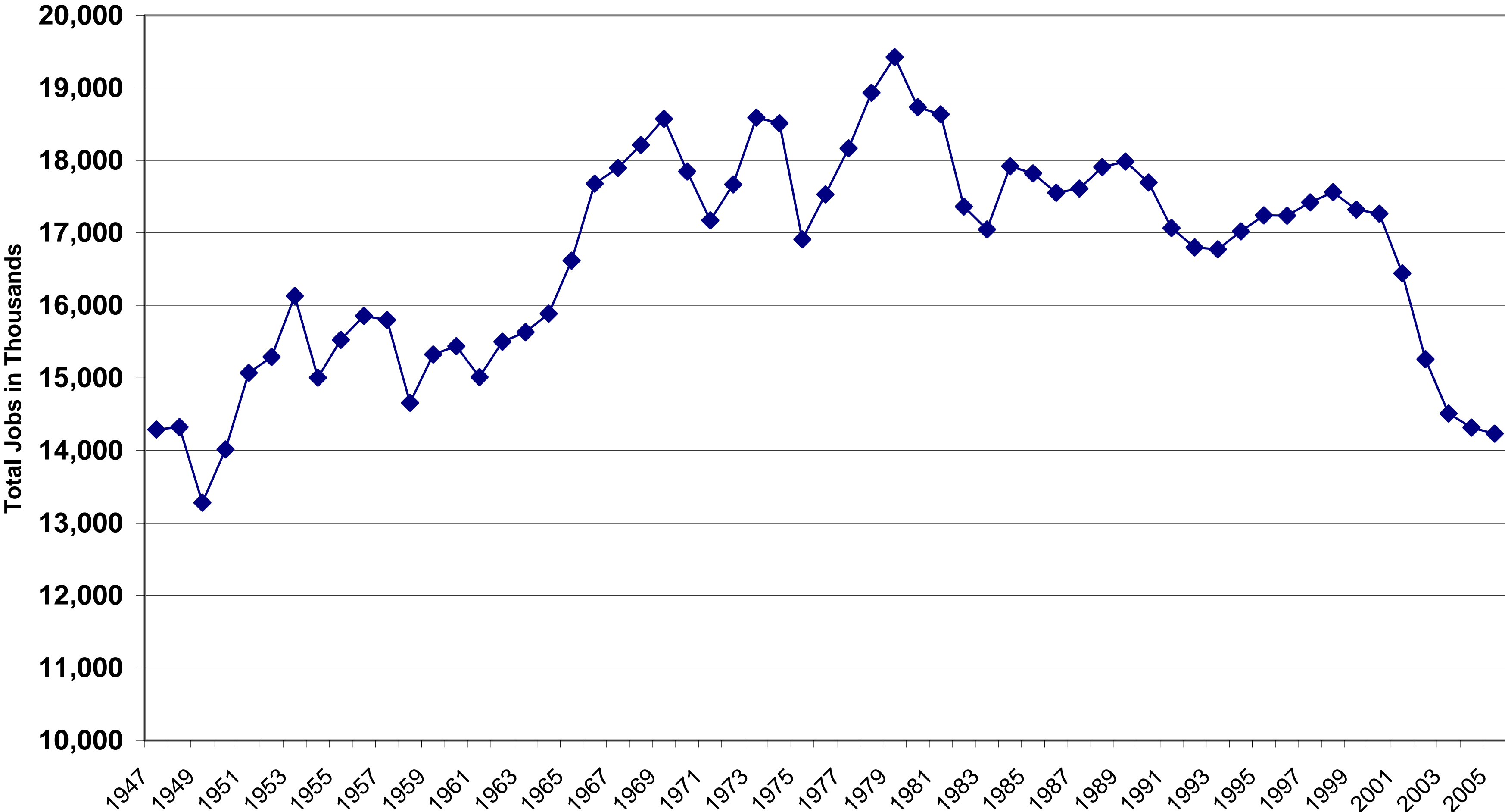
A. Foundations

- U.S. economy in grave trouble
- U.S. health care addicted to more money for business as usual (BAU)
  - starkly unsustainable
- Caregivers follow the money toward excessive care for shrinking numbers of well-insured patients
- Affordable high-quality care for all is essential to political and social stability
- It's achievable—easiest problem to fix
- No villains (accidents happen)

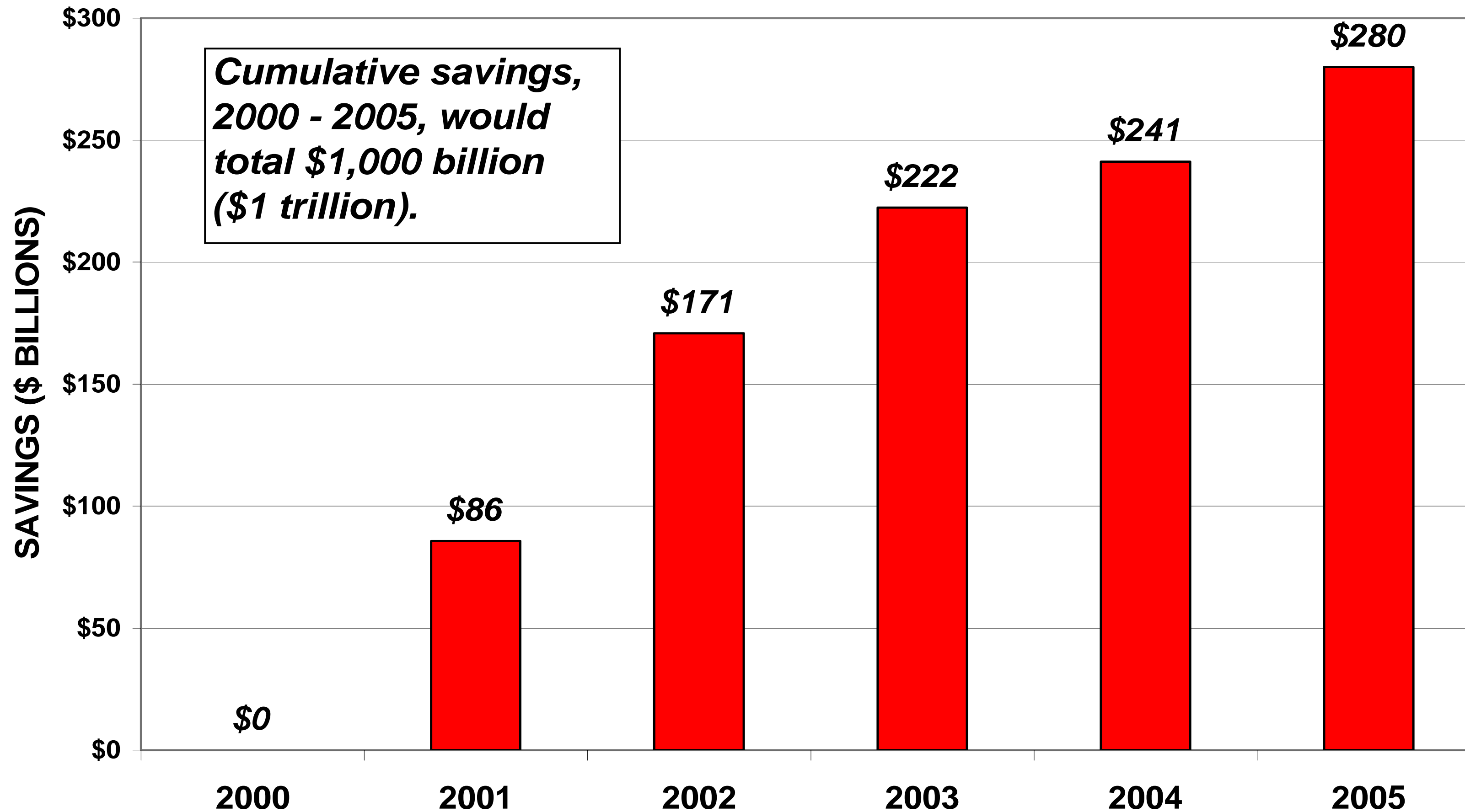
U.S. Federal Budget + Trade Deficits, 1994 - 2004



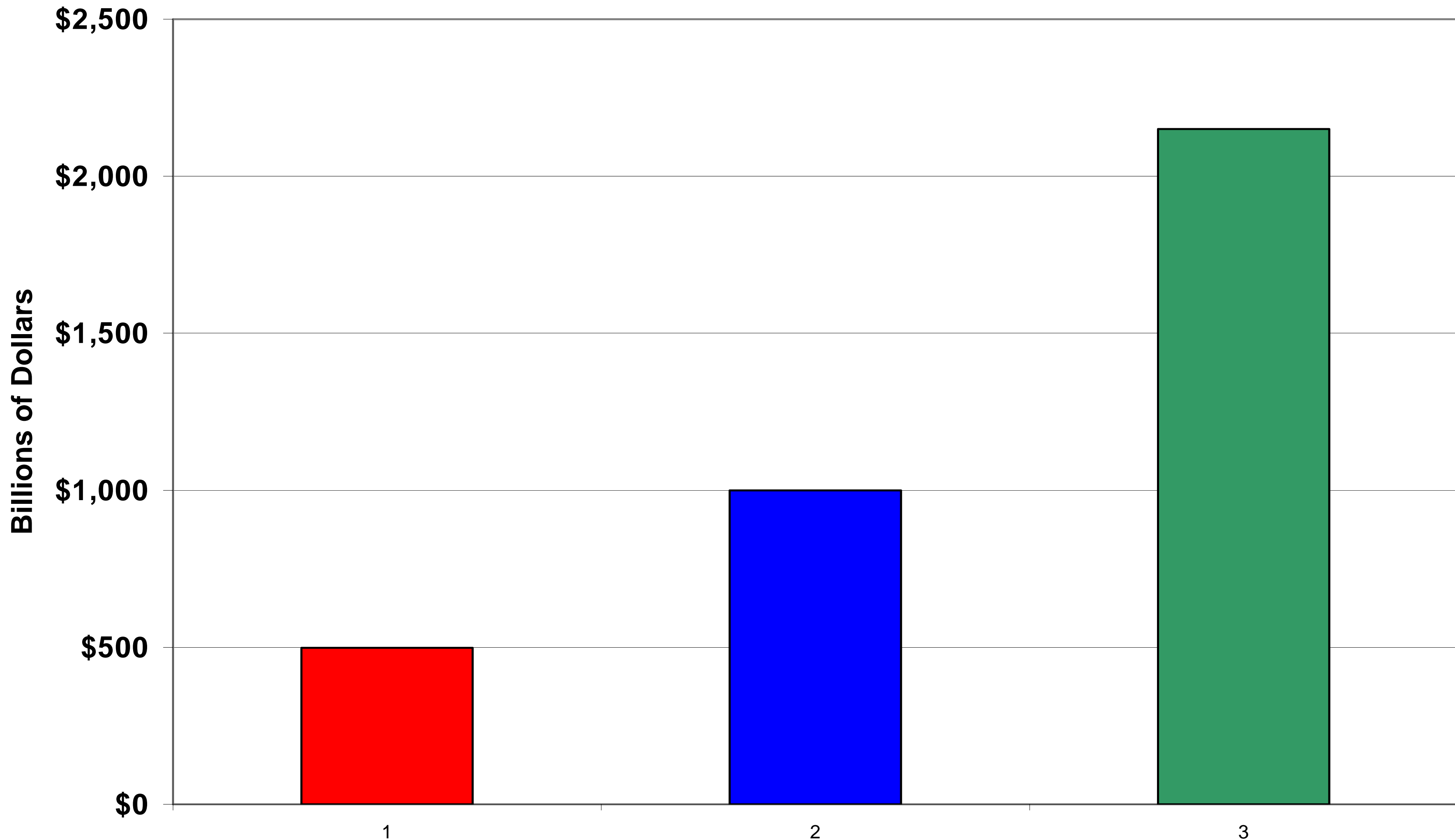
Manufacturing Employment, U.S., 1947-2002, Thousands of Jobs



