State Universal Coverage Initiatives—
Designing Plans that Could Both Work and Pass

Rekindling Reform

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The ideas and evidence offered here were developed in concert with my fellow-director, Debbie Socolar.

Overview

A. Introduction: a few reasons for reform's inertia

1. Lessons from the Clintons
2. Lessons from single payer's stagnation
3. Cost – coverage conundrum

B. Problems

1. Is our health care sustainable?
2. Spending increases, national
3. Coverage cuts, national
4. Economic doubts
5. Pressure points

C. Causes

1. Economy
2. Revenue sources
3. Costs
4. Coverage
5. Caregiver configuration
6. Failure to prepare

D. Solutions that address causes

E. Moving forward

1. Economic contingencies and political panic
2. Getting ready

A. REFORM'S INERTIA

1. Clintons' failure

a. <u>Conventional views</u>

- Their bill wasn't ready in time
- Too complicated
- Not pre-sold politically to doctors, business, press
- Gingrich built on small business and insurer opposition to deny a victory to Dems
- Clintons diffused their energy—NAFTA
- Didn't prepare to defend against Harry+Louise, "no exit" and other ungrounded attacks
- Economy re-started

b. Other views (mine)

- Never really tested—another abstract idea for 1/7th of the nation's goods and services
- What did the president know?
  - How would reform actually work, how to get care, from whom?
  - How would everyone be covered and who would pay for uninsured?
  - What regional budgets, boundaries, data on current spending?
- Clintons didn't know—so failed to rebut lying critics
- Fear of unknown, big change hard to exaggerate
- Total spending would rise owing to employer mandate + cigarette tax
- Employer mandates really are regressive
- States differed greatly in cost and coverage problems, receptivity to trying something new, trust in government
- Doctors' opposition
- Once appearance of health cost crisis passed, few fervently favored Clintons

2. Single payer stagnation—why?

- Have models or studies of savings convinced anyone? Not yet. Maybe we need different types of studies.
- Administrative waste sounds too glib to explain so much waste—what about clinical waste?
- More administrative waste is associated with mistrust than with complexity
- How will it work the morning after? Patient uncertainty, worry—will I be able to keep getting care I'm used to?
- Will it really contain cost? Why do we think doctors, hospitals, drug makers, nursing homes, dentists, and others will keep their costs under the ceiling of total national or regional revenue provided?
- By what methods will caregivers be paid?
- Most doctors oppose single payer—what can change?
- How do caregivers make transition from "enrich yourself" market thinking to spending carefully?
- It feels too easy, mechanical, brittle, bloodless
- World's dumbest bumper sticker

- **3. Cost – coverage conundrum**
- We spend enough to care for everyone but there's little constituency for cost control
- Few perceive benefit from containing cost
- Need mechanisms to stretch today's dollars to cover everyone—squeeze out waste + recycle it
- Most cost controls have failed badly
- Incremental coverage improvements (Kerry, employer mandates) rely on boosting spending even higher (get everyone in and then we'll contain cost)
- Today, it's hard to imagine politics that could permit passage of even incremental improvement.
- Economic crisis → new politics + high pressure to care for all, but there'll be less money to meet more demands

B. PROBLEMS

1. Is our health care sustainable?
2. Spending increases, national
3. Coverage cuts, national
4. Economic doubts
5. Pressure points
   - By state—spending and coverage differences
   - Capacity to generate revenue—inter-payer differences
   - By sector—which areas of health care are most vulnerable?

1. Is our health care sustainable?

- Definitions
- Predictions

Sustainability Defined

- Maintaining something, keeping it in existence, supplying it with necessities

- Enjoying political and financial support adequate to finance and deliver health care as usual—business as usual—in the decade ahead with no more than moderate adaptations.

3 Viewpoints on Sustainability

1. Physicians, hospitals, other **caregivers**—will we be able to garner revenue needed to survive and steadily improve both quality of patient care and our incomes?
2. **Payers**—will we be willing and able to supply the revenue that caregivers expect and patients require?
3. **Patients**—will enough of us be protected against health costs, and be able to obtain needed, competent, and timely care?

Summary of Risks to Health Care's Sustainability

1. **External**
   - The economy—robust or struggling?
   - Specific payers—will they be able and willing to finance business as usual?
2. **Internal**
   - Will health costs continue to rise much faster than GDP?
   - Will insurance coverage stabilize or drop?
3. **Value** for money—will health care provide enough value, to enough Americans?

QUESTION:
Assessment of Sustainability

- How would you assess the sustainability of today's U.S. health care on a five-point scale, A – B – C – D – E ?

A = Today's U.S. health care is essentially very sustainable with at most minor modifications

B – C – D

E = Today's U.S. health care is not sustainable and will require major modifications

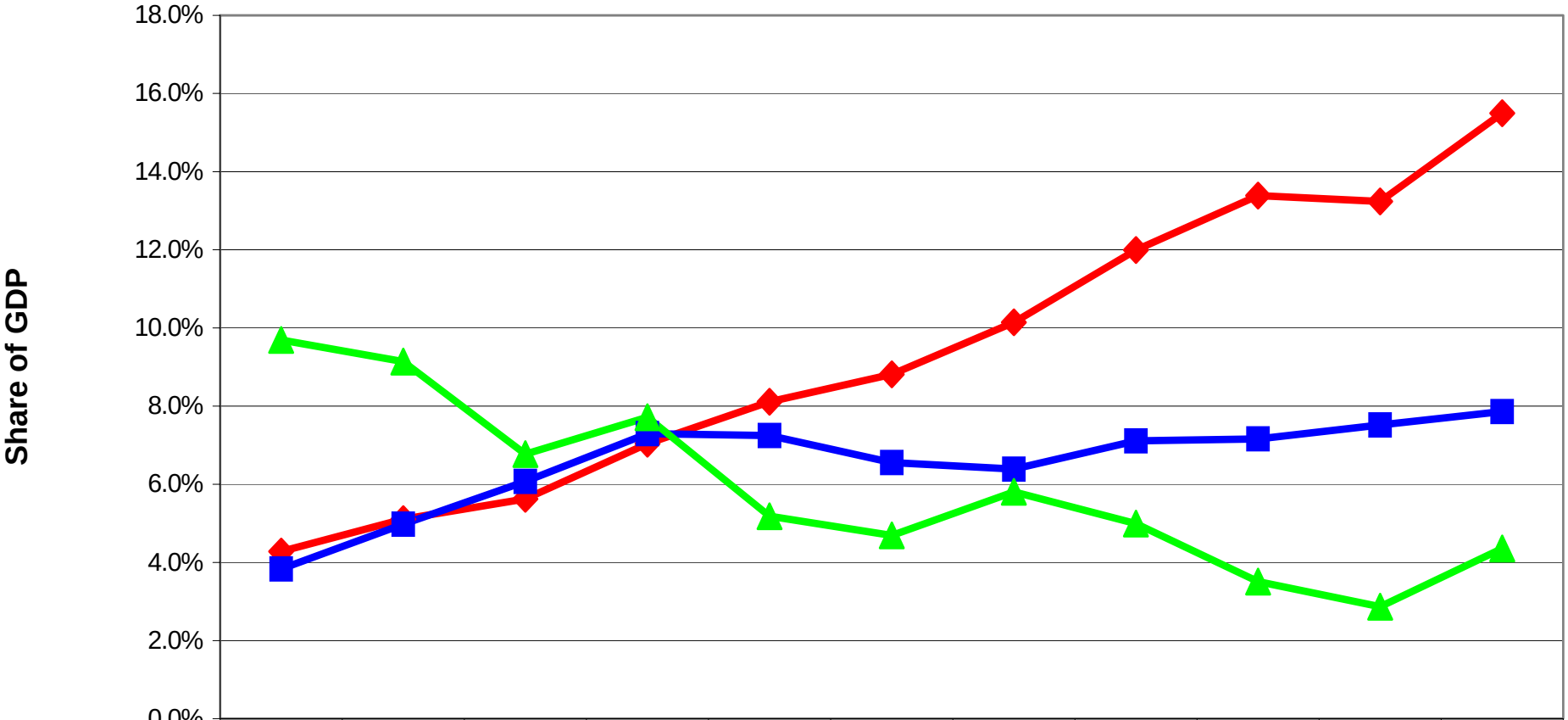
QUESTION: Between today and the spring of 2015, which of these events do you consider likeliest?

A. **Stable** health share of economy + **drop** in share uninsured	**B**. **Stable** health share of economy + **rise** in share uninsured
C. **Rising** health share of economy + **drop** in share uninsured	**D**. **Rising** health share of economy + **rise** in share uninsured

2. Spending increases, national

- Defense, health, education—no one knows this
- Rising share of economy
- Projected forward to 2014