U.S. HEALTH SAVINGS, 2000 - 2005, IN $ BILLIONS
HAD HEALTH BEEN HELD TO 2000'S 13.2% OF GDP



Health, Education, Defense, 2006



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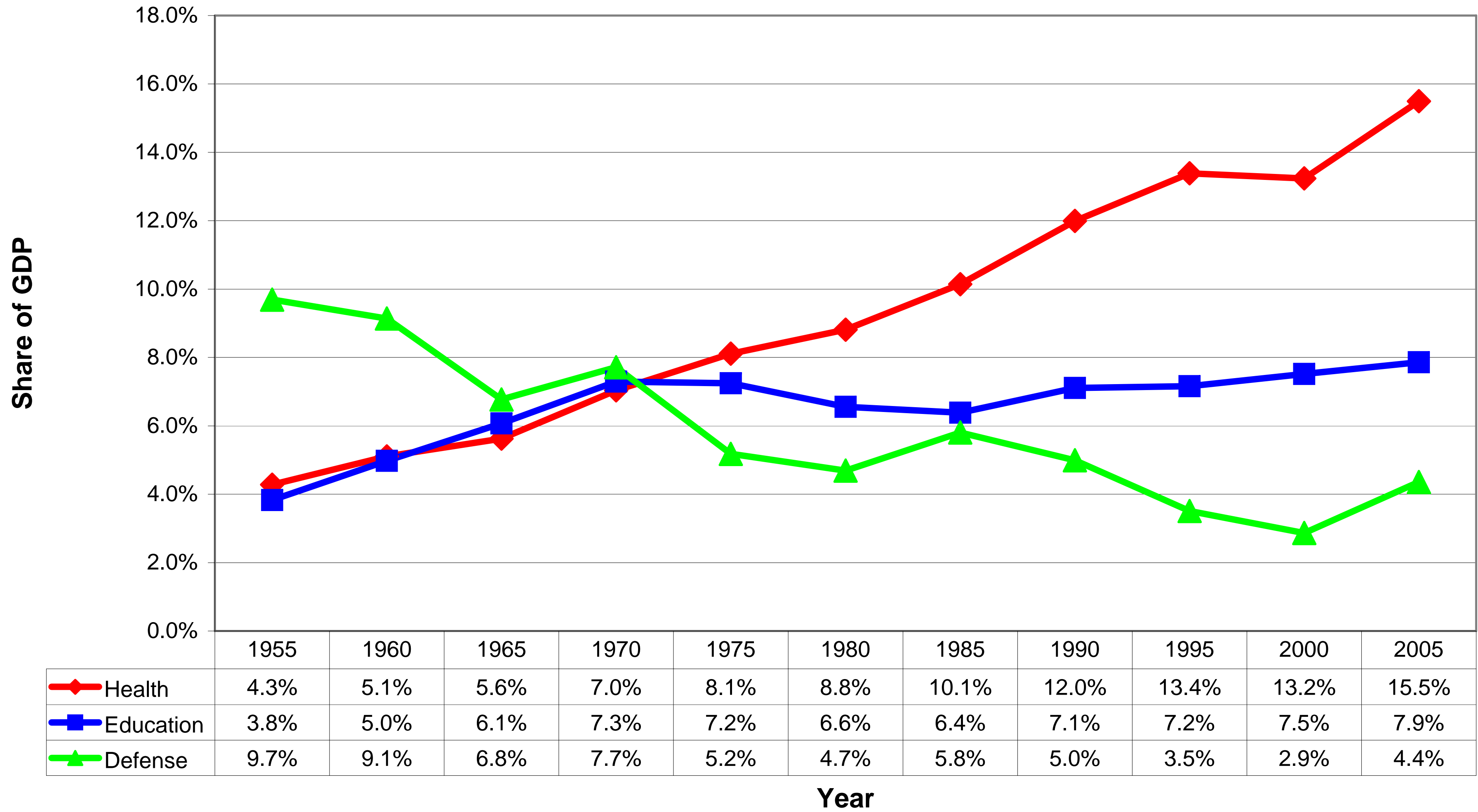
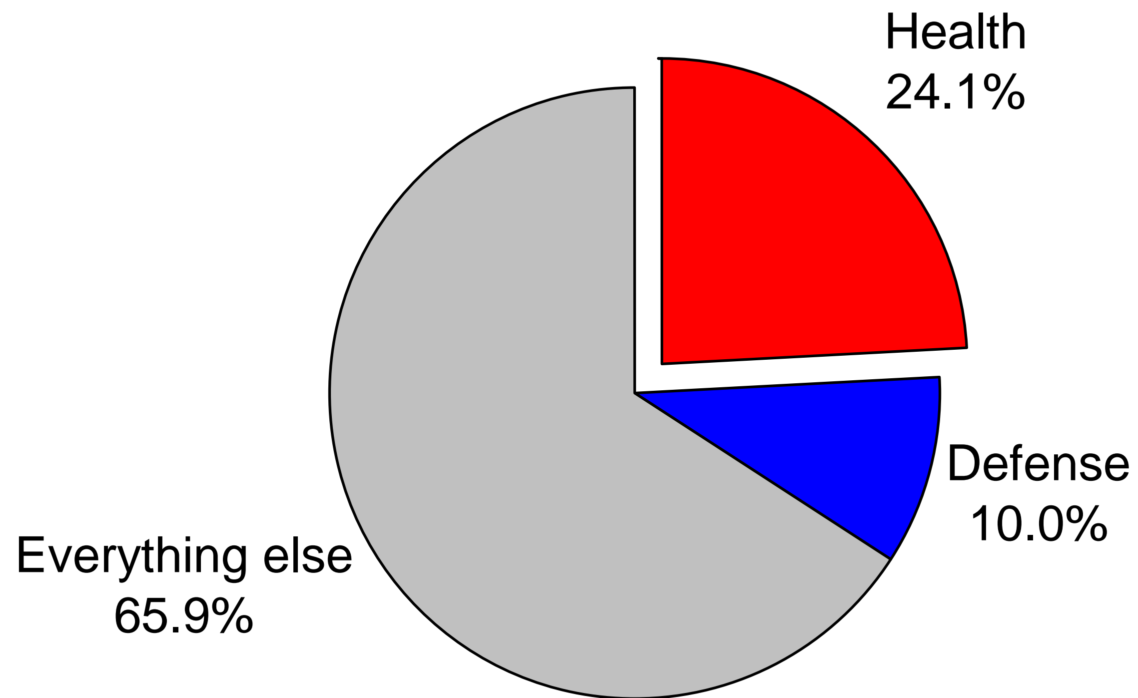
HEALTH, EDUCATION, AND DEFENSE SHARES OF U.S. GDP, 1955 - 2005

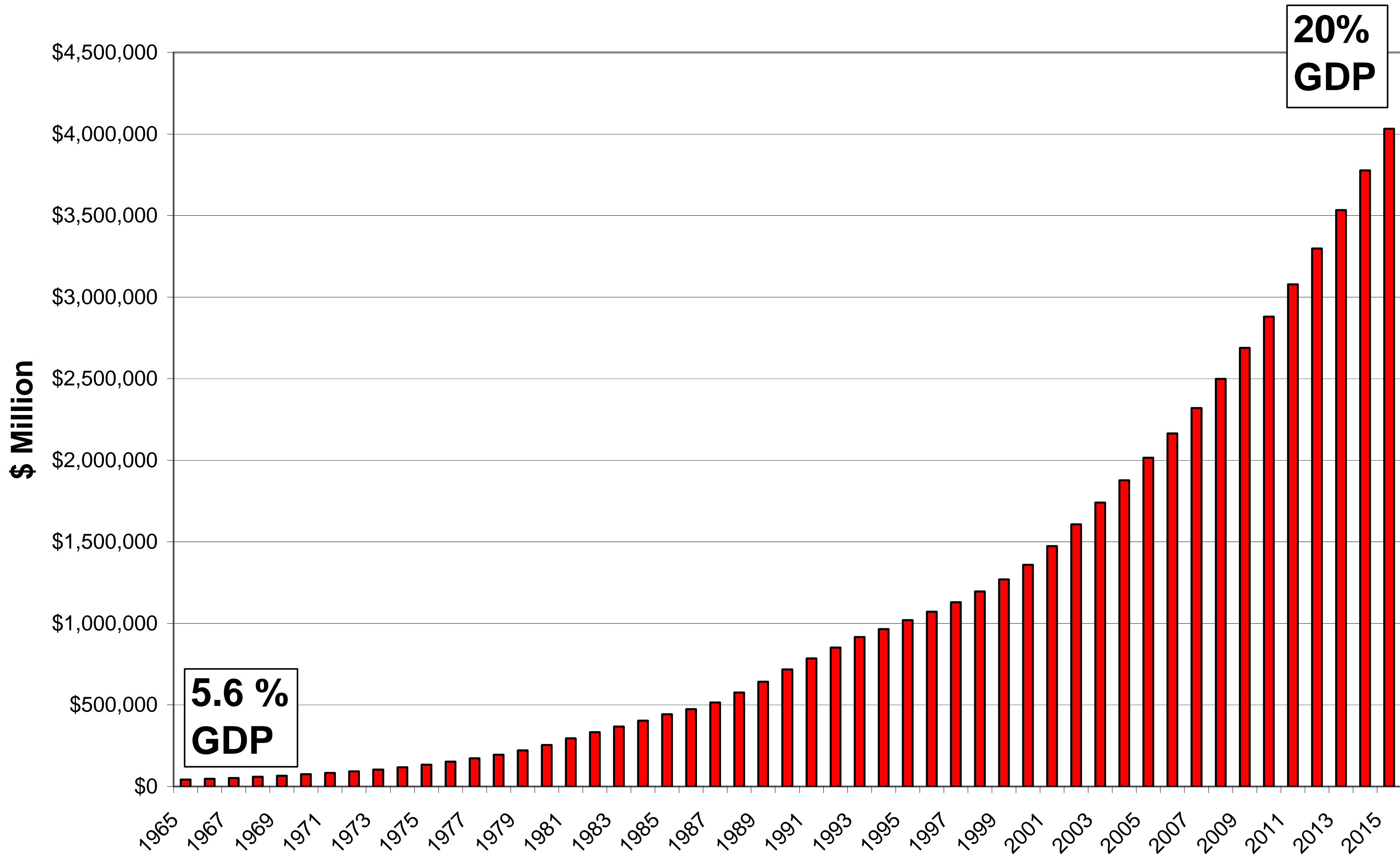


	1955	1960	1965	1970	1975	1980	1985	1990	1995	2000	2005
Health	4.3%	5.1%	5.6%	7.0%	8.1%	8.8%	10.1%	12.0%	13.4%	13.2%	15.5%
Education	3.8%	5.0%	6.1%	7.3%	7.2%	6.6%	6.4%	7.1%	7.2%	7.5%	7.9%
Defense	9.7%	9.1%	6.8%	7.7%	5.2%	4.7%	5.8%	5.0%	3.5%	2.9%	4.4%