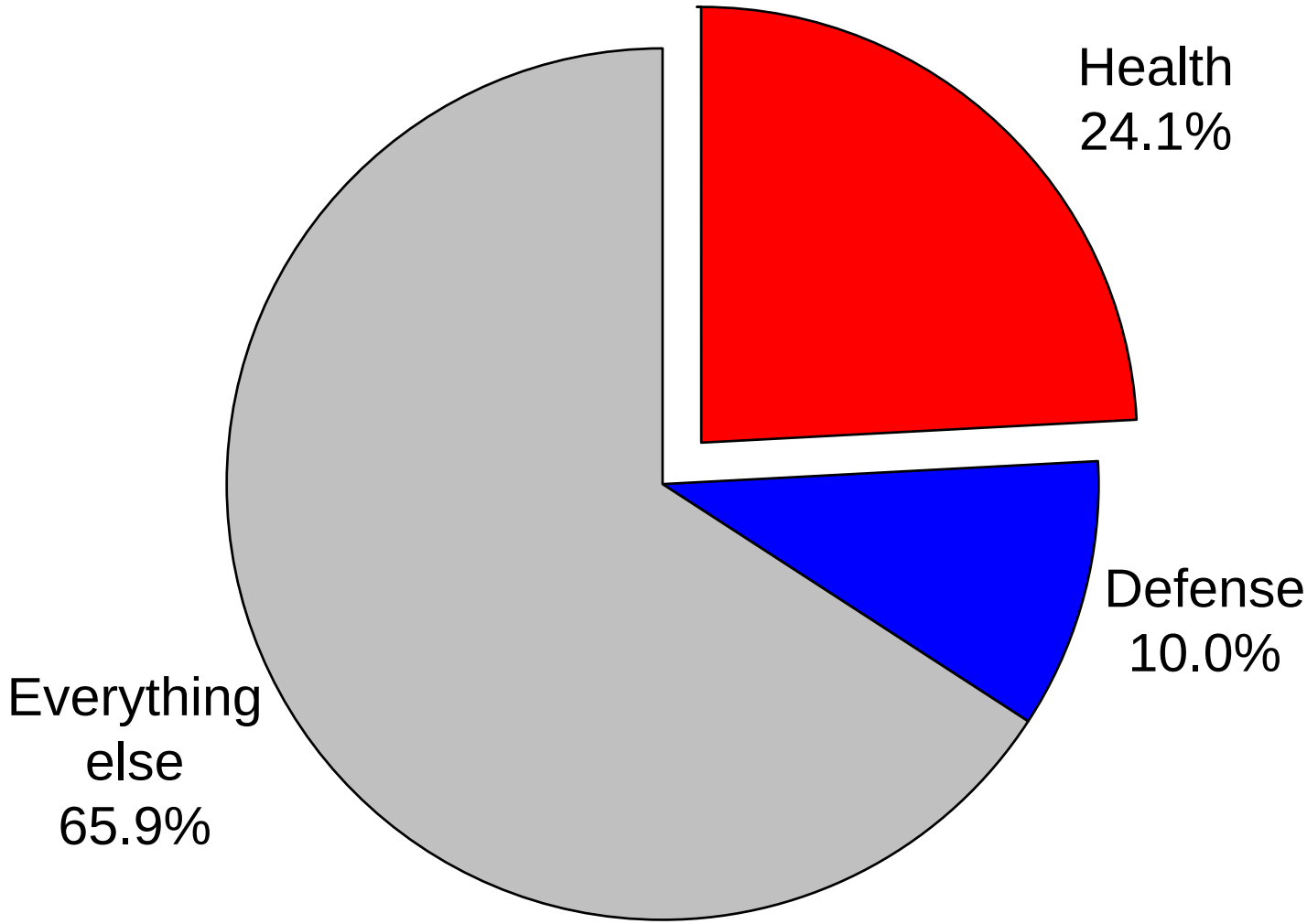
HEALTH, EDUCATION, AND DEFENSE SHARES OF U.S. GDP, 1955 - 2005



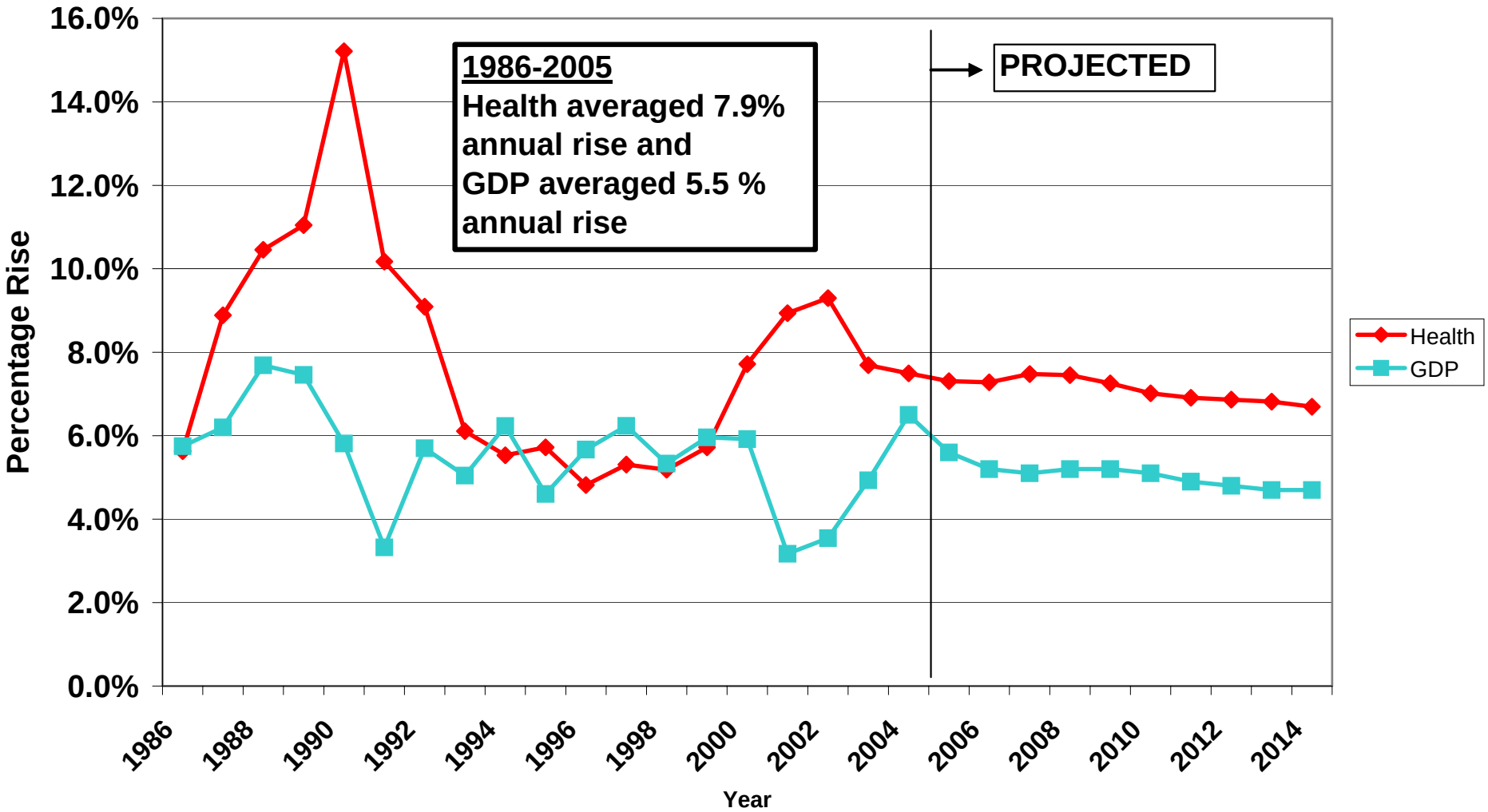
	1955	1960	1965	1970	1975	1980	1985	1990	1995	2000	2005
Health	4.3%	5.1%	5.6%	7.0%	8.1%	8.8%	10.1%	12.0%	13.4%	13.2%	15.5%
Education	3.8%	5.0%	6.1%	7.3%	7.2%	6.6%	6.4%	7.1%	7.2%	7.5%	7.9%
Defense	9.7%	9.1%	6.8%	7.7%	5.2%	4.7%	5.8%	5.0%	3.5%	2.9%	4.4%

Year

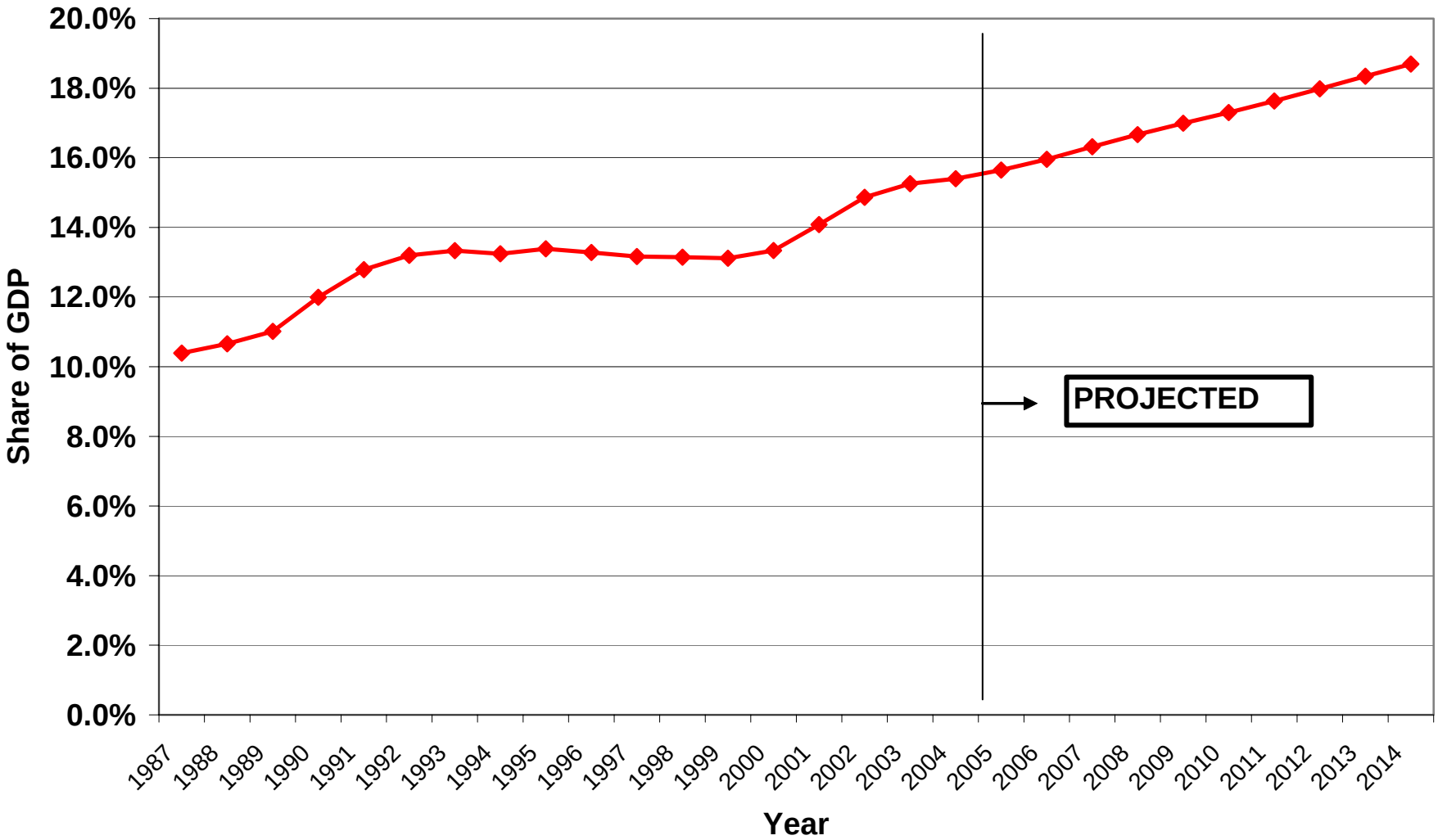
SHARES OF GDP GROWTH, 2000 - 2005



Percentage Rise in Health Spending and GDP, U.S. 1985 - 2014



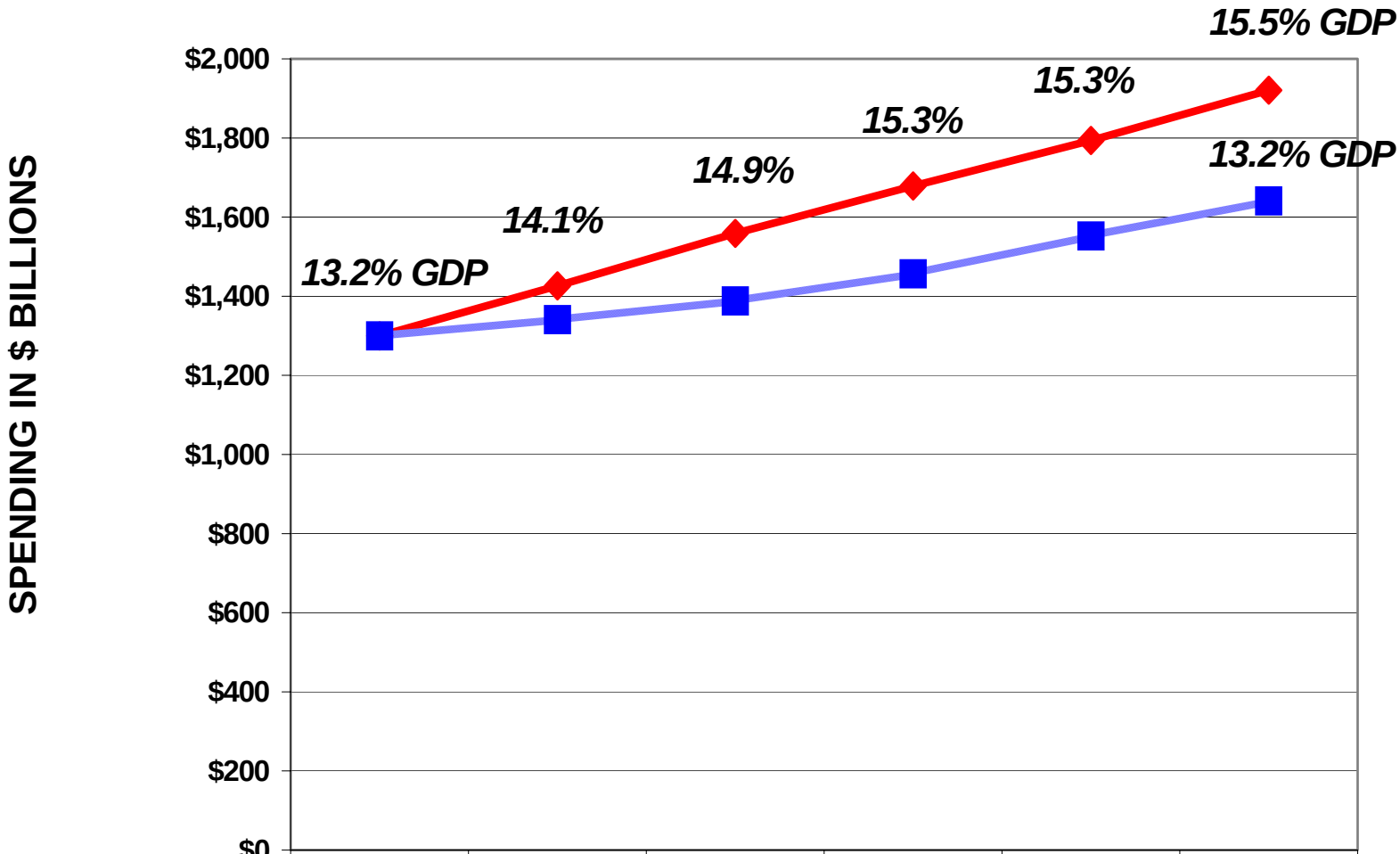
Health's Share of GDP, 1987 - 2014



HEALTH CARE'S ADDICTION TO MORE MONEY FOR BUSINESS AS USUAL

U.S. HEALTH SPENDING, 2000 - 2005

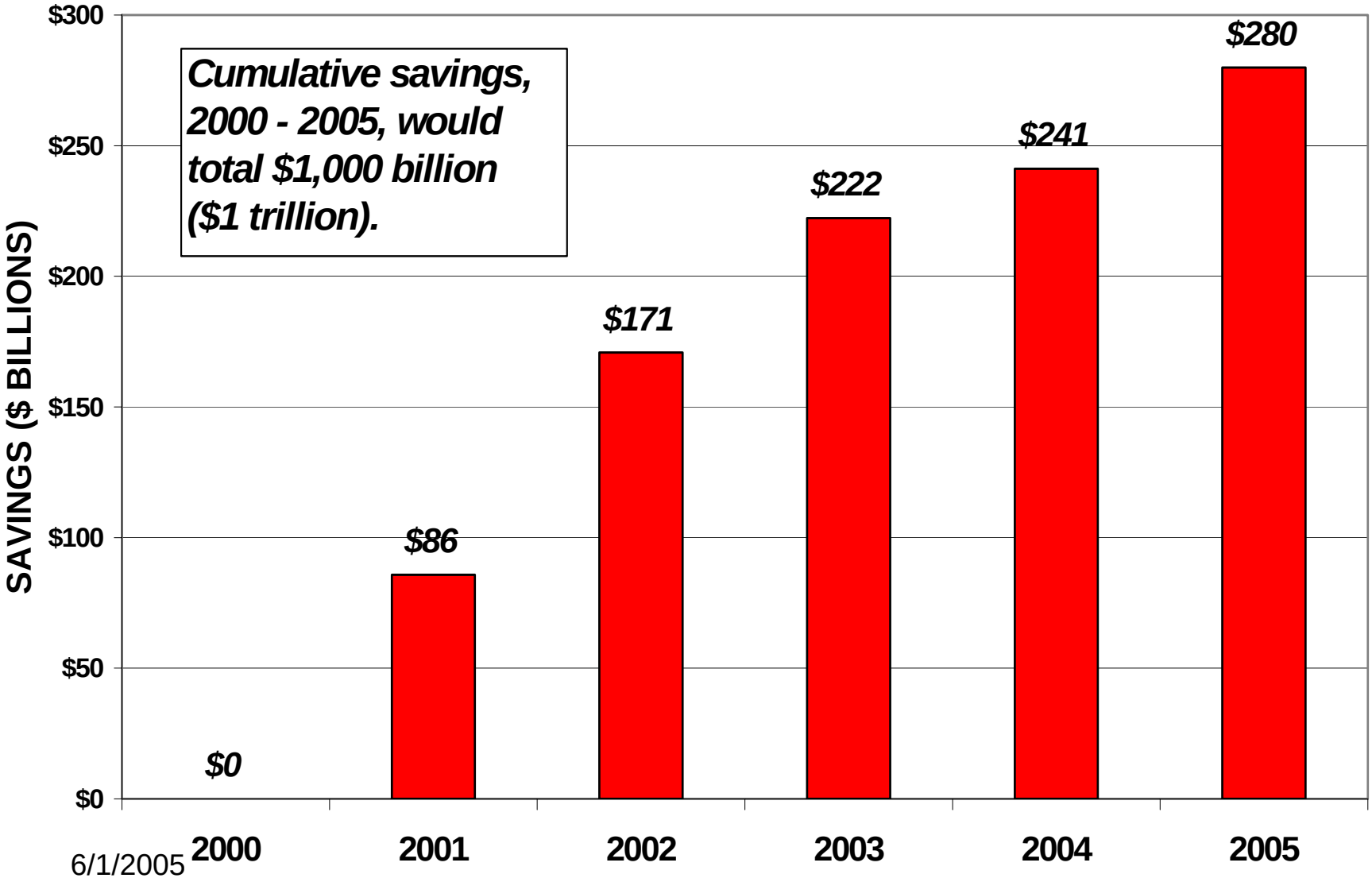
ACTUAL SPENDING versus SPENDING HELD TO 13.2% OF GDP



	2000	2001	2002	2003	2004	2005
ACTUAL SPENDING	$1,300	$1,426	$1,559	$1,679	$1,794	$1,921
SPENDING AT 13.2% GDP	$1,300	$1,341	$1,388	$1,457	$1,552	$1,641

U.S. HEALTH SAVINGS, 2000 - 2005, IN $ BILLIONS

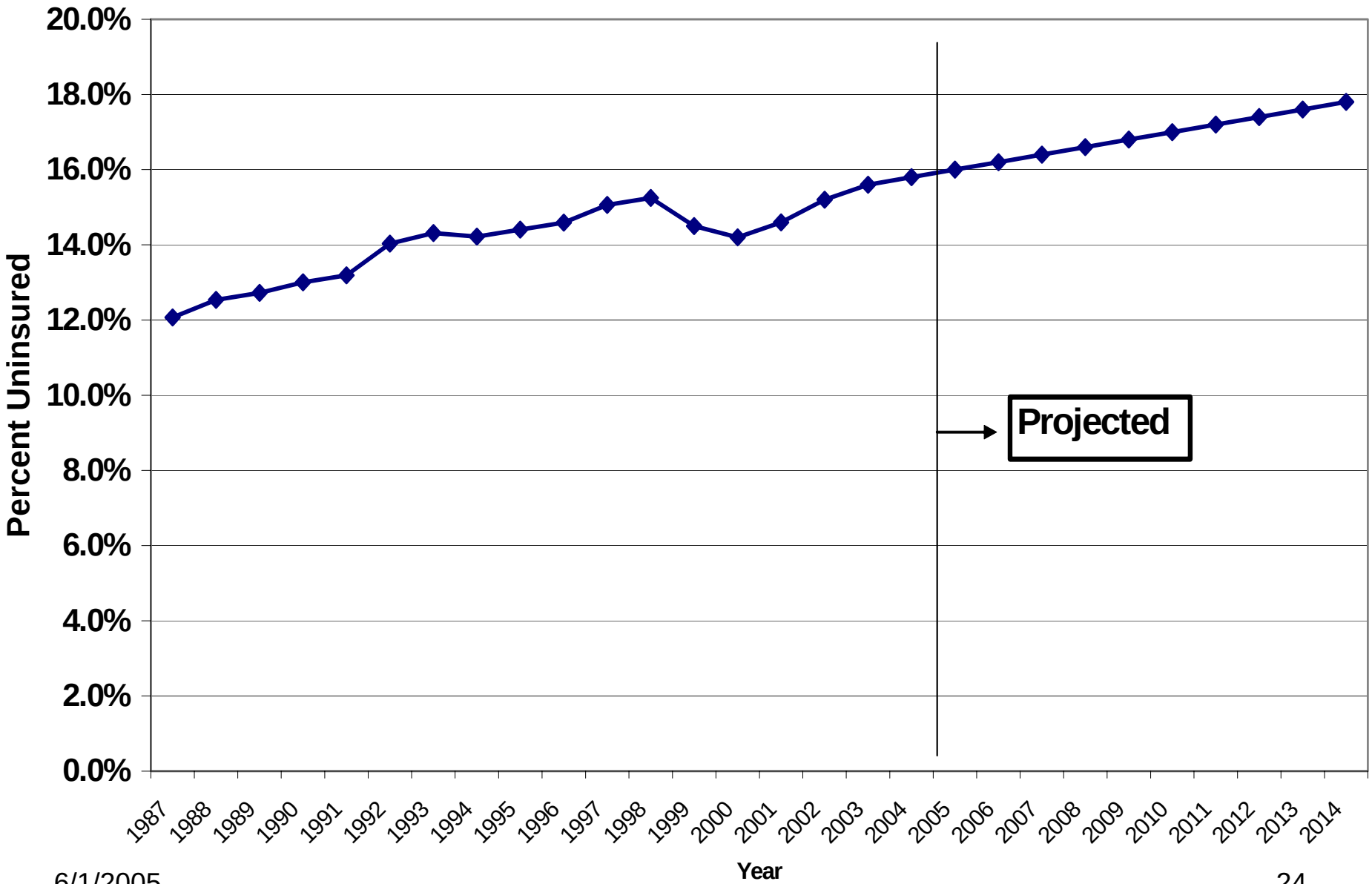
HAD HEALTH BEEN HELD TO 2000'S 13.2% OF GDP



3. Coverage cuts, national

- People with no insurance
- People with inadequate insurance

Percent Uninsured, 1987 - 2014



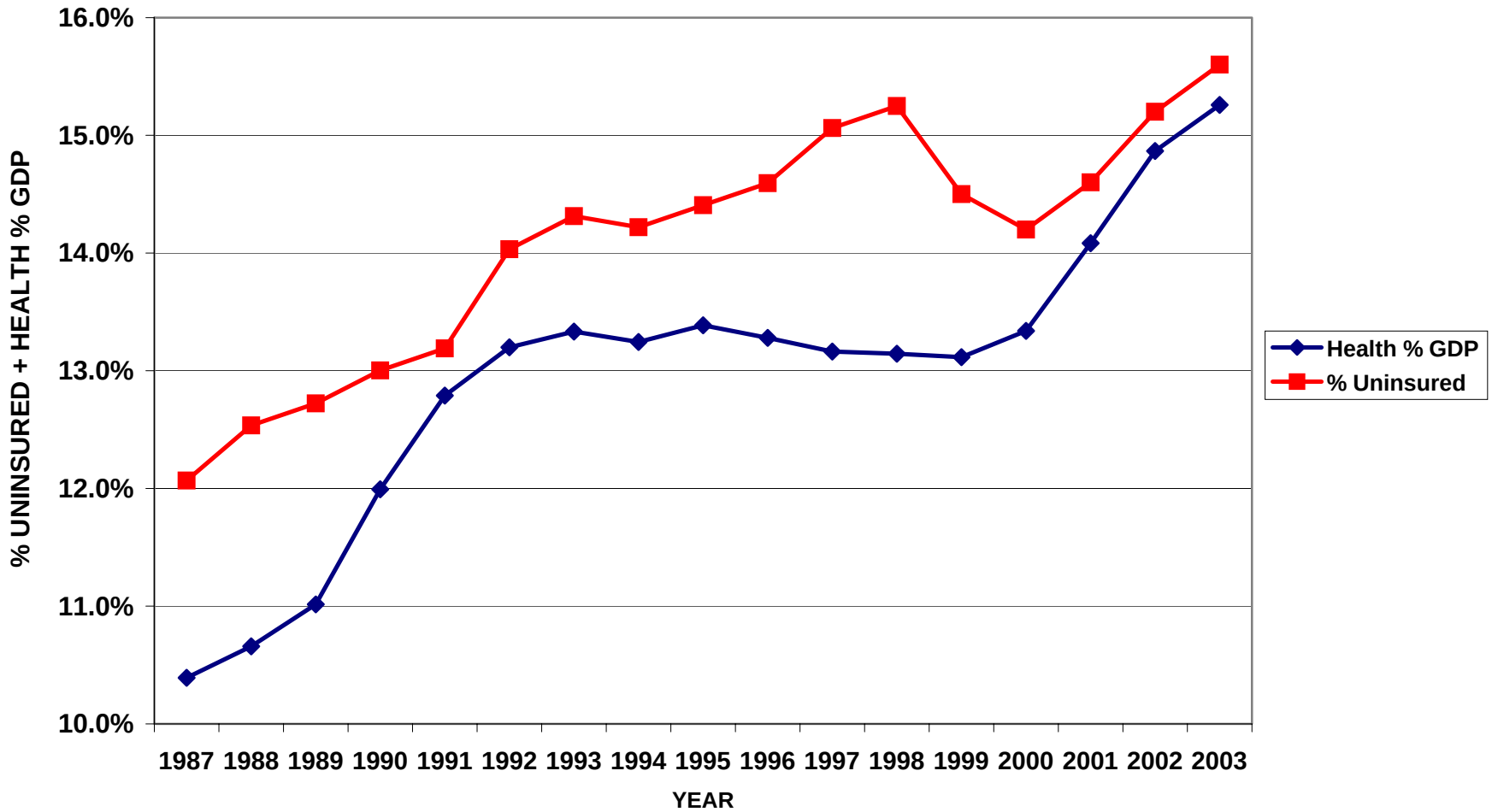
Financial Coverage

- 45 million (1 in 7) are uninsured
- Some 30 million are financially under-insured
- Lack of insurance by sector
  - Pharmaceutical 75 million
  - Dental 100 million
  - Long-term care 200 million+
- Out-of-pocket co-payments, co-insurance, and deductibles are rising, as are employee shares of premiums