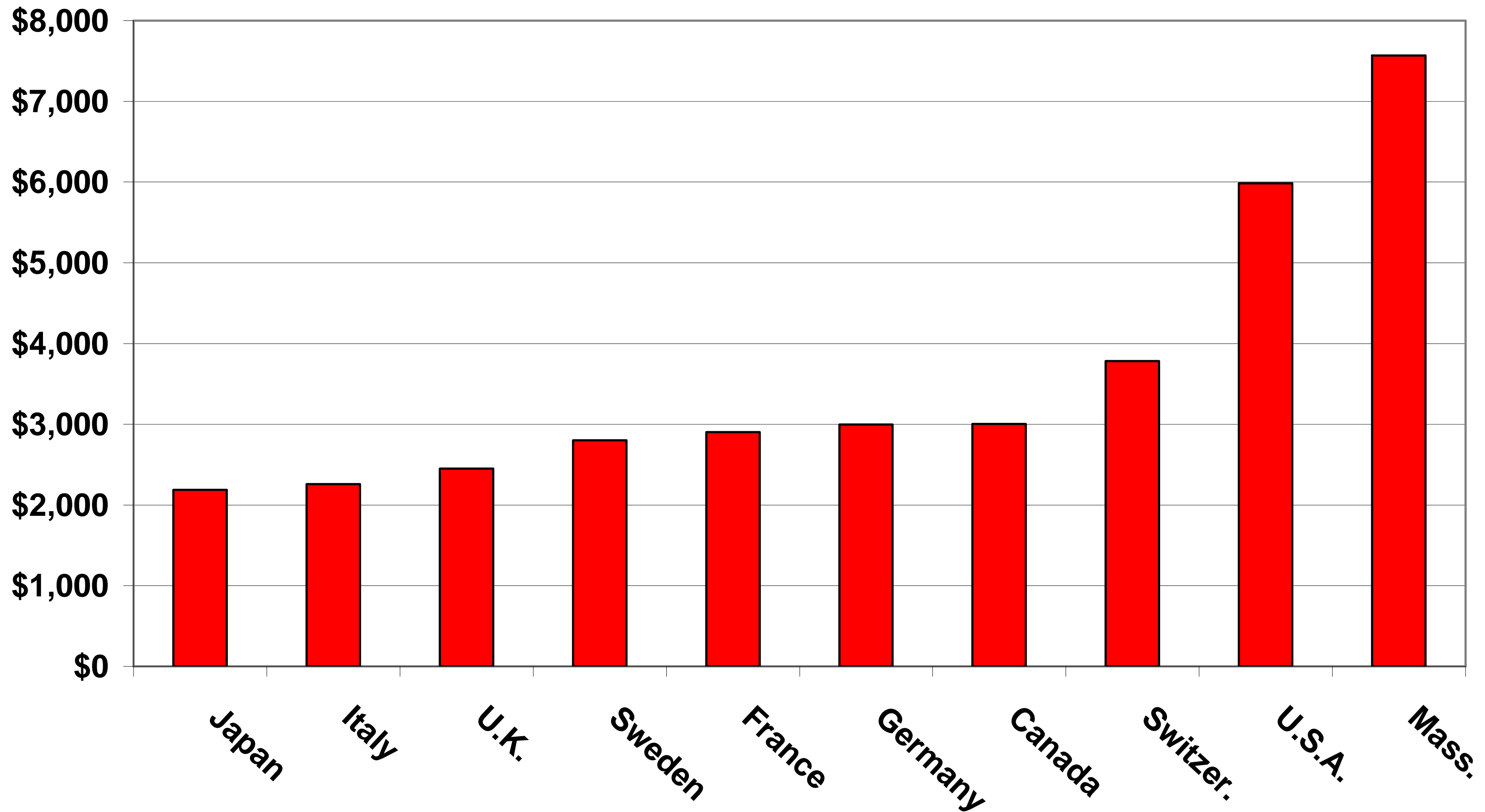
SHARES OF GDP GROWTH, 2000 - 2005



U.S. Health Spending, 1965 - 2015



Health Spending per Person, Selected Wealthy Nations, 2003



How Would We Cope IF—?

real revenue for health care fell 10-20% ?

- Impossible to cut cost that fast
- Bankruptcy? 1000 of 5000 hospitals close?
- Slash incomes – like California IPA MDs?
- Gut services for Medicaid, uninsured patients?

Insurance coverage

- Nationally,
  - 1 in 5 working-age adults lack health insurance
  - 1 in 4 Americans have no Rx insurance
  - About 1 in 2 have no dental insurance
  - Few have adequate mental health insurance
  - Under 15 percent have any long-term care insurance

Suggestion: Aim of Health Care Is 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 about bankruptcy
3. And without worry about losing insurance coverage ever, in good times and bad

Two Paths Forward

1. Affordable, sustainable high-quality care for all
   - More insured patients
   - Greater share of money for care
   - Care follows clinical need, evidence on what works
2. Less care for fewer people at greater cost
   - Care provision increasingly follows money, the increasingly uneven income distribution
   - Growing over-service to shrinking pool of well-insured patients,
   - More hospital closings
   - Both small and big threats to doctors' incomes

Medical Insecurity Threatens Our Economic, social, political stability

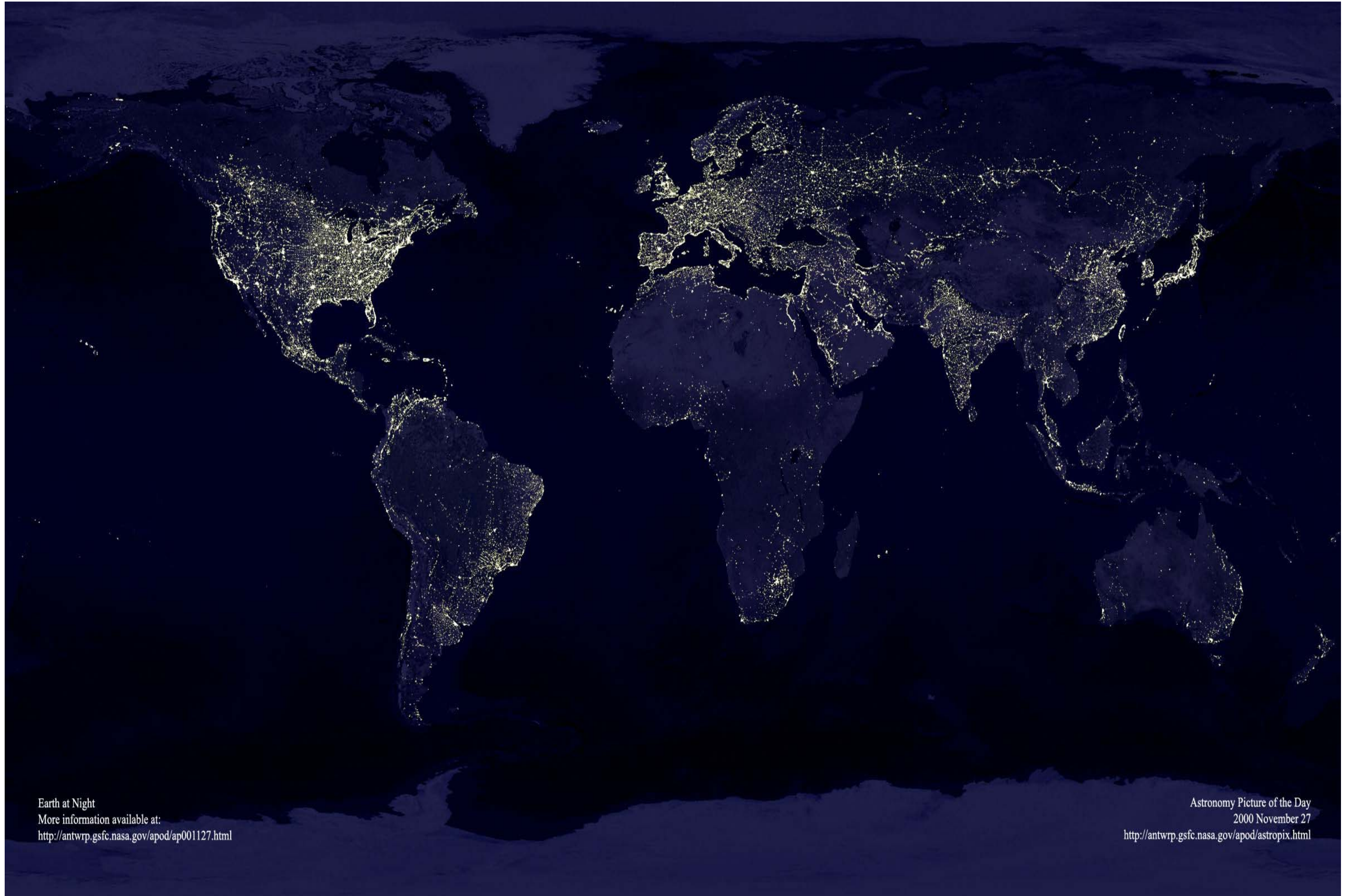
- Economic
  - High health costs help make U.S. goods uncompetitive, boost trade deficit
  - Health costs crush living standards of non-wealthy Americans, threaten bankruptcy
- Social
  - Affordable and high-quality health care for all should be a glue that helps to hold us together as a people
  - Nations with very unequal incomes still finance health care for all
  - 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

Health Spending and Jobs

- More money spent on health care means more health care jobs, other things equal
- But where does that money come from? It means less money for everything else
- Unless health care is exported to other regions (care given to patients from out-of-state, NIH $s). Not a big share.
- And care that attracts patients or research financing becomes too costly for people who depend on it routinely.