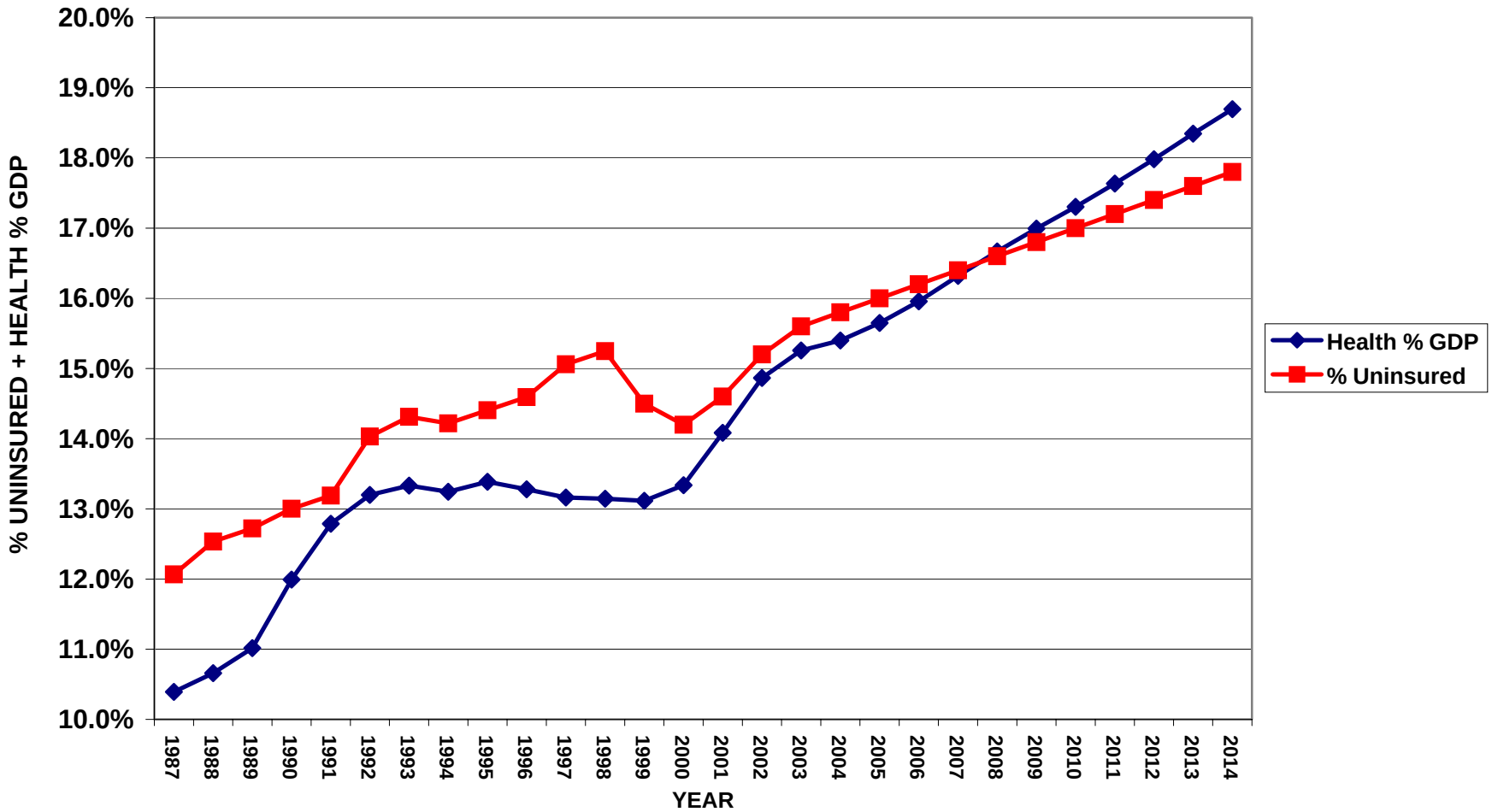
Cost + coverage =

Health Crisis Index

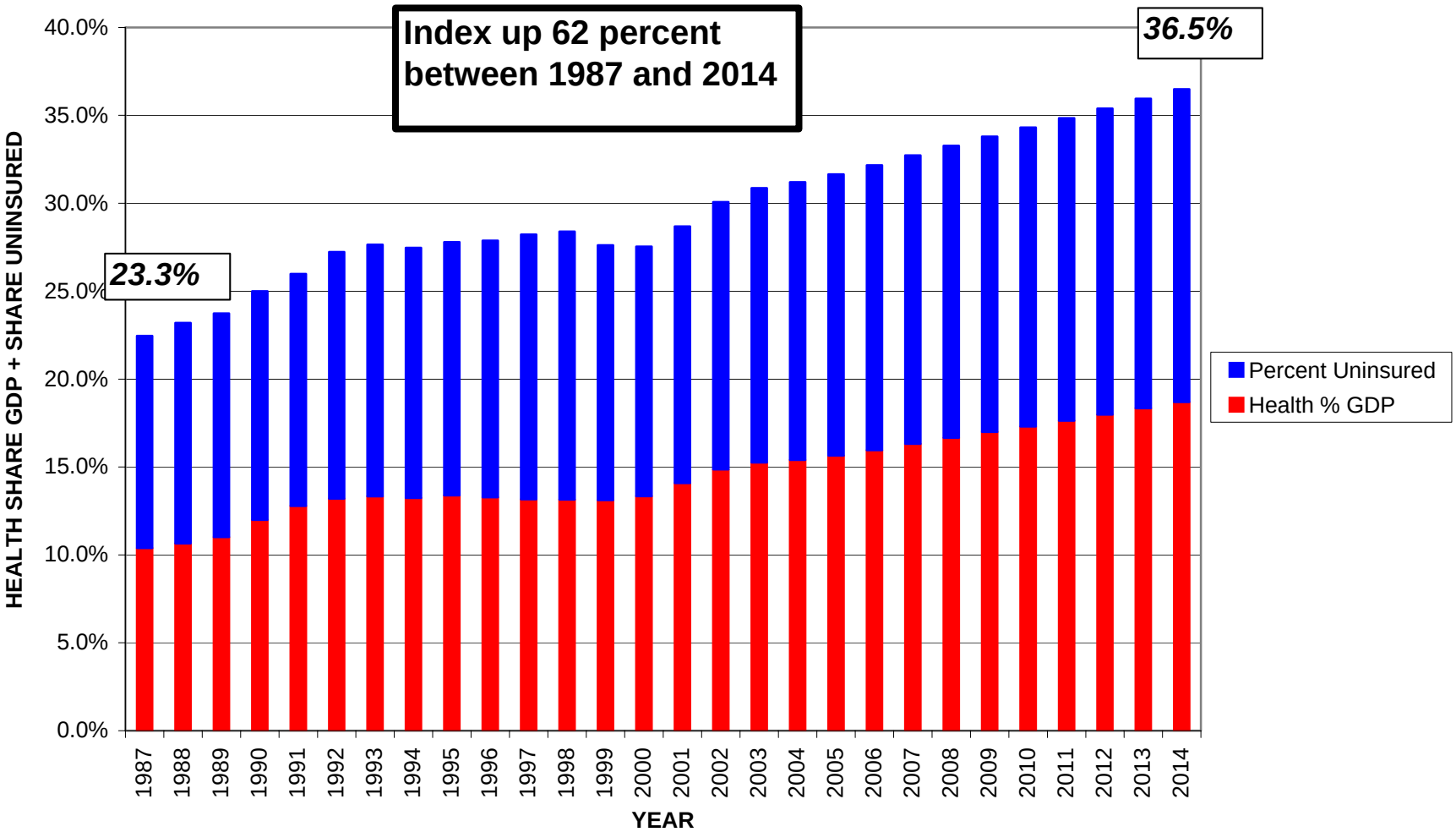
SHARE UNINSURED AND HEALTH'S SHARE OF GDP, 1987 - 2003



SHARE UNINSURED AND HEALTH'S SHARE OF GDP, 1987 - 2014



HEALTH'S SHARE OF GDP + SHARE OF PEOPLE UNINSURED, 1987 - 2014



4. Economic doubts

- Optimism
- Pessimism
- Data

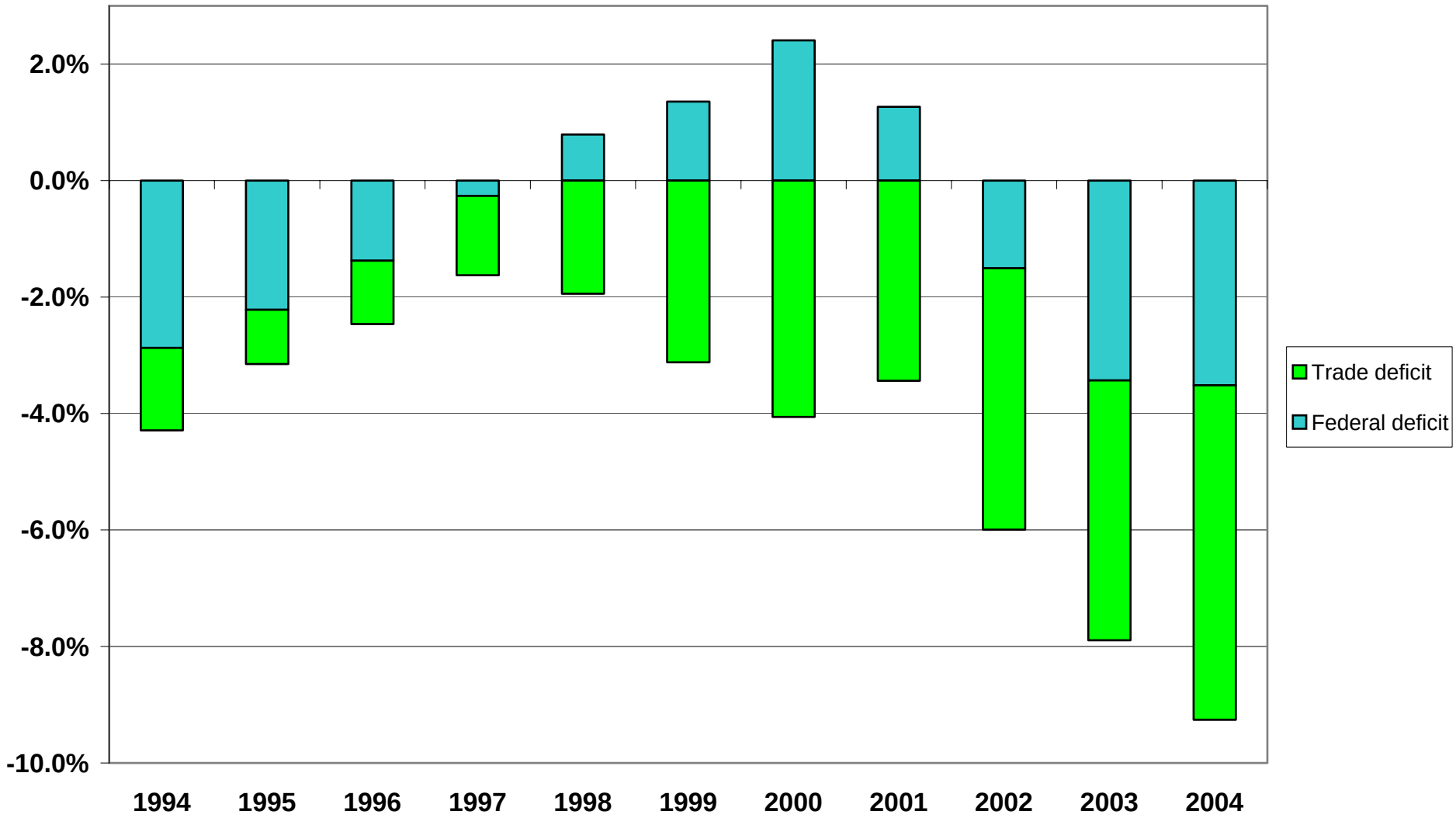
External Economic Influences

- **Reasons for optimism**
  - Entrepreneurial innovation of U.S. economy
  - Resilience and drive of market have been proven repeatedly
  - Even if U.S. living standards decline relative to other nations, they'll still be very high as measured in real income per American

External Economic Influences

- **Reasons for pessimism**
  - Living beyond our means
    - federal deficit approaching 4 percent of GDP
    - trade deficit approaching 6 percent of GDP
  - Low domestic savings → borrow from others, who might not lend in future
  - Tools to fight recessions—low big deficits and low interest rates—are being used aggressively during ostensibly good times

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



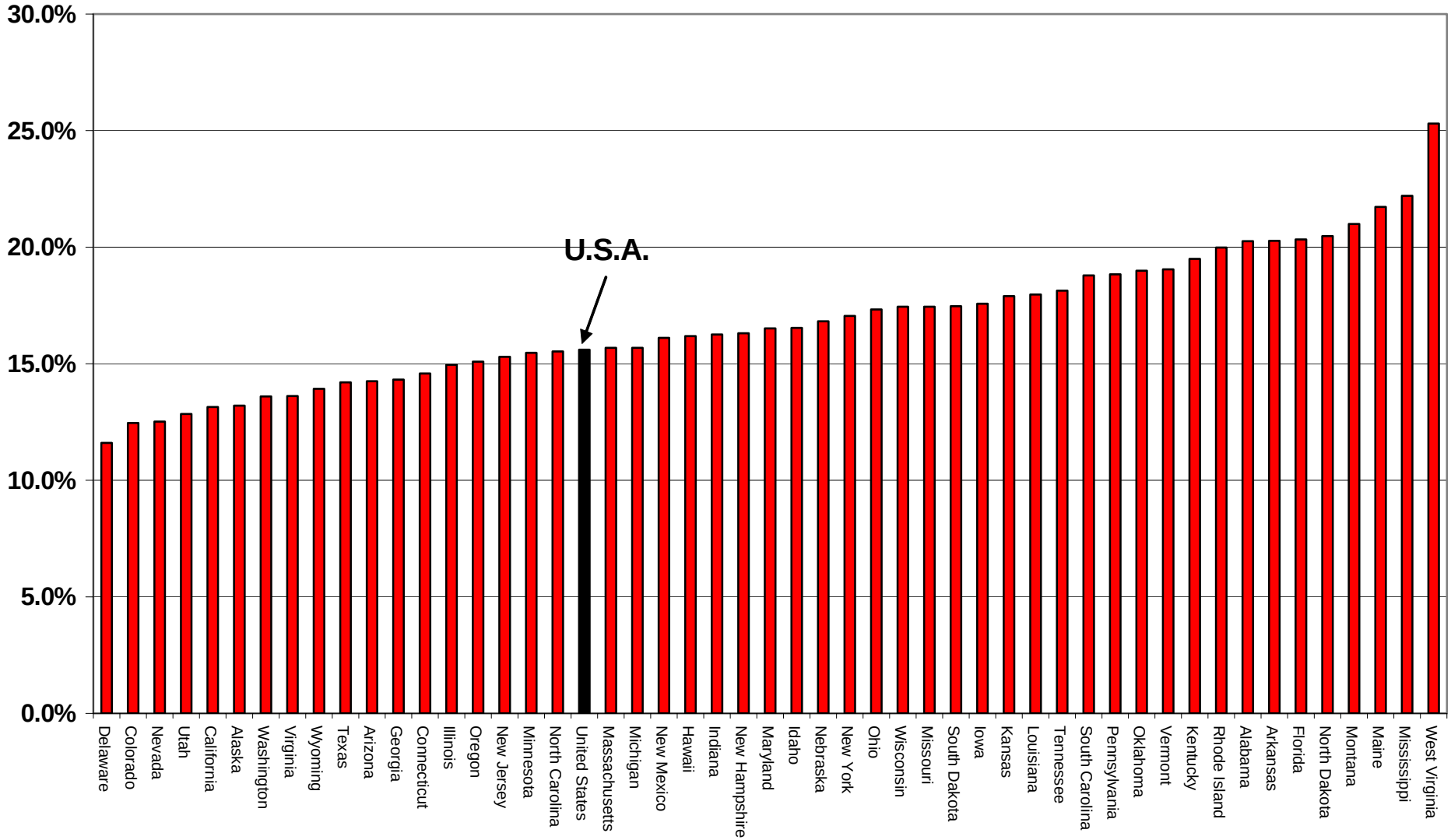
5. Pressure points

- By state—spending and coverage differences
- Capacity to generate revenue—inter-payer differences
- By sector—which areas of health care are most vulnerable?

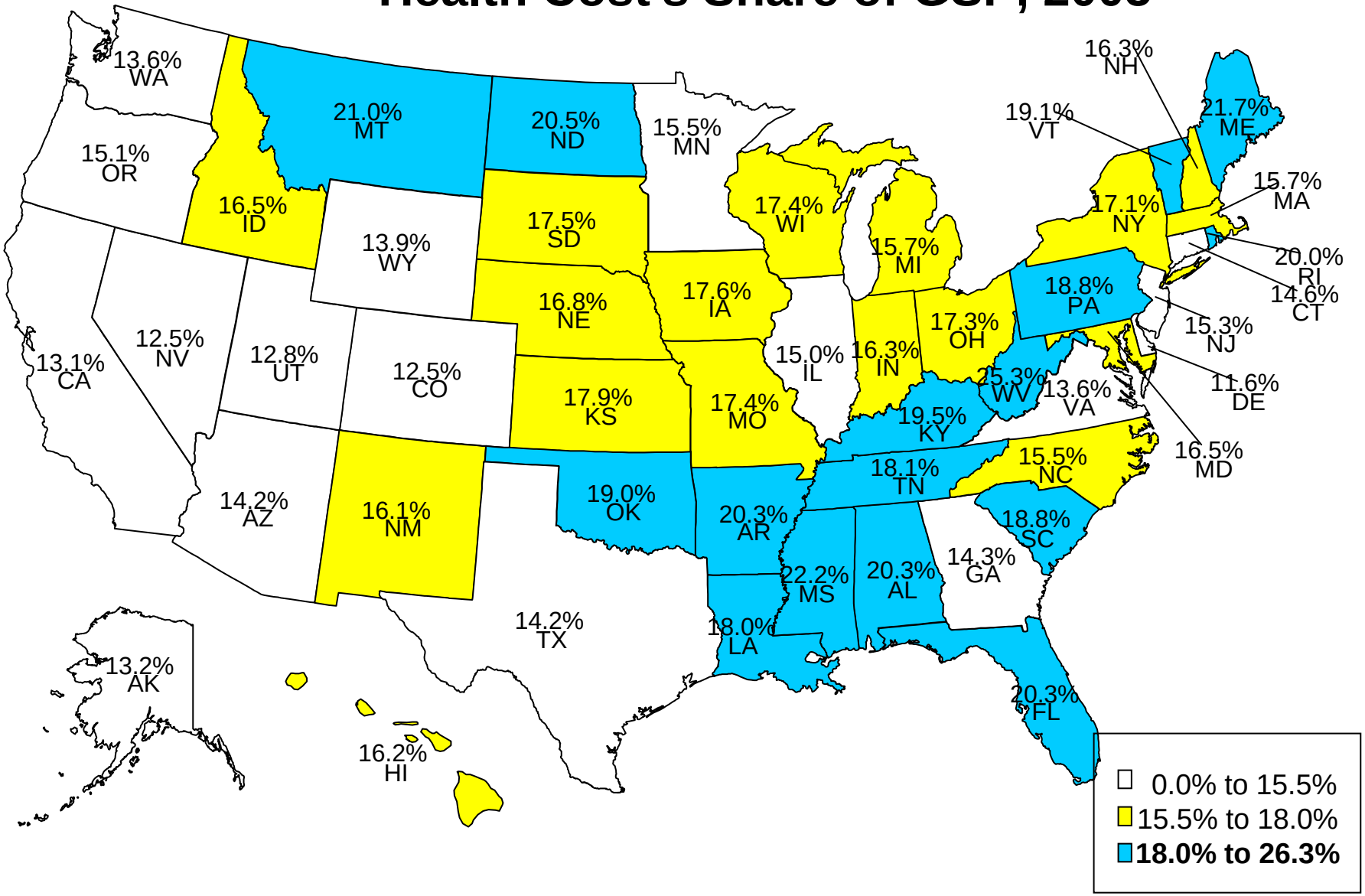
- Anticipating pressure, threats, and preparing to respond—jobs of caregivers, payers, governments

Which states are likelier to experience greater difficulty in sustaining their health care?

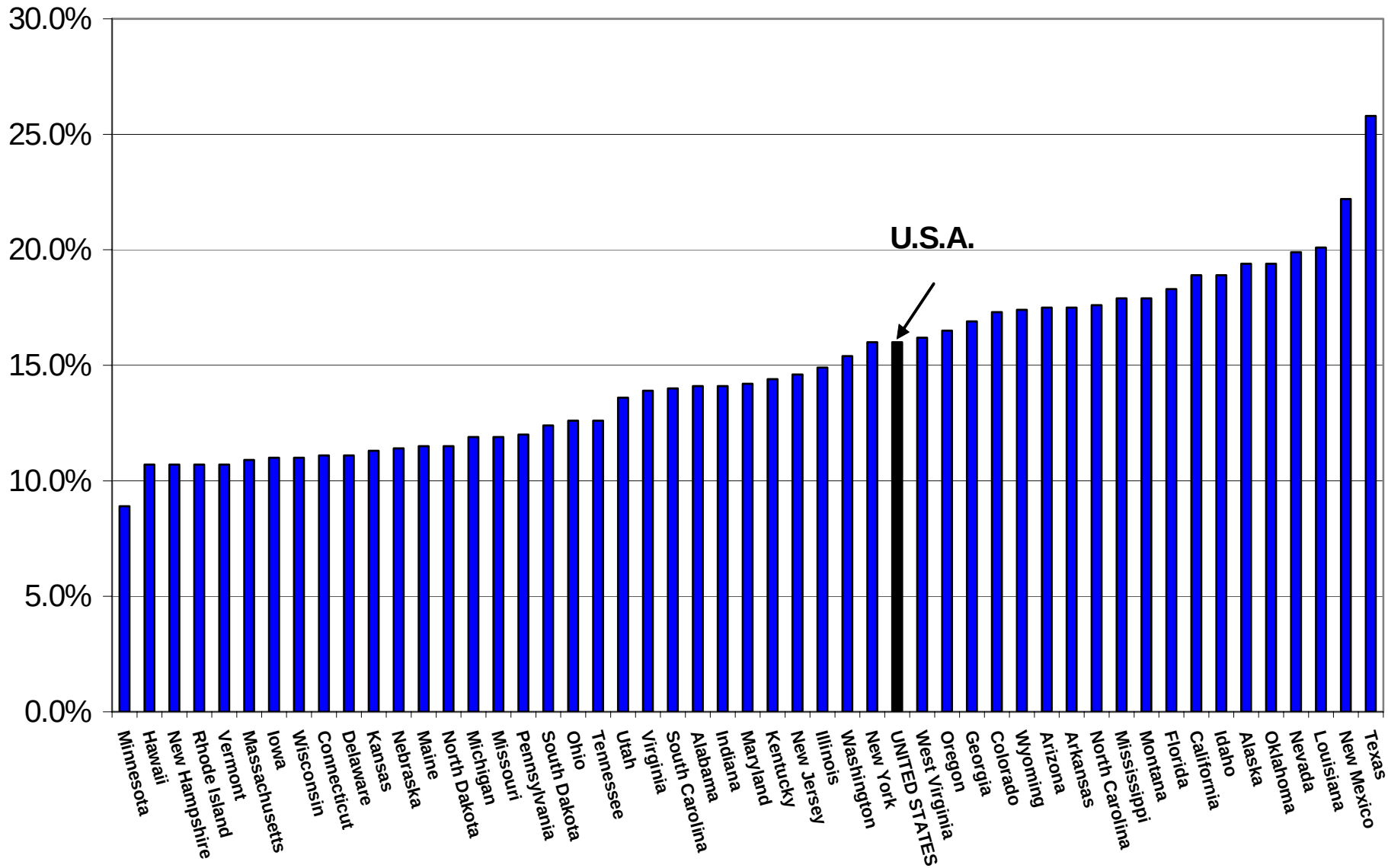
Health Cost's Share of Each State's Economy, 2005