B. Massachusetts Excursion

Massachusetts in Perspective



Massachusetts Health Spending = ½ of Canada's (5x our population)

Massachusetts Health Spending = Holland's (2.5 x our population)

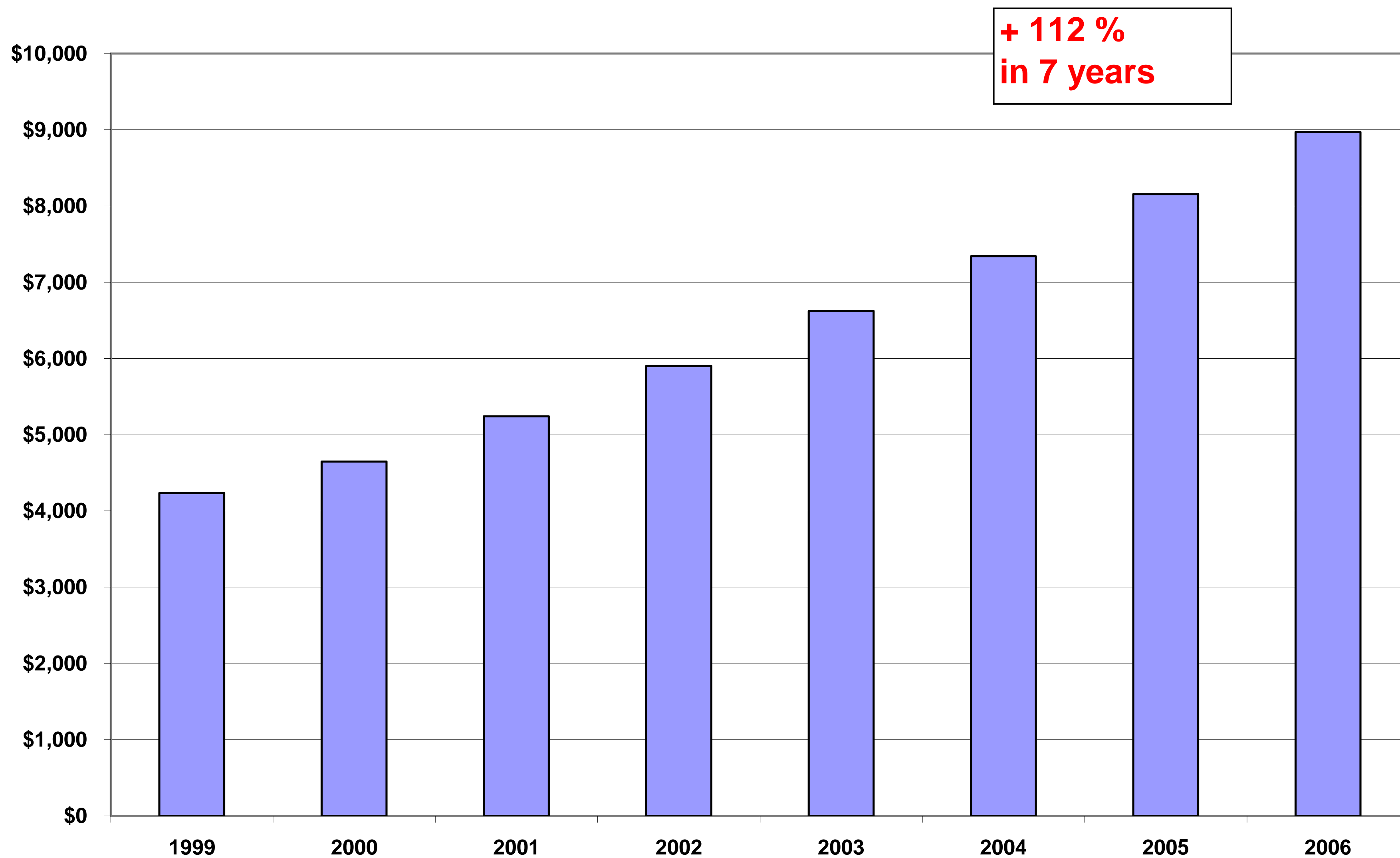
How much would health spending in Massachusetts drop this year if we spent at the

U.S. national average— $15 B (25%)

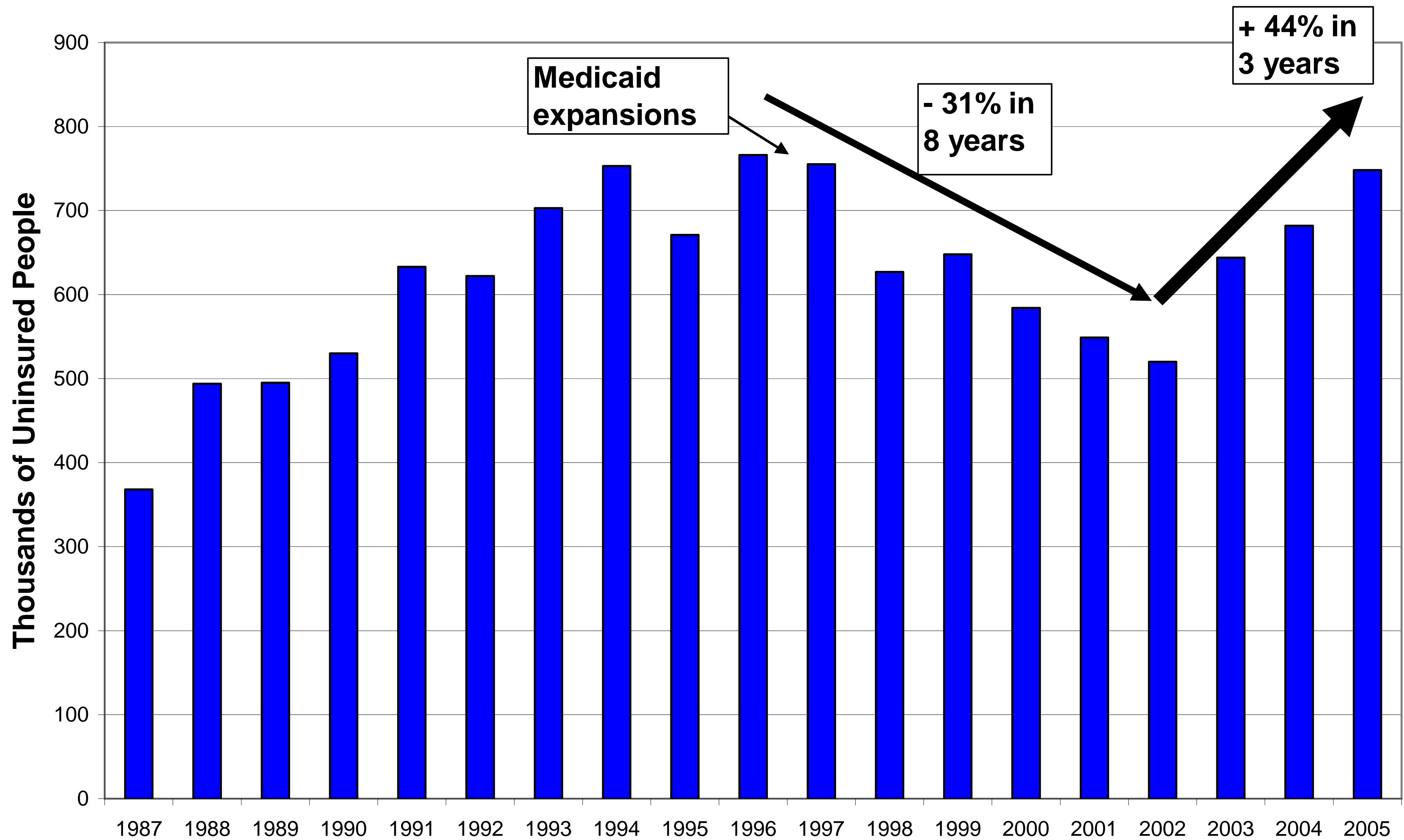
French-German average— $36 B (61%)

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

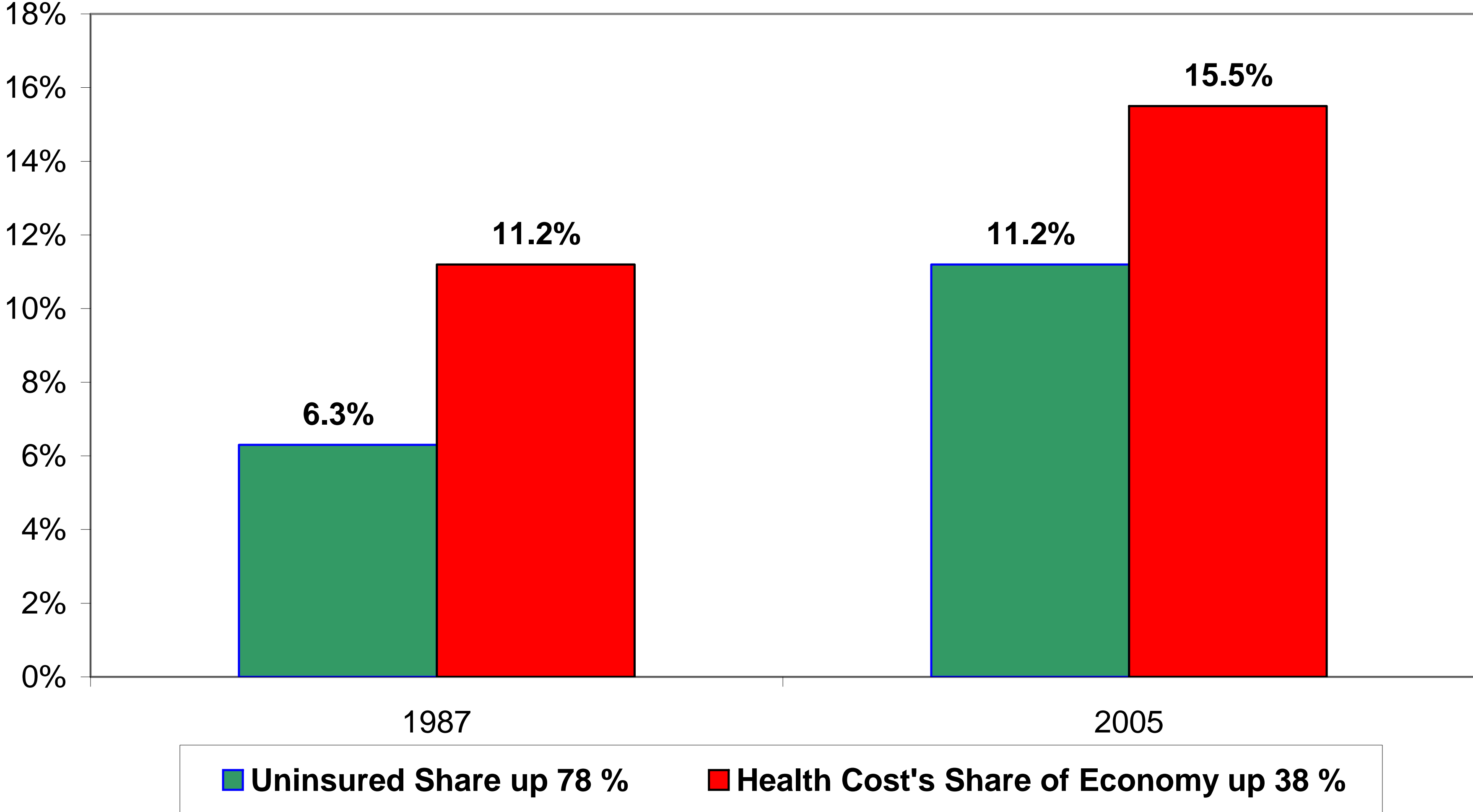
Boston-area Health Care Cost per Employee, 1999-2006