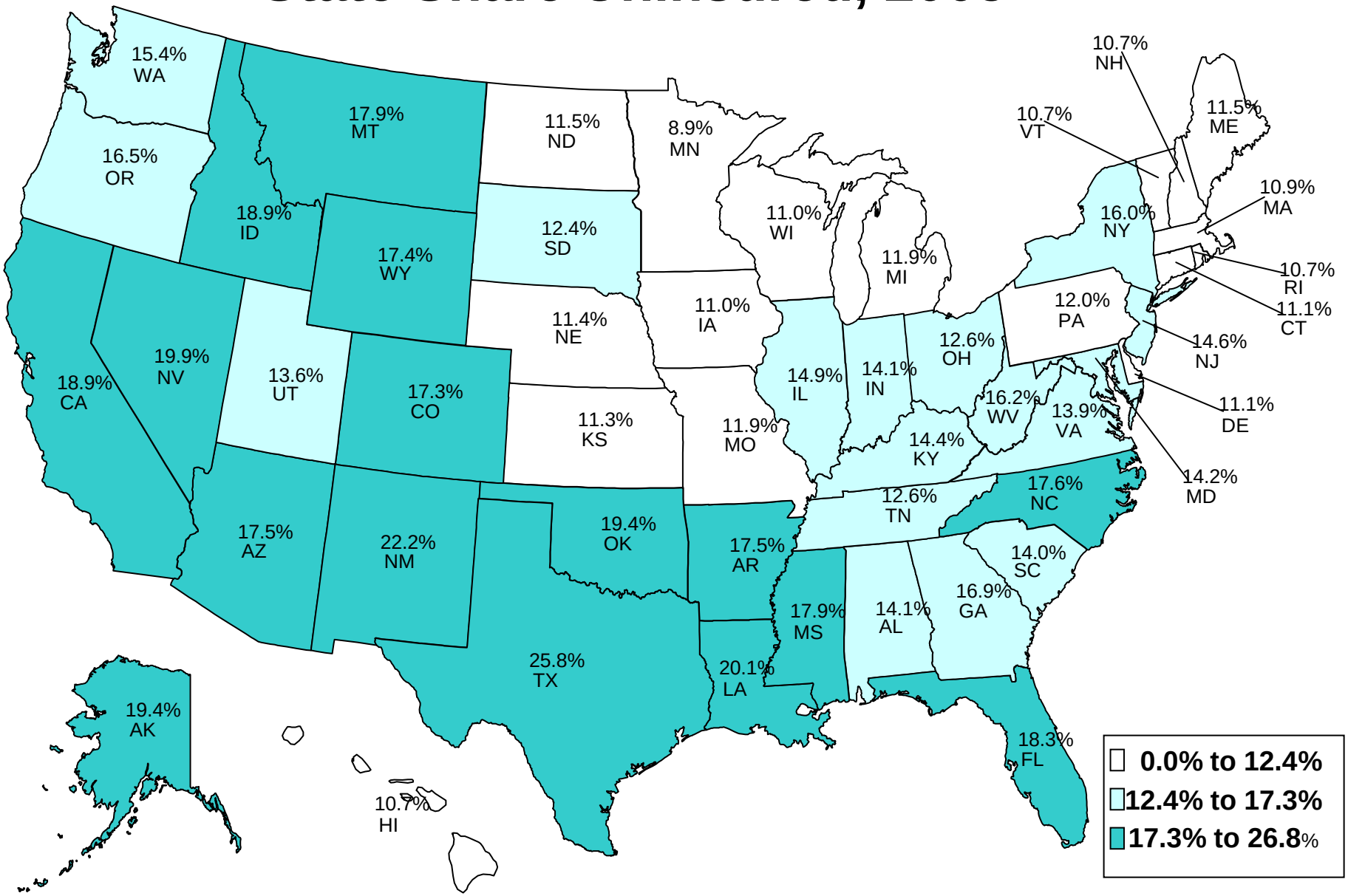
Health Cost's Share of GSP, 2005



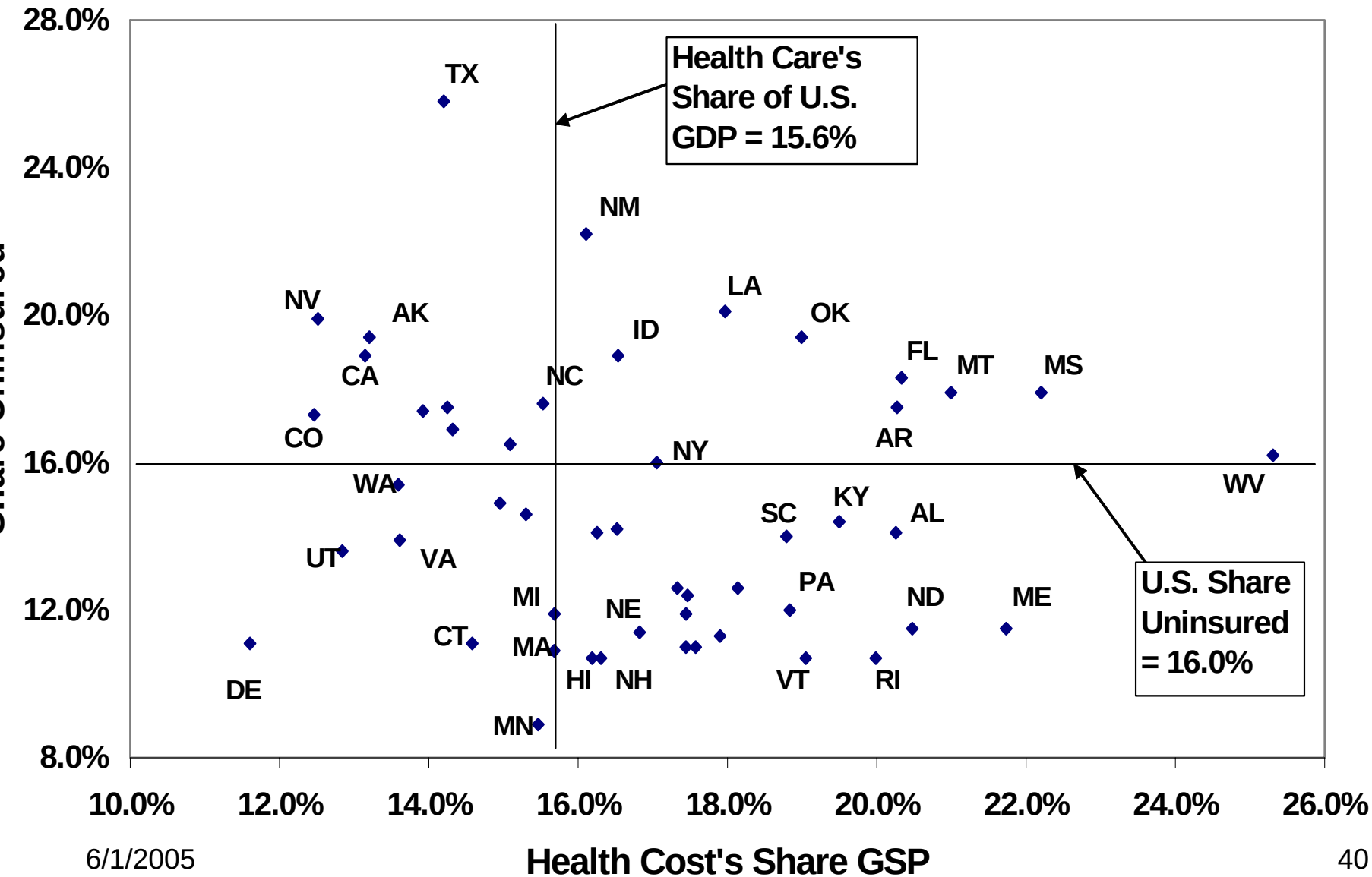
Share of People Uninsured, 2005



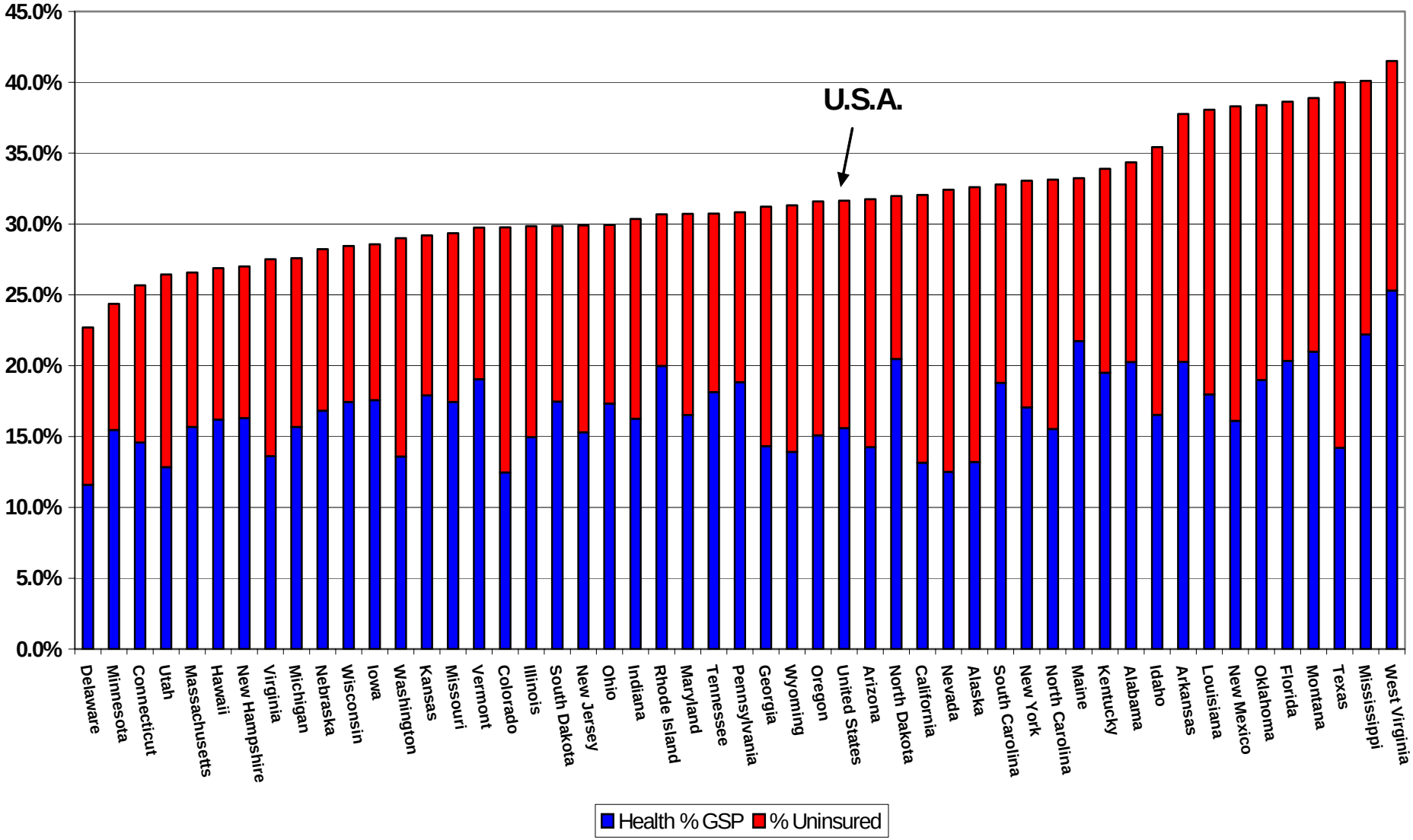
State Share Uninsured, 2005



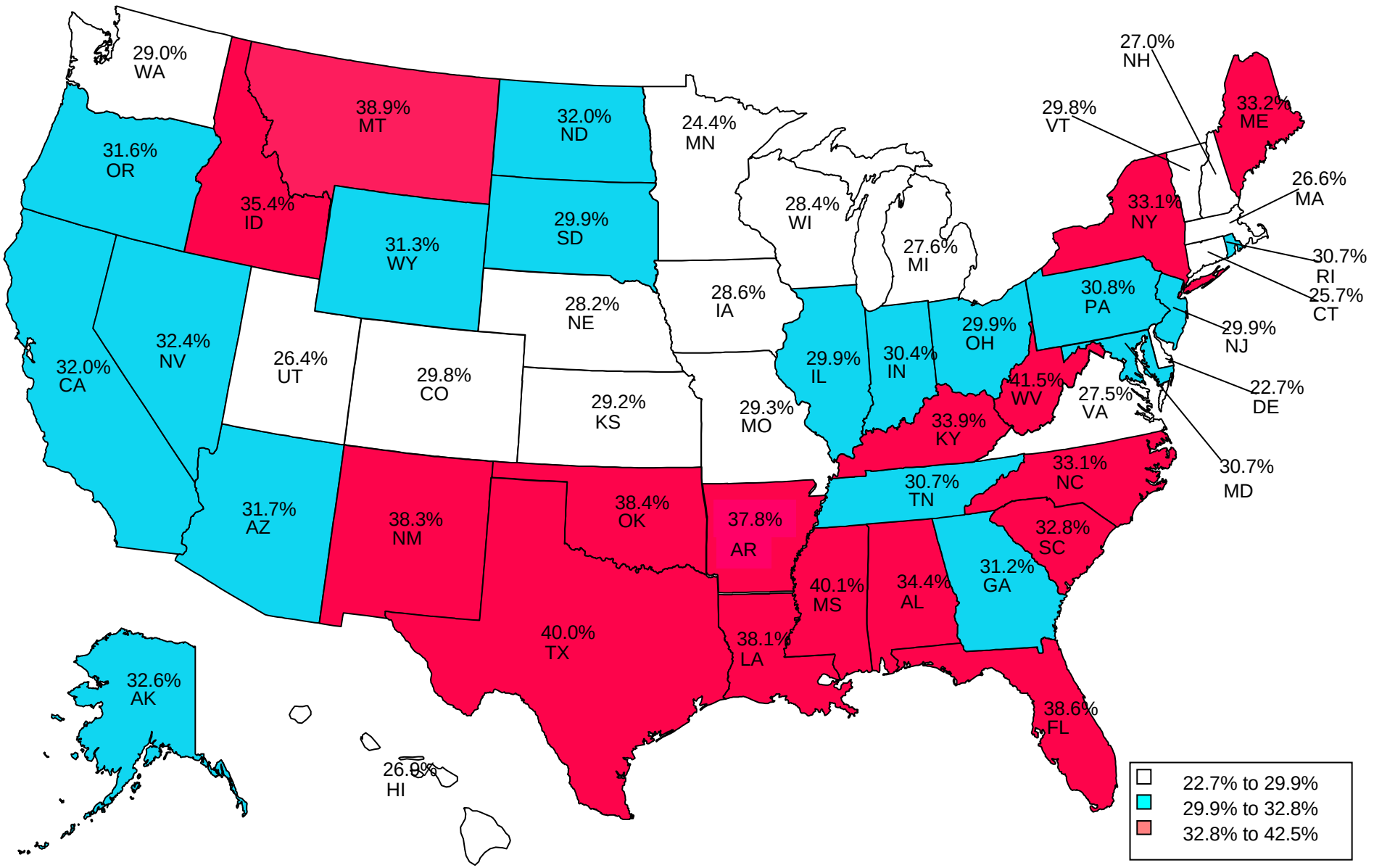
Health Cost Share of GSP By Share Uninsured, 2005



State Health Crisis Index, 2005, Ranked



State Health Cost Share of GSP + Share Uninsured, 2005



Which payers are likelier to find it hard to sustain their payments for health care?

Where the money comes from—

Sources of revenue to finance U.S. health care, 2005

Source of revenue	$ billion	% of revenue
Medicare	$332	17%
Federal Medicaid	182	9%
State Medicaid	135	7%
Private insurance	691	36%
Out-of-pocket	262	14%
Other public + private	336	17%
Total	$1,936	100.0%

Will some payers face greater pressures to slow growth in revenue?

- Whether the U.S. economy thrives or not, payers are experiencing varying levels of difficulty in generating increased revenues to finance health care. Consider
  - Federal worries about Medicare costs
  - Missouri's recent vote to eliminate its Medicaid program in 2008
  - Cities' and towns' difficulties in finding dollars for employees' health insurance
  - General Motors' $5 billion yearly obligation for workers' and retirees' health care

If payers are forced to economize, will they directly address patients or caregivers?

Patients

- Reduce eligibility, the number of people they cover?
- Raise employee/member/beneficiary share of premium?
- Raise out-of-pocket costs?
- Cease to cover certain services?

Caregivers—Reduce rates (DRG's, MD fees, nursing home or drug prices)?

Transmission of cuts from patients to caregivers

Hit to patient	Transmission to caregiver
Cut eligibility	Fewer paying customers → volume drops → particular harm to caregivers with higher fixed costs
Raise patient premium share	Patients drop coverage, fewer paying customers
Raise OOPs	Some patients cease seeking care, others fail to pay OOP to caregiver

Cuts, transmission, responses

Mode of cut	Transmission to caregivers	Caregivers' responses
Cut coverage	Lower volume	Raise price? Market to insured? Bankruptcy?
Higher OOPs	Lower volume + risk of lower revenue	Aggressive collections?
Cut specific service	Lower volume	Cease providing?
Fee cuts	Lower price	More efficient? Bankruptcy?

Which types of health care are likelier to face greater threats to sustaining care to patients and garnering adequate revenue?

Where the money goes—
Personal Health Spending by Type of Care, 2005

Category	$ billion	share of health $
Hospital care	**$589**	**30%**
Physician + related services	**426**	**22%**
Nursing home + home health	**171**	**9%**
Prescription drugs	**224**	**12%**
All other personal health care	**254**	**13%**
Personal health care subtotal	**$1,664**	**86%**

Which sectors will face greater stresses?

- This will depend partly on which sources of revenue are likelier to be squeezed. Broad Medicaid cuts, for example, are likeliest to crimp LTC spending.
- Sectors
  - Hospital
  - MD
  - LTC
  - Rx

- Sector-specific solutions—

(NYS Rx buying power vs. nations!)

New York State Pressure Points and Opportunities

- High personal health spending
  - Second-highest per person
  - Second-highest total, about 1/12 of U.S.
- But median income slightly below average
- Medicaid paid 31% personal health spending (1998), highest in nation, versus U.S. average of 16%
- Second-highest MDs/population, with very high share specialists; maldistribution
- 21 percent above U.S. acute beds/1,000 people (3.4 versus 2.8) but very hard to save by closing beds
- Rx spending (2004) was $19.5 billion → save $4.6 billion by paying Federal Supply Schedule prices

A few New York State realities

	NY	US	NY % US	NY rank
Health $ 2005	$156 B	$1.9T	---	---
Health $/person 2005	$8,100	$6,477	+25%	2
Health % economy 2005	17.1%	15.6%	+10%	23
Medicaid % personal hlth $ 1998	31%	16%	+94%	1
Hospital $/person 2003	$2,081	$1,548	+34%	3
Hospital operating margin ’03	-0.9%	3.7%	---	50
Hospital beds/1,000 2002	3.4	2.8	+21%	15
Patient care MDs/1,000 ’02	3.25	2.25	+45%	2
Mean retail Rx price 2002	$63.93	$54.58	+17%	3
% of people in HMOs 2004	30.4%	23.7%	+28%	7
% lacking insurance 2002-03	15.4%	15.4%	---	20

Health Care's Capacity to Respond to a 5% Drop in Real GDP

- A substantial (5%) drop in real GDP, whether gradual or sudden—or even a freeze—would boost pressure to slow the rise in health spending, or even to cut spending.
- In response to this pressure, physicians and hospitals might react flexibly and successfully to protect themselves and their patients. Or they might not.

QUESTION: How do you assess physicians' and hospitals' current abilities to react to a 5% drop in real health spending?

- **A** = high current ability to react in ways that minimize harm to all patients and to caregivers themselves

B – C – D

- **E** = low current ability to minimize harm to all patients and to caregivers themselves

Precedents for anticipating or preparing caregiver responses

- What did hospitals and doctors do during the Depression of the 1930s?
- What did Medicare-dependent home health agencies and short-term nursing homes do after implementation of cuts from Balanced Budget Act of 1997?
- What have under-financed hospitals been doing in recent decades?
- How did Canadian hospitals and physicians respond to the revenue freezes and cuts of the 1990s?
- Which caregivers survive tight revenue?
- Consequences of caregiver responses for patients and for stability of U.S. health care?

C. CAUSES OF PROBLEMS

1. Economy
2. Revenue sources
3. Costs
4. Coverage
5. Caregiver configuration
6. Failure to prepare

1. Causes of economic problems

- Political stability in much of Asia + openness to investment → flight of U.S. capital, technology, jobs. Will they ever return? How?
- Dollar's power = other nations have long let us live beyond our means—can they safely cease doing so?
  - U.S. 2005 apparently plays worldwide borrowing/ demand-boosting role of Germany in 1925
  - We borrow to buy. Others pretend we'll be able to repay them. Do Chinese and others need strong dollar to keep exporting here? For how long? What if they pull the plug? Will a deep drop in dollar's value hike imports' prices, badly slicing real incomes here?
  - How to break this financial addiction in ways that give the U.S. economy a soft landing?
- Hollowing out of U.S. economy, movement toward a virtual economy?
  - Consequences for U.S. employment, economic growth, real income, and income inequality?
- How to maintain U.S. political stability (essential to continued borrowing) while economy hollows out, income inequality grows, and real incomes drop for many?
  - Game Boys and Toyotas = bread and circuses?
  - If U.S. real incomes grow absolutely even if drop relative to industrializing world, U.S. political stability would be enhanced.