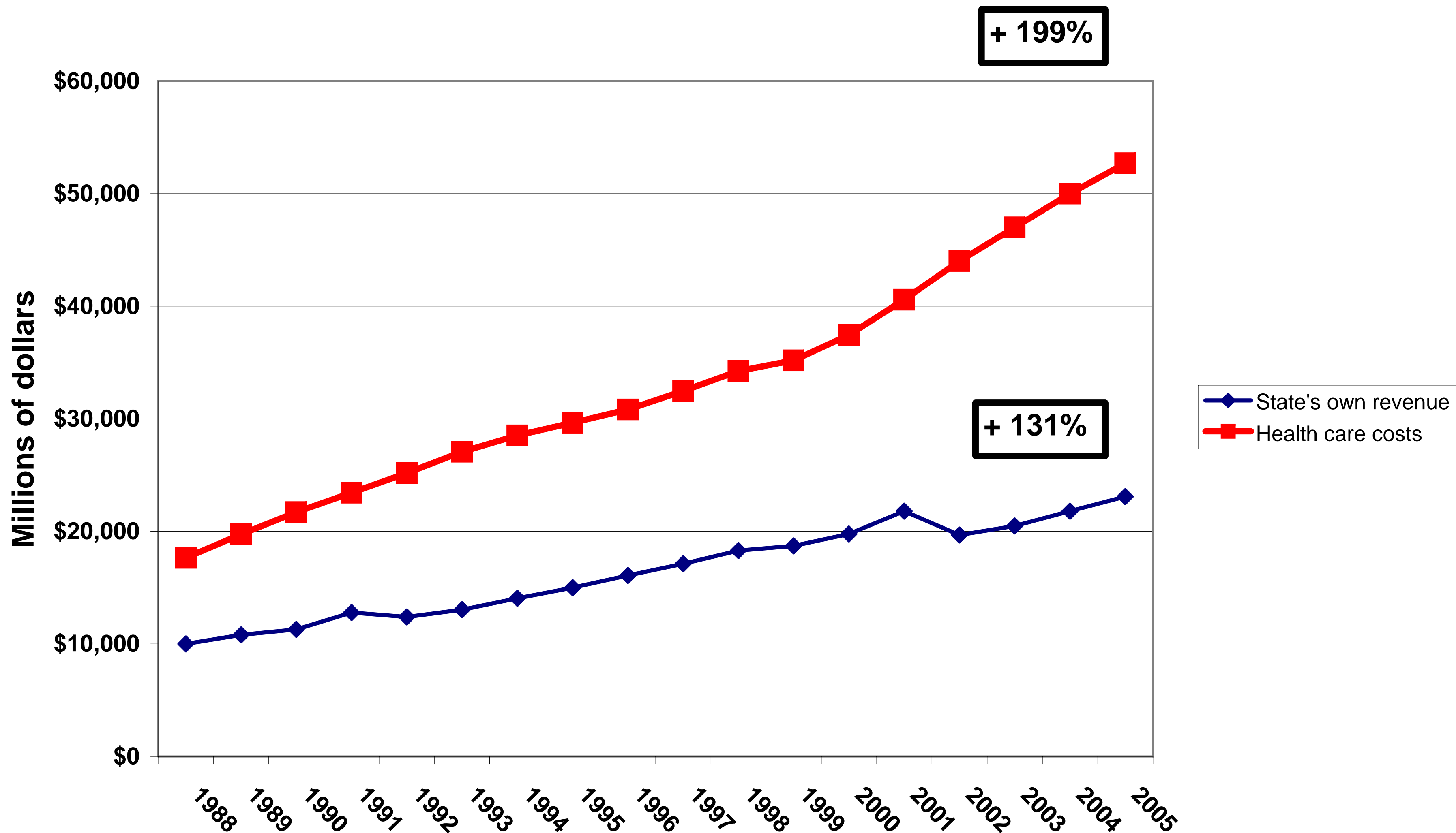


Uninsured People in Massachusetts, 1987 - 2005



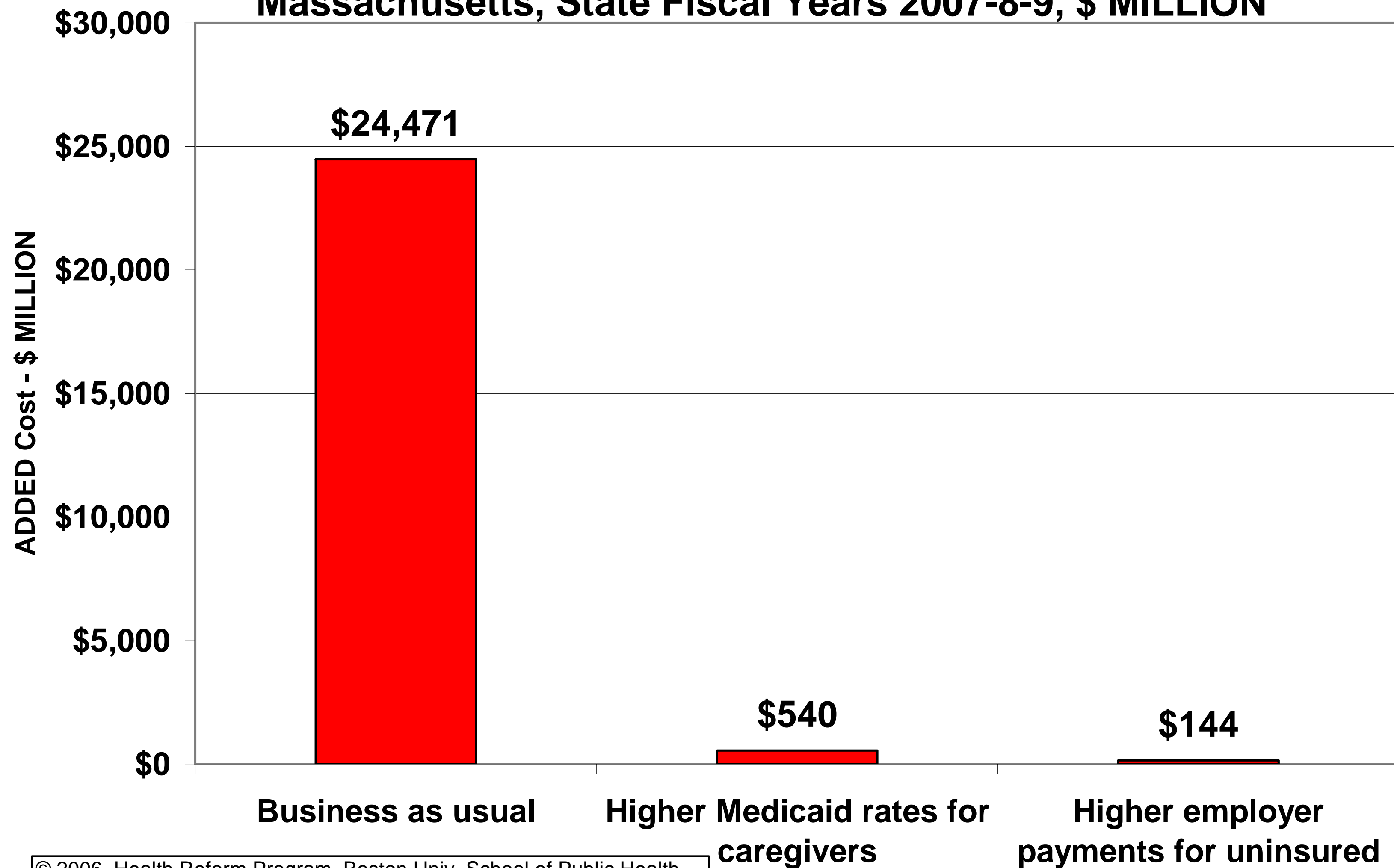
Health Cost's Share of Massachusetts Economy and Uninsured Share of People, 1987 + 2005




Massachusetts Health Costs Rose Far Faster than State's Own Revenue, 1988 - 2005
+ 199%
+ 131%
Millions of dollars
$60,000
$50,000
$40,000
$30,000
$20,000
$10,000
$0
1988
1989
1990
1991
1992
1993
1994
1995
1996
1997
1998
1999
2000
2001
2002
2003
2004
2005
State's own revenue
Health care costs

Conceive Elephant → 18 Months' Gestation → Deliver Mouse

- Cost of good coverage > willingness or ability to pay (^cost + ^uninsured people)
- No constituency for cost control, so
  - Hospitals get higher Medicaid rates
  - Uninsured get flimsy, costly individual mandate with inadequate subsidies
  - Business obsesses about employer assessment, ignores soaring cost of BAU
- Bill that will pass can't work;
  bill that would work can't pass



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Realities—spending

	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 spending, 2004	12.2%	12.7%	- 4%	31
Hospital spending/person, 2004	$2,357	$1,639	+ 44%	1

Realities – hospitals

	Mass.	U.S.	Mass. vs. U.S.	Mass. Rank
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

Realities – MDs, RN, insurance

	Mass.	U.S.	Mass. vs. U.S.	Mass. Rank
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

C. Problems, Causes, and Possible Solutions

- Cost
- Coverage
- Quality/appropriateness
- Caregiver configuration and survival
  - Hospitals
  - Physicians