2. Causes of constricting revenue

- Arise from economic problems + rising health costs themselves
- Health absorbing unaffordable shares of local + state government revenues, and revenues of many businesses with older workers
- Hospitals, doctors, drug makers, HMOs don’t see or don’t want to see the gathering storm

3. Causes of high health costs

QUESTION: Which of these possible sources of recent/future increases in U.S. health costs do you think is the most salient?

A Aging population

B New technology boosts outcomes but *inevitably* costs more; demanding patients

C Legacy of open-ended health care spending + stark failure of almost all cost controls

- badly designed cost controls or weak political will to enforce them?

D Waste

E Efforts to boost coverage

A. Share of U.S. population over 65

- 9.2% in 1960
- 12.4% in 2000
- 20.0% in 2030

- But most wealthy European nations now have elderly population shares that approach the level the U.S. will reach in 2030. And they now spend about one-half as much per person as we do.

B. New technology boosts outcomes but *inevitably* costs more

- YES: Implantable defibrillators, left-ventricular assist devices, better stents, better anesthetics, and better meds all cost more—and they're worth it. And sovereign consumers demand more.
- NO: If we rewarded cost-reducing technologies generously, they could cut cost in health care, as they do elsewhere in the economy.
  - How about a Nobel prize for something much cheaper (and just as good) as an existing technology?
  - How about a very big prize for an Alzheimer's drug that really works (and slashes nursing home costs)?

C. Legacy of open-ended financing and failure of cost controls

- 1945-1972: most people thought that higher health spending was a very good idea. Hospitals and physicians got used to blank check financing.
- Post-1973, caregivers haven't cheerfully accepted either market or regulatory spending restraints.
  - Caregivers have successfully gamed most cost-cutting methods, though often with great effort.
  - Both physicians and hospitals have understandably gravitated toward more lucrative—and costly—patterns of specialized care—the most specialized in the world.
- Cost controls not politically popular—who gains?

Trapped by romantic memories

- Many doctors and hospitals are trapped in the blank-check glories of pre-1973 health care finance. They can't accept limits on their incomes and fight or game every cost control.
- Most big drug makers ("we know we're defying gravity") are trapped in a world-without-a-business-plan of reliance on garnering one-half of their world-wide incomes from 5 percent of the world's people (U.S.A.)
- Those who want to protect or expand coverage know that trade-offs are necessary, but most caregivers imagine—or publicly pretend—that more money for business as usual is a realistic option.

Let’s connect the neurons

- In other wealthy nations, everyone knows that spending more on health means spending less on other things
- There, caregivers have essentially adapted patterns of clinical services to the financial reality of finite revenue and the political reality of serving all people.
- Americans often pretend these two things are not necessary. This is delusional.

D. Waste—1/2 of health spending?

1. **Clinical**: unnecessary care, incompetent care
   - Sometimes financially motivated
   - Sometimes caused by defensive medicine
   - Sometimes owing to ignorance of efficacy or cost
2. **Administrative**
   - Owing to complexity
   - And <u>especially</u> owing to payers' mistrust of caregivers: death by a thousand paper cuts
3. **Excess prices**
   - Rx, supplies, some incomes
4. **Fraud, theft**
   - Light punishment, owing partly to delusion that stealing health dollars is a victimless crime: since financing is open-ended, we just need to boost revenue further

E. Efforts to boost coverage

- Important in 1960s, as Medicare and Medicaid raise spending rapidly
- Seldom important subsequently
  - Medicaid growth, for example, has tended to partly offset drop in private insurance
- New Medicare Rx benefit (Part D) may raise spending, if enough people enroll

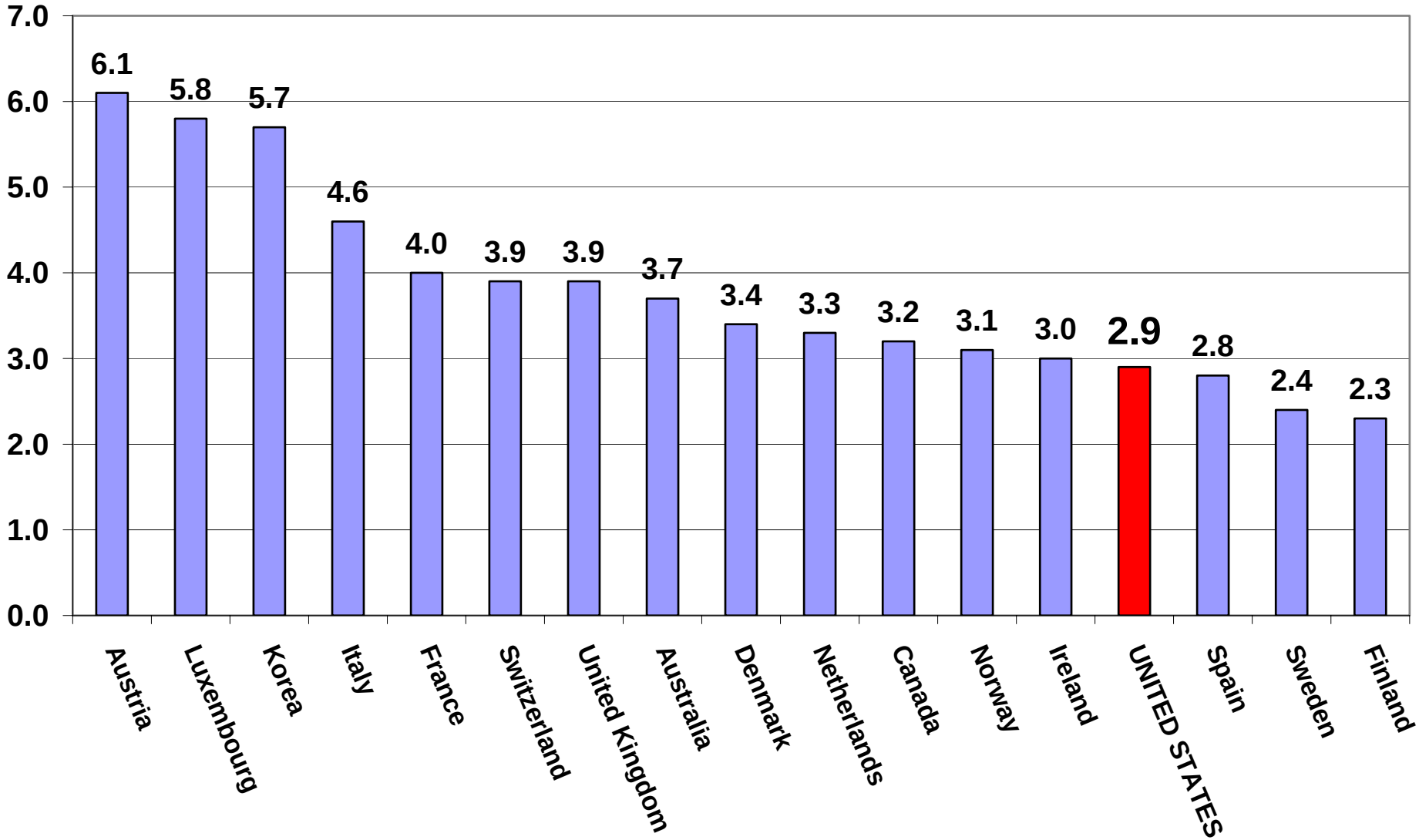
4. Causes of coverage problems

- Costs grew high before covering everyone
- Weak unions
- Regressive nature of insurance financing
- Racial, ethnic, geographic links to lack of coverage
- Others

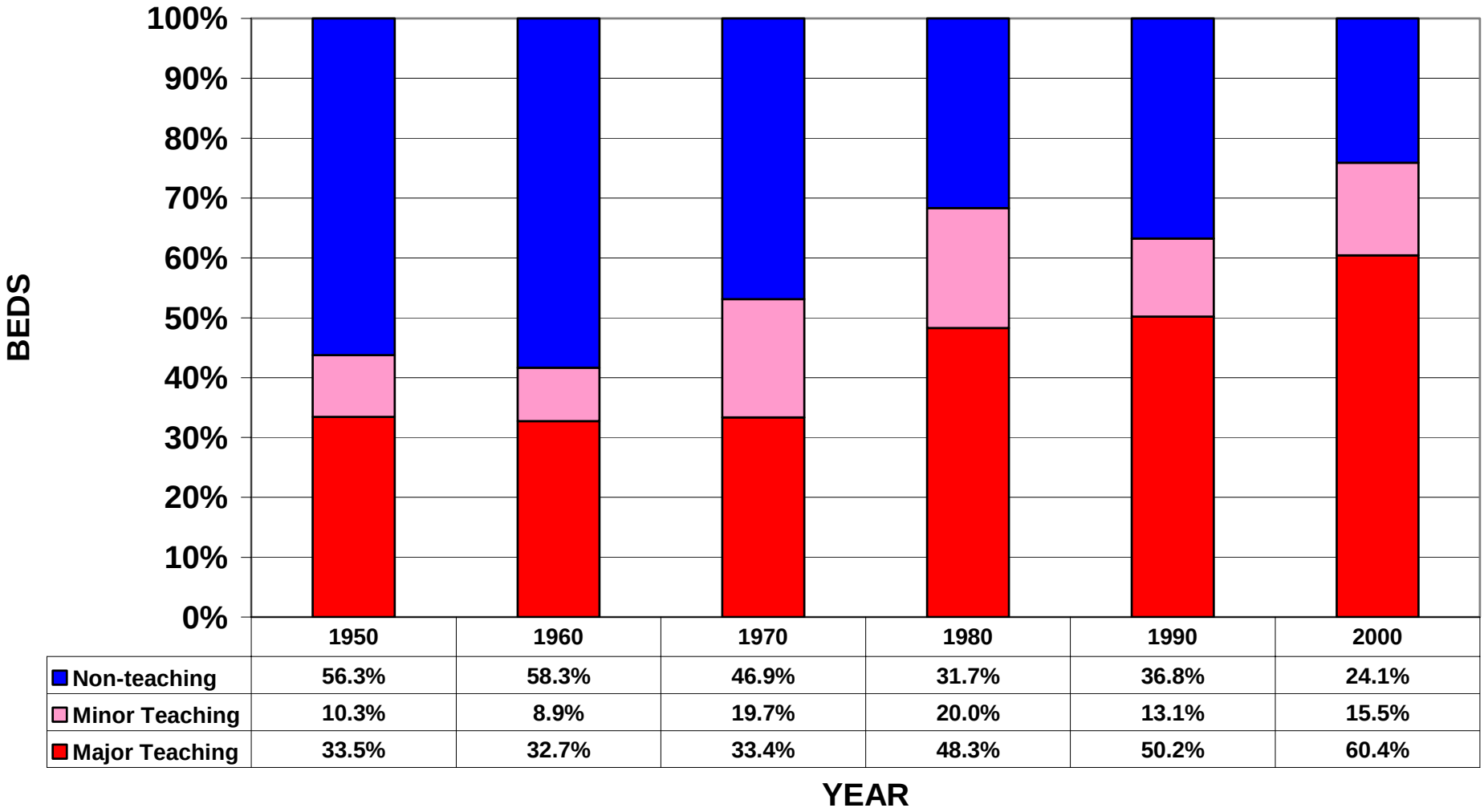
5. Causes of caregiver malconfiguration

- Specialization remains remunerative to MDs, hospitals
- Teaching hospitals disproportionately survive—have salaried MDs, more profitable payer mix, money in bank, political connections
- Teaching hospitals need specialized residents—especially in face of cut in hours
- Little public, planned pressure for balance
- Little public support to protect needed caregivers