Emphases

- Contain cost + improve coverage by cutting waste
- Physicians (not "consumers") are strategic
- Neither cost control nor coverage possible without physicians' engagement + support
- Professionalism within a budget?
  - Whose budget? Whose professionalism?
  - Why would physicians be motivated to do that?
- Sustaining right shape of hospitals + MDs

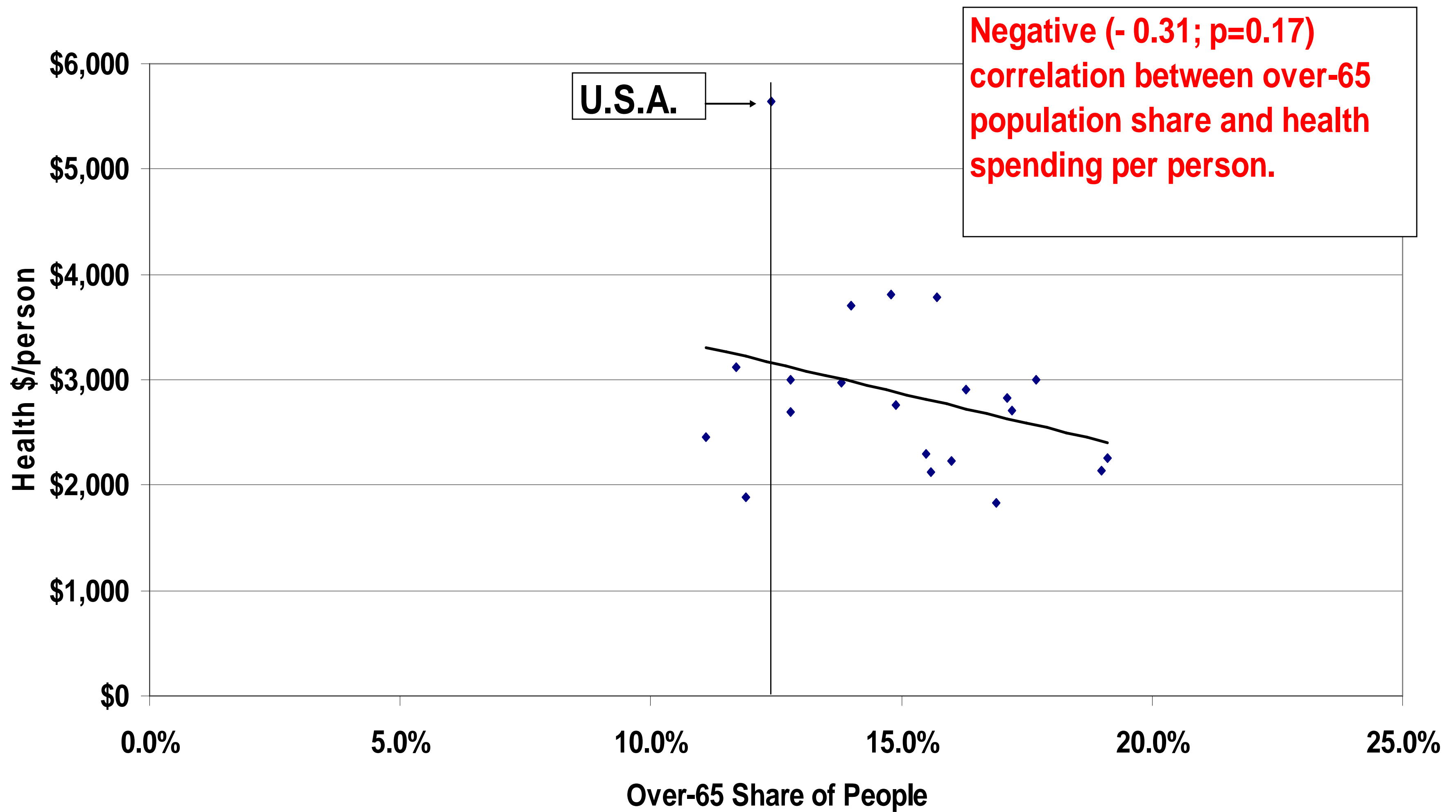
Conventional causes, solutions -1/2

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
Negative (- 0.31; p=0.17) correlation between over-65 population share and health spending per person.
U.S.A.
$6,000
$5,000
$4,000
$3,000
$2,000
$1,000
$0
Health $/person
0.0%
5.0%
10.0%
15.0%
20.0%
25.0%
Over-65 Share of People

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

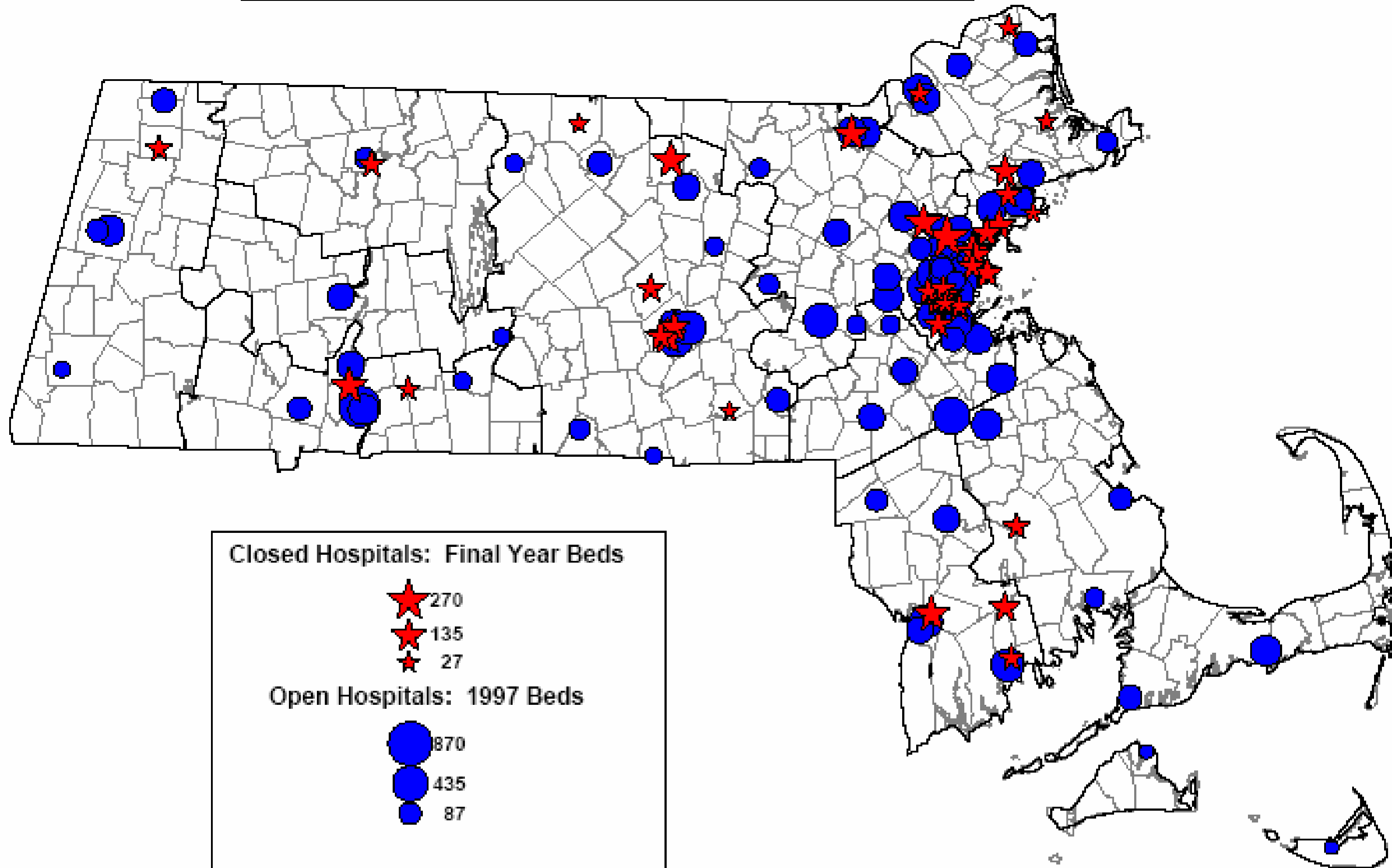
Causes	Solutions
Hospitals closing	Pay all needed hospitals enough if efficient; bolster community hospitals
Primary care MD shortage	Train more, pay more?
Some specialist shortages	Pay hospitals to hire enough

Hospital + Physician Configuration

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



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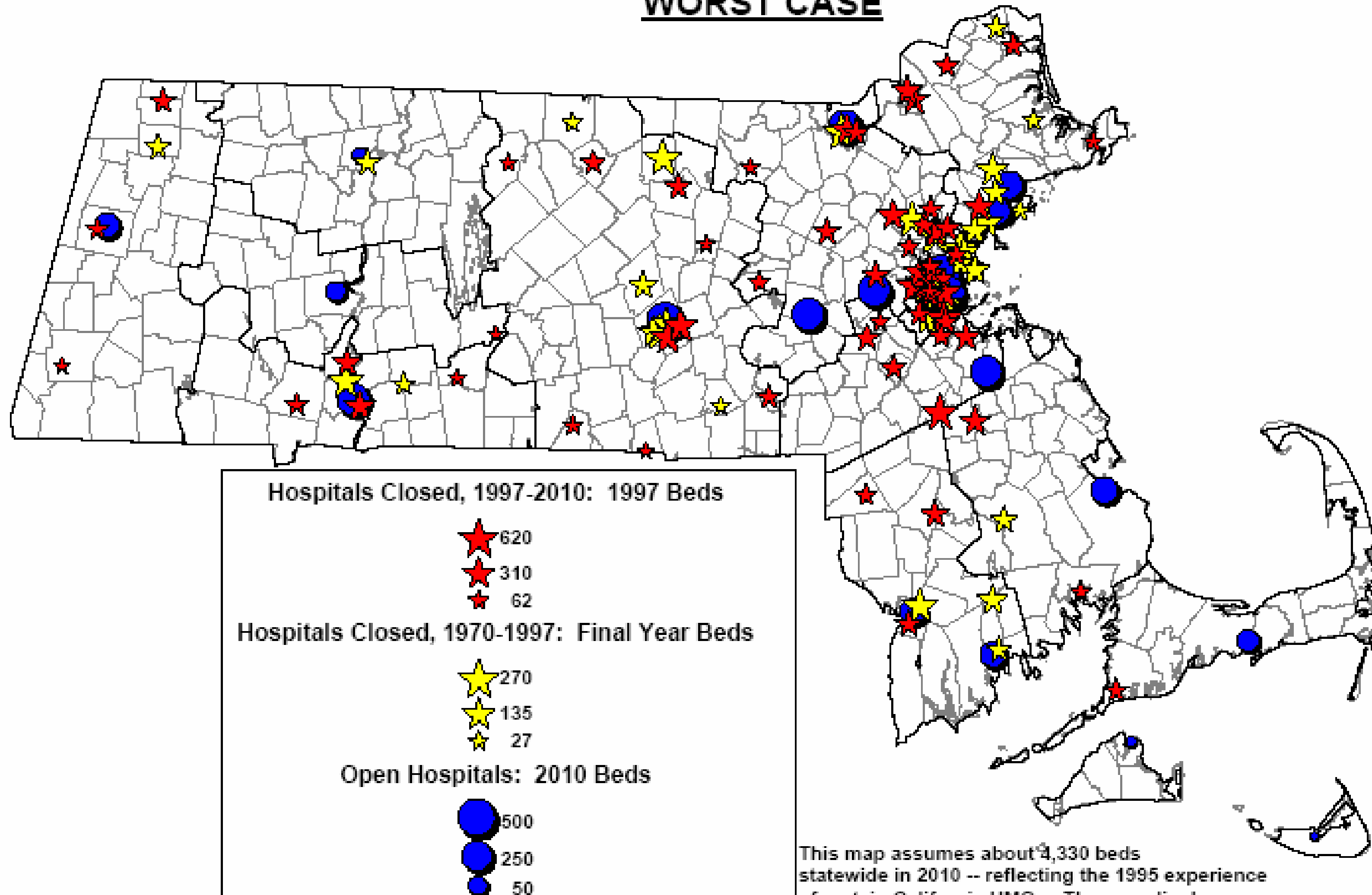
MAP 5: MASSACHUSETTS HOSPITALS THAT MIGHT SURVIVE, 1997-2010
WORST CASE



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.

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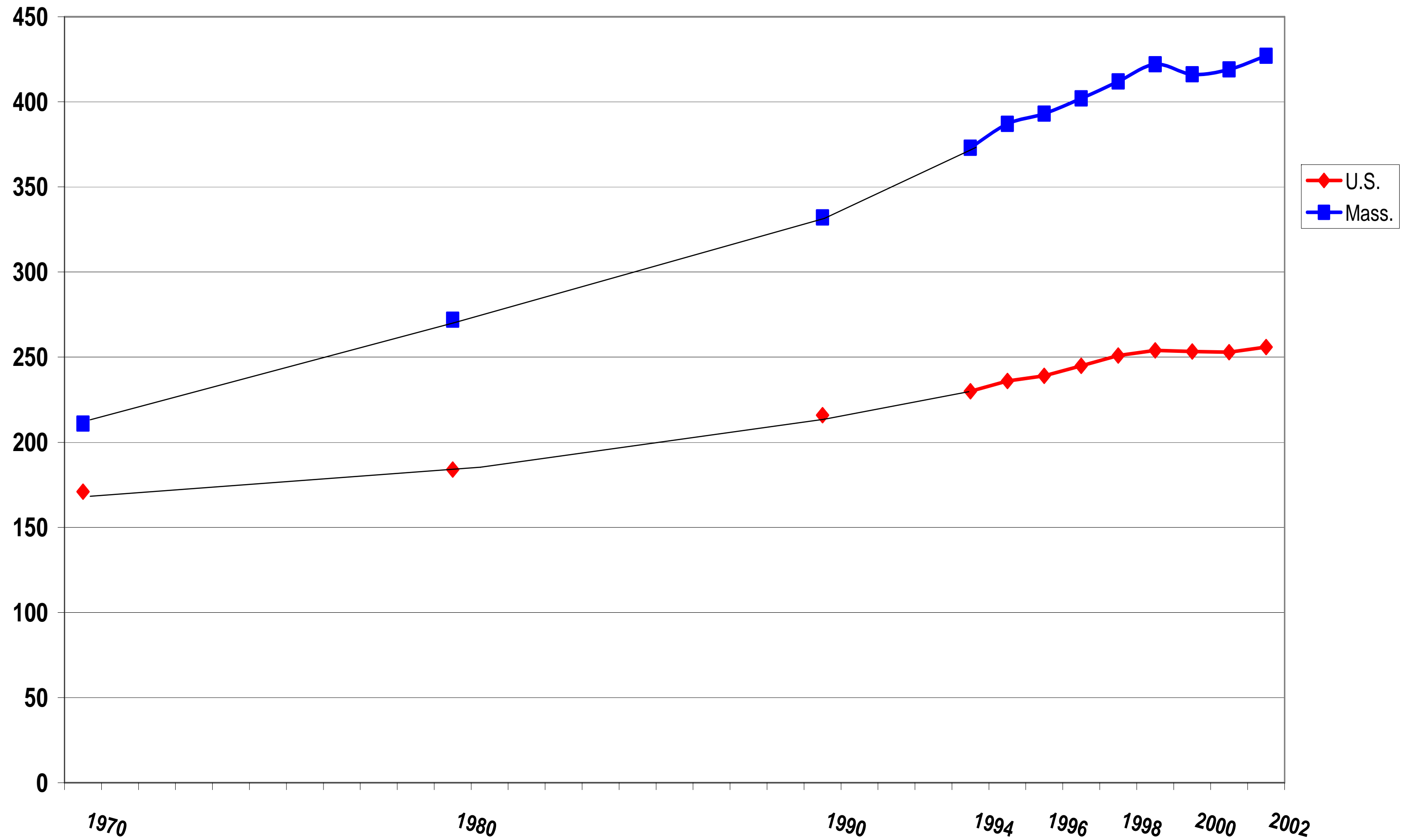
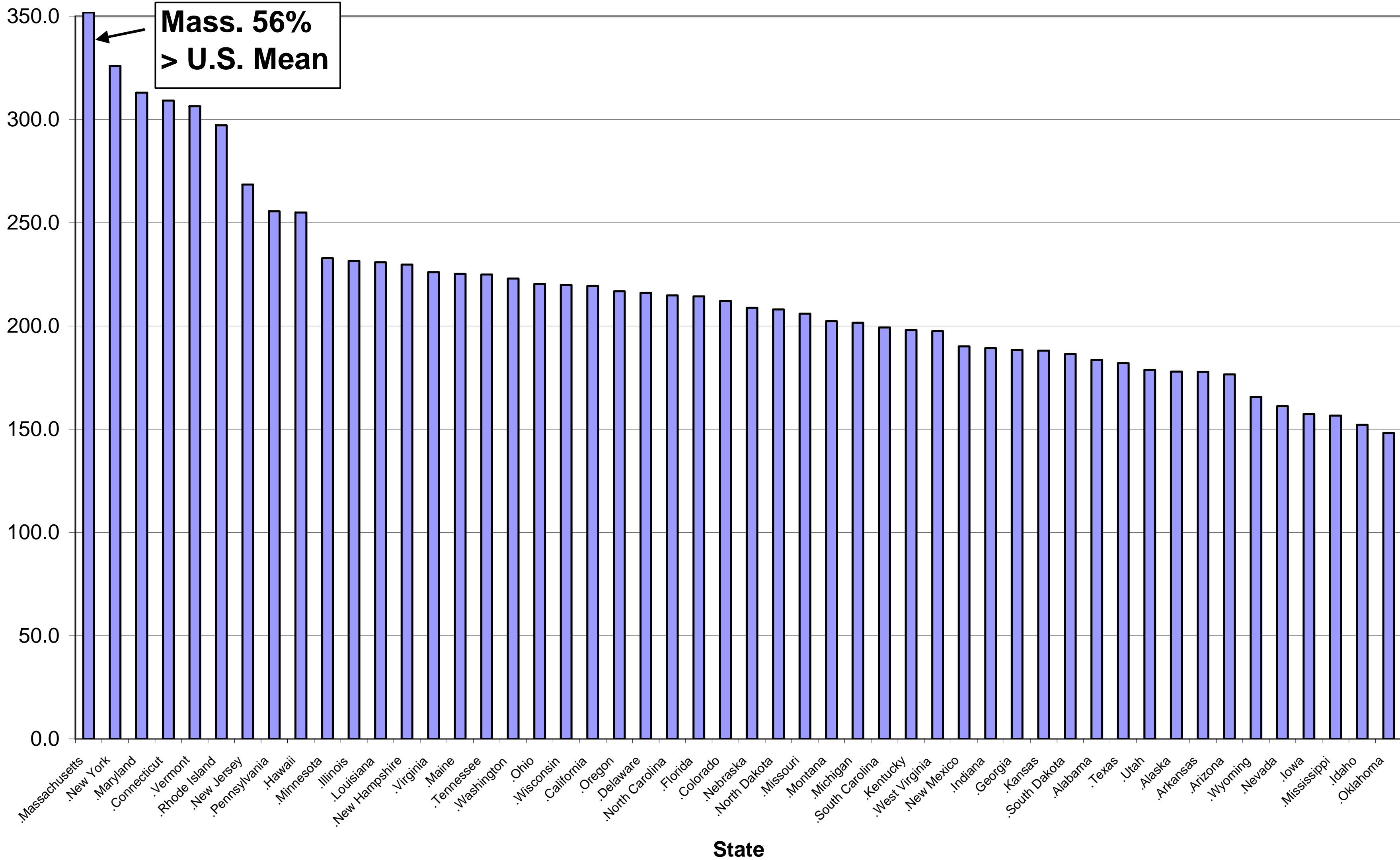
Massachusetts Physicians

- Per person spending on physicians about 20 percent higher here than nationally
- But 40-55% more physicians per 1,000 people practice here than nationally
- So average income per physician is substantially below national average
- Yet our physician excess over national average steadily grows

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





Patient Care Physicians per 100,000 People, by State, 2002
Mass. 56%
> U.S. Mean
350.0
300.0
250.0
200.0
150.0
100.0
50.0
0.0
.Massachusetts
.New York
.Maryland
.Connecticut
.Vermont
.Rhode Island
.New Jersey
.Pennsylvania
.Hawaii
.Minnesota
.Illinois
.Louisiana
.New Hampshire
.Virginia
.Maine
.Tennessee
.Washington
.Ohio
.Wisconsin
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.Oregon
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.Nebraska
.North Dakota
.Missouri
.Montana
.Michigan
.South Carolina
.Kentucky
.West Virginia
.New Mexico
.Indiana
.Georgia
.Kansas
.South Dakota
.Alabama
.Texas
.Utah
.Alaska
.Arkansas
.Arizona
.Wyoming
.Nevada
.Iowa
.Mississippi
.Idaho
.Oklahoma
State

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 and to stabilizing health care

- 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

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 deductibles, co-pays, and other financial barriers between sick people and needed care

Wholesale regulation by government

- Regulation half-hearted
  - No motivation to contain cost—no palpable benefit
  - 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

<u>Genuine free market requires</u>

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!)

<u>All of these are absent in health care.</u>

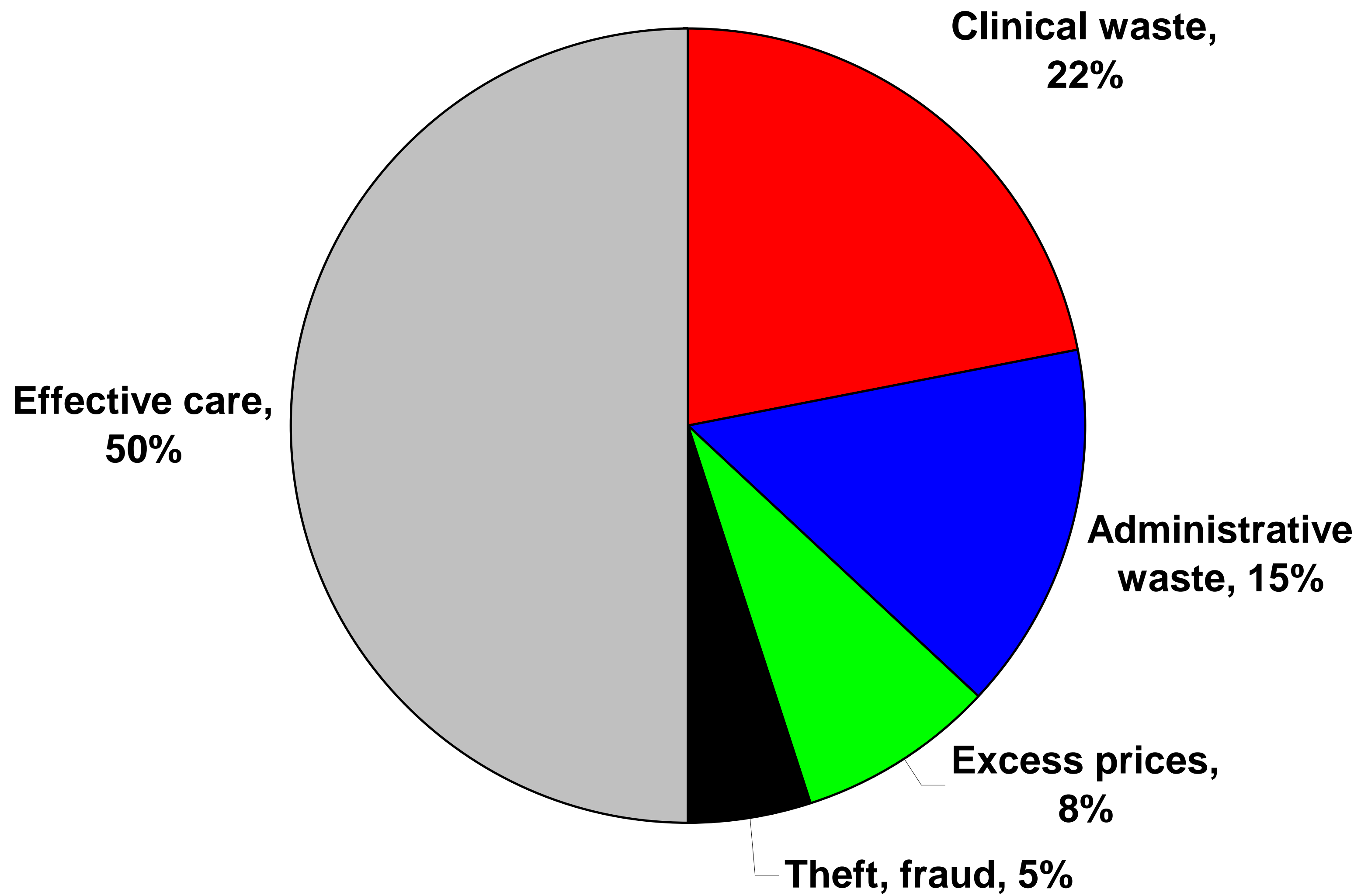
3. Cost control + coverage = allies

- Can't cover everyone unless contain cost
- Can't contain cost without
  - persuasive motive and
  - effective and acceptable means
- Winning durable high-quality care for all and protecting needed doctors/hospitals are the motives to contain cost by cutting waste.
- All means of cutting waste must embody recycling of savings to finance care for all, protect needed doctors/hospitals, and improve quality.

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)
   Most: 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
P U B L I C	**A** Payers cut fees to caregivers, Regulate supplies of caregivers	**B** Empower MDs to spend carefully→ they cut clinical waste + paperwork
M A R K E T	**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
P U B L I C	•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
M A R K E T	•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. Some saving by consolidating financing + covering everyone

<u>Savings won by cutting administrative waste stemming from complexity</u>

- 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

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

Most waste persists after payment is consolidated

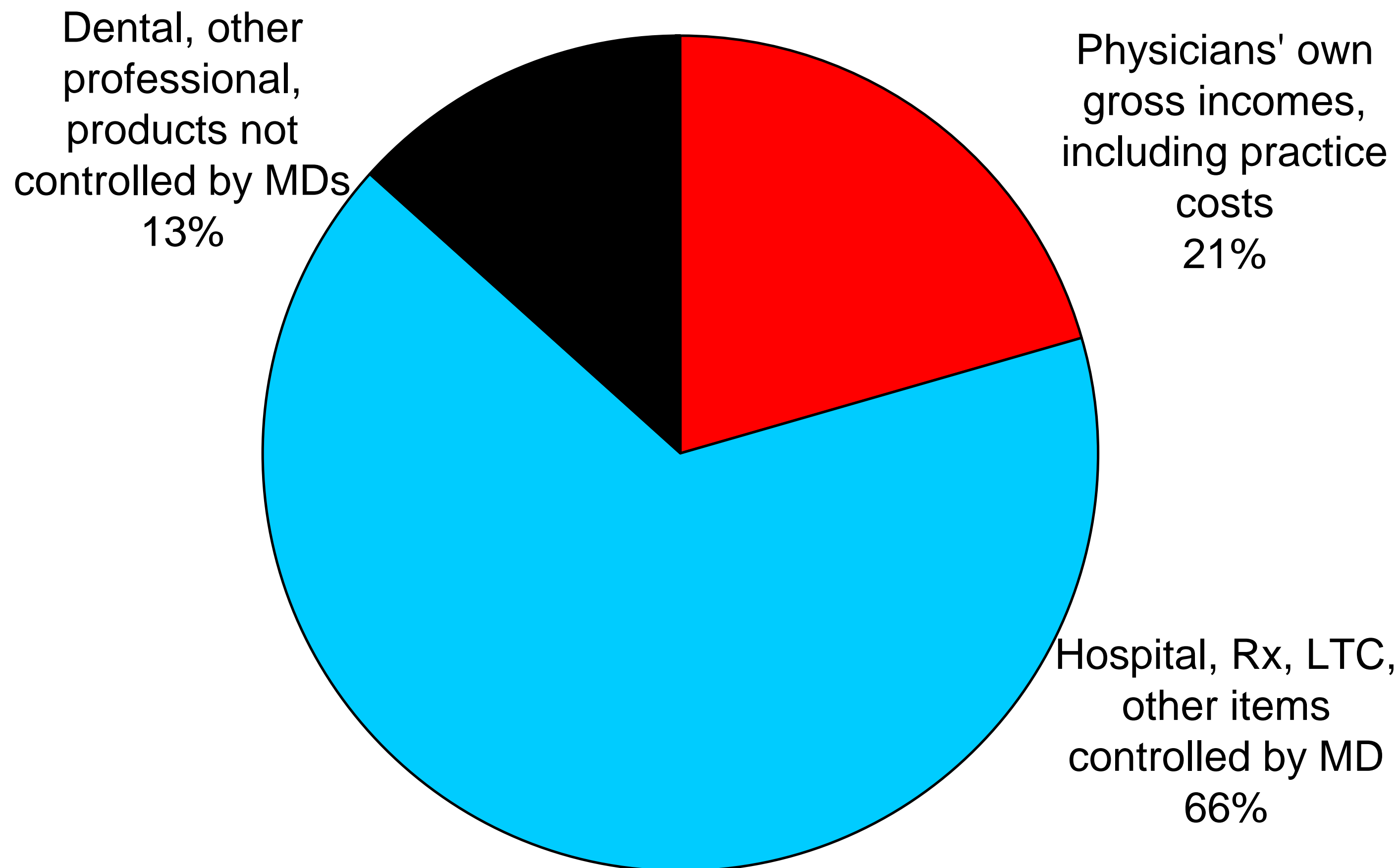
Consolidated financing makes it easy to cap revenue and cover all, but doesn’t address waste caused by

- 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’s revenue caps
- 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
  - Ends threat of malpractice suits
  - Ends paperwork stemming from mistrust/complexity
  - Liberates physicians to use evidence to care for all
  - In exchange for doctors' agreement to
    - care for everyone well
    - stay within budgets (that have much more money than is available today)
    - weed out waste patient-by-patient

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



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. Grow up and acknowledge that
   - ✓ pathology is remorseless but resources are finite
   - ✓ so need spend carefully

c. Pay doctors in ways that allow us to trust them to spend the money carefully
   - ✓ Doctors get about 21 cents on health dollar but keep only 8 cents after practice costs—
   - ✓ <u>how they garner the 8 cents is key to everything</u>

A few more means to cut waste

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

e. Regional budgets

f. Three watertight compartments
   - ✓ One for physicians' 21 cents/8 cents
   - ✓ One for the other 66 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.
- Groups of 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 (as in Maryland)
- 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!)

D. How to Move Forward?

In Practice, Why Would Physicians Care/Spend More Carefully?

- Fear that BAU might soon crash?
- Deal is sufficiently attractive professionally?
- Deal offers more money for patient care?
- Shape medicine that will attract their children?
- BUT, to spend carefully, would physicians need
  - data on costs and value of various diagnostic/therapeutic interventions?
  - financial pressure/reward?
  - sea change in attitudes?
    - Like the English + Welsh Nonconformist denominations that helped engender sober and industrious machinists who drove the U.K.'s industrial revolution?
    - Where would that sea change come from?

Physicians' Motives Vary

- Professional competence (follow scientific standards or practice art)
- Caring, kindness, availability
- Follow financial incentives or clinical need?
- Money versus prestige
- Collegiality/integration versus entrepreneurial/financially autonomous

Opportunities

- National or state health care crisis might spark demand for reform, but what would we do then?
  - Federal/state governments, hospitals, and medical societies have no contingency plans
    - We make bird flu preparation look good
  - Now is time to learn how to cut waste, pay for care, and organize delivery of care
  - States need to be able to experiment—not possible now

One hand for yourself and one for the ship