Acute Beds/1,000 Citizens, Wealthy Nations, 2000-2002

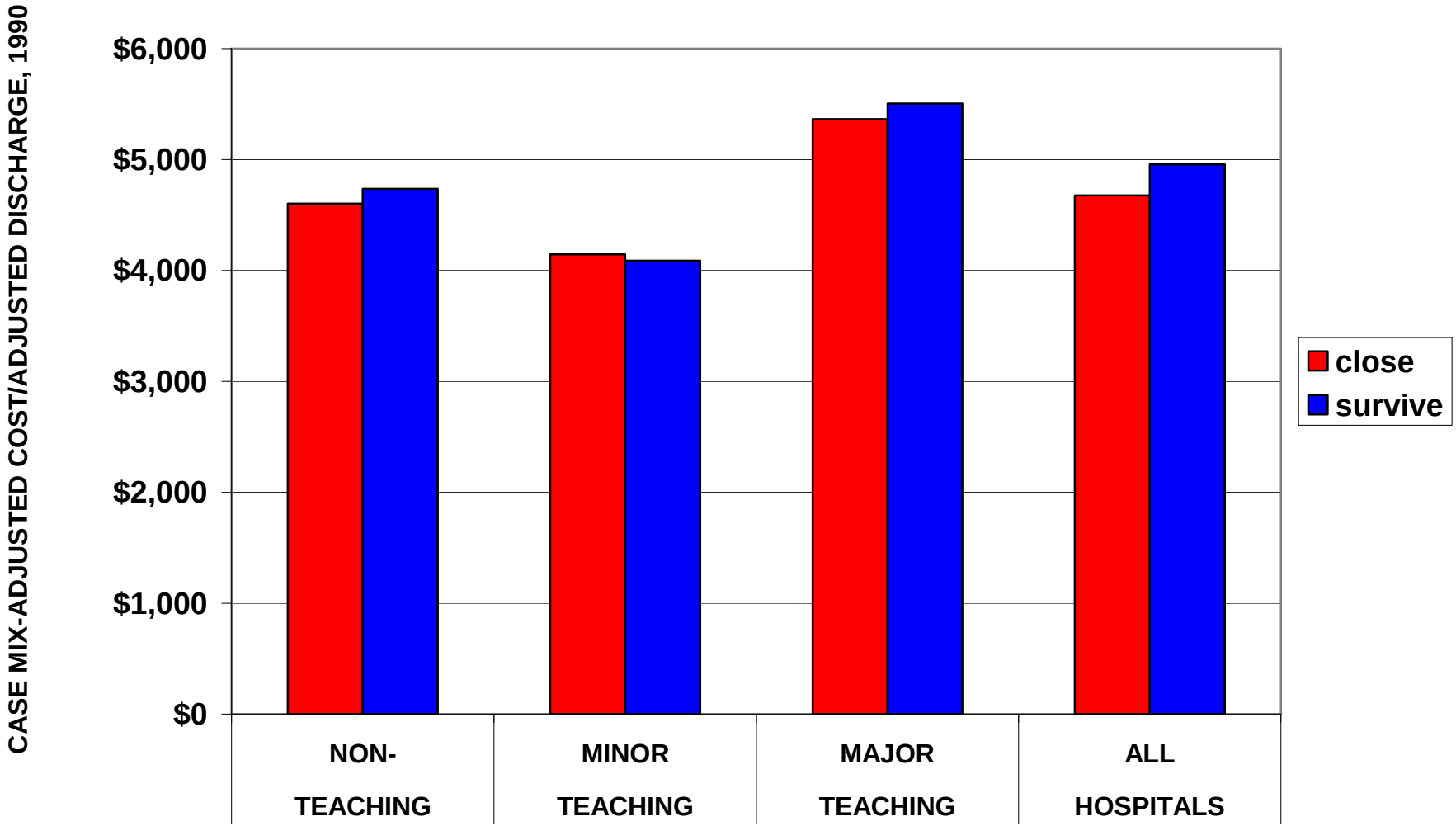


SHARE OF BEDS BY TEACHING STATUS, 51 CITIES, 1950-2000

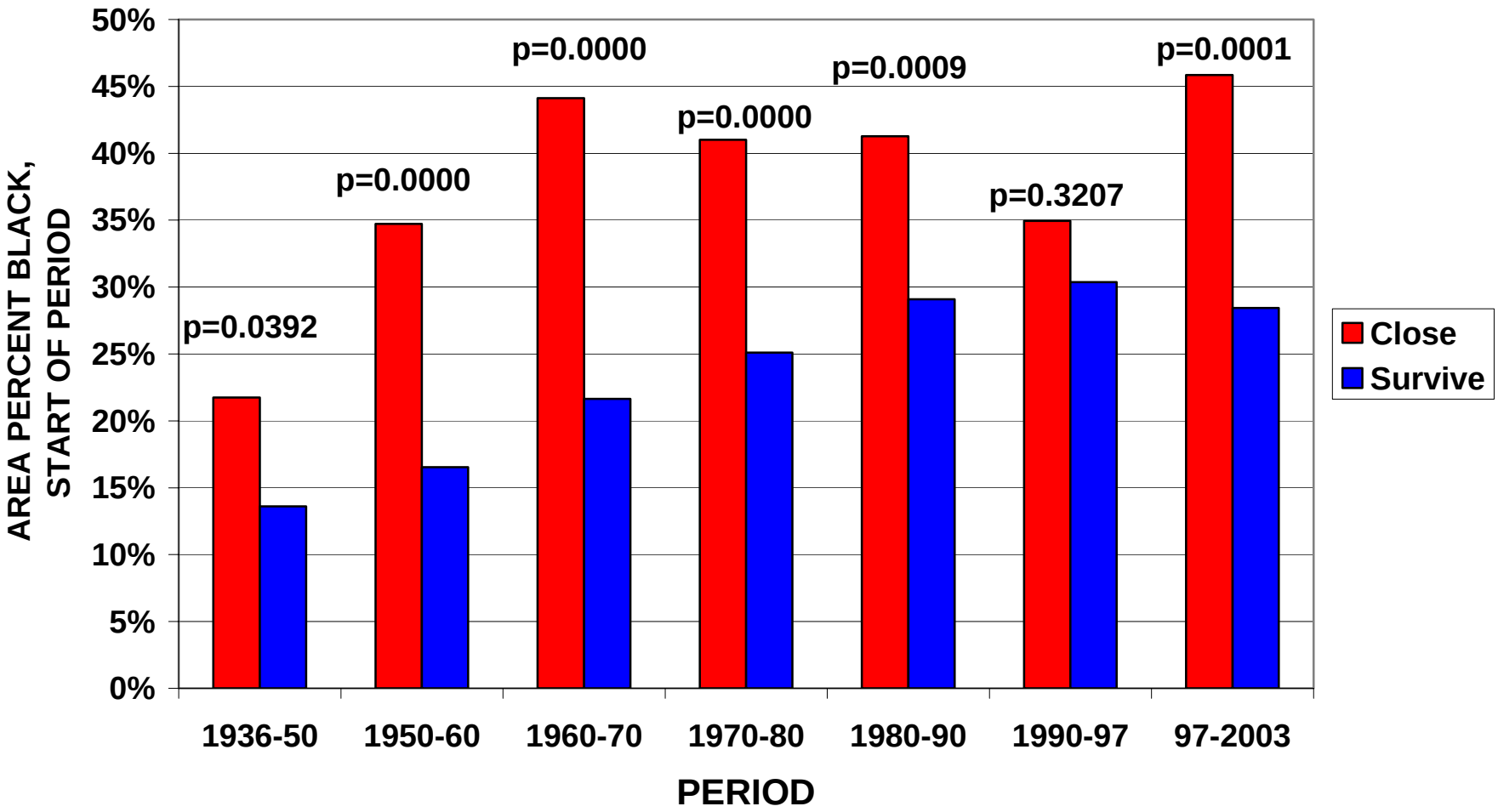


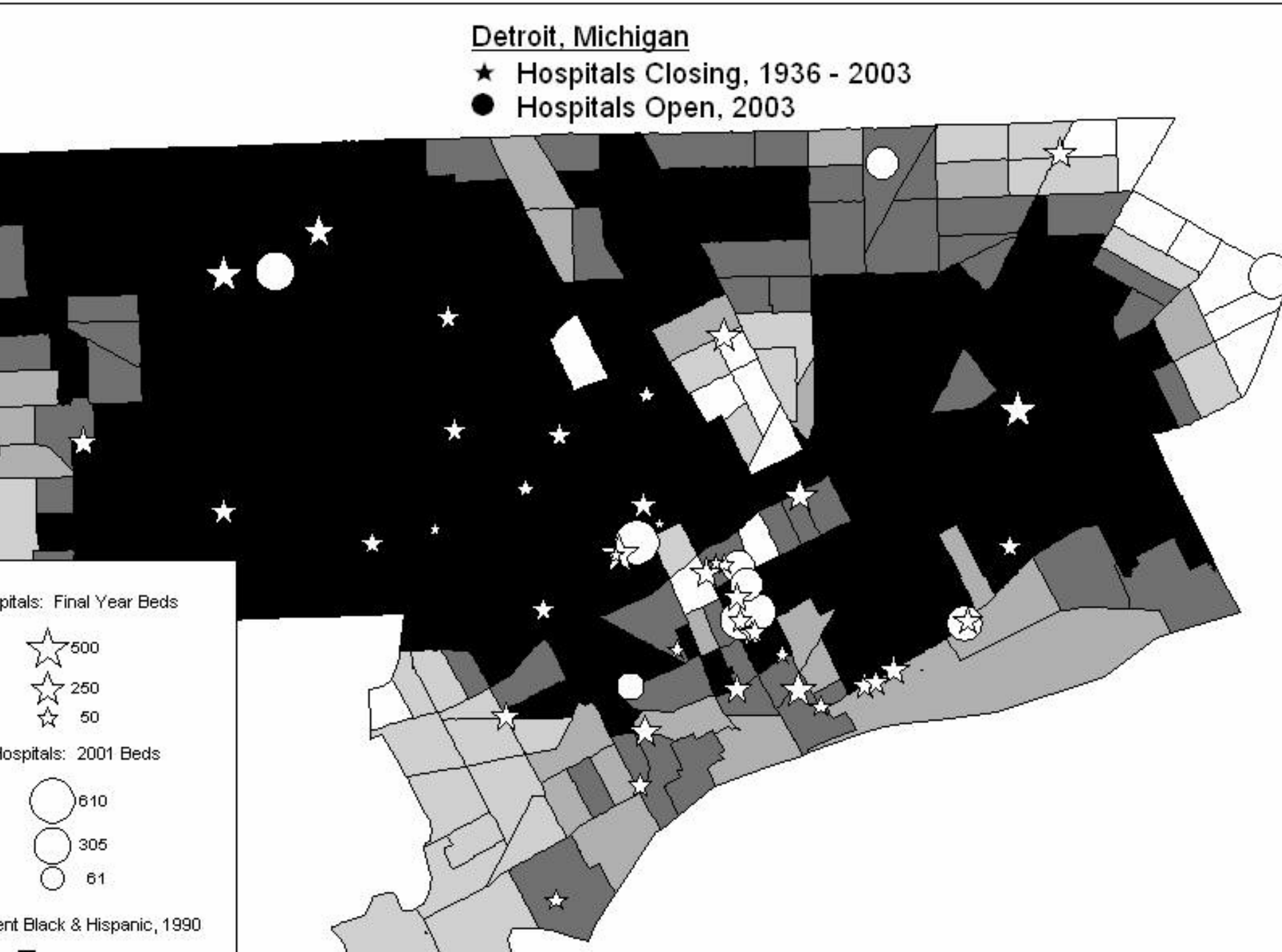
	1950	1960	1970	1980	1990	2000
Non-teaching	56.3%	58.3%	46.9%	31.7%	36.8%	24.1%
Minor Teaching	10.3%	8.9%	19.7%	20.0%	13.1%	15.5%
Major Teaching	33.5%	32.7%	33.4%	48.3%	50.2%	60.4%

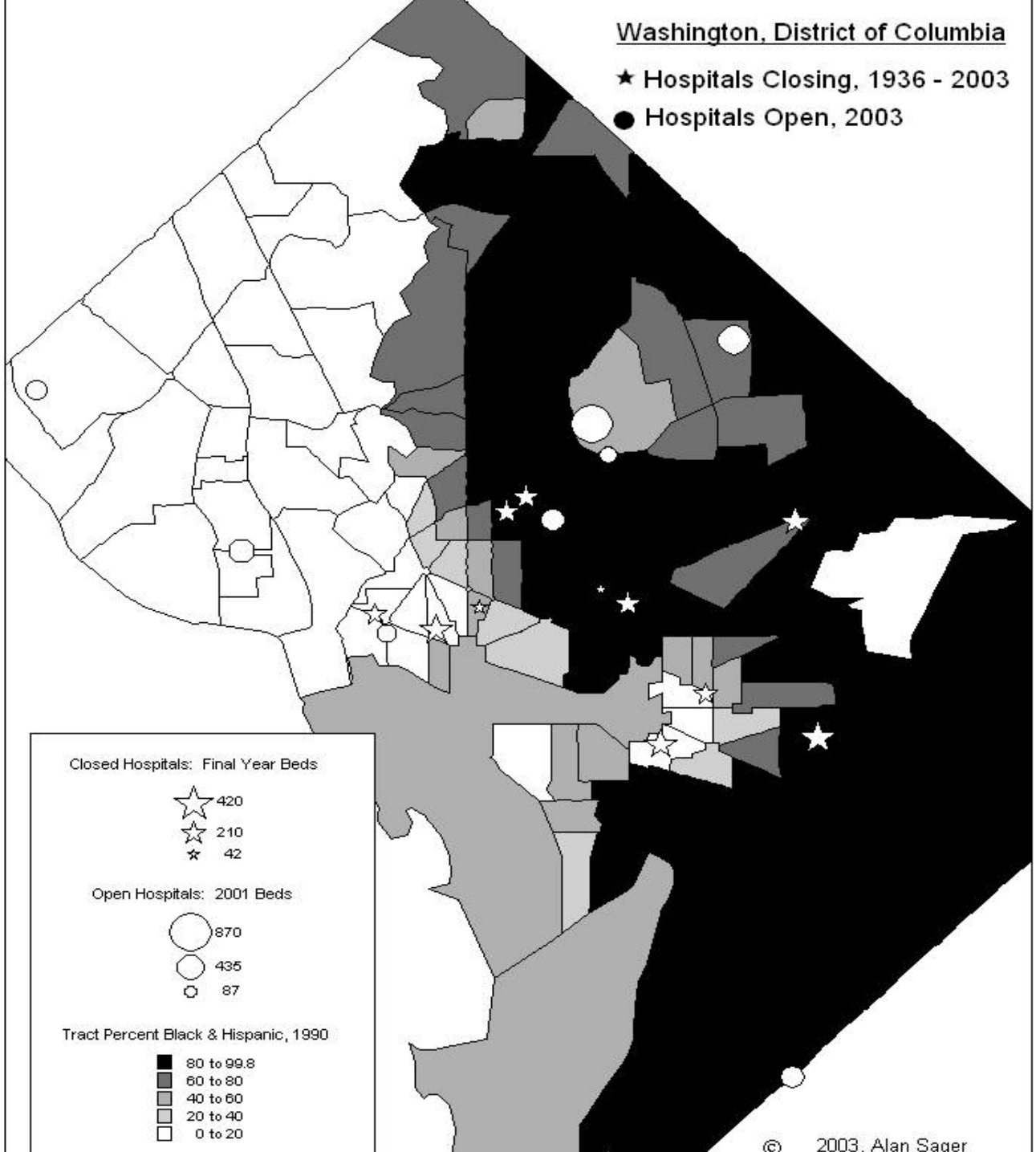
EFFICIENCY OF CLOSED AND SURVIVING HOSPITALS, BY TEACHING STATUS, 1990-2003



AREA PERCENT BLACK, NON-PROFIT HOSPITALS CLOSING AND SURVIVING, 1936 - 2003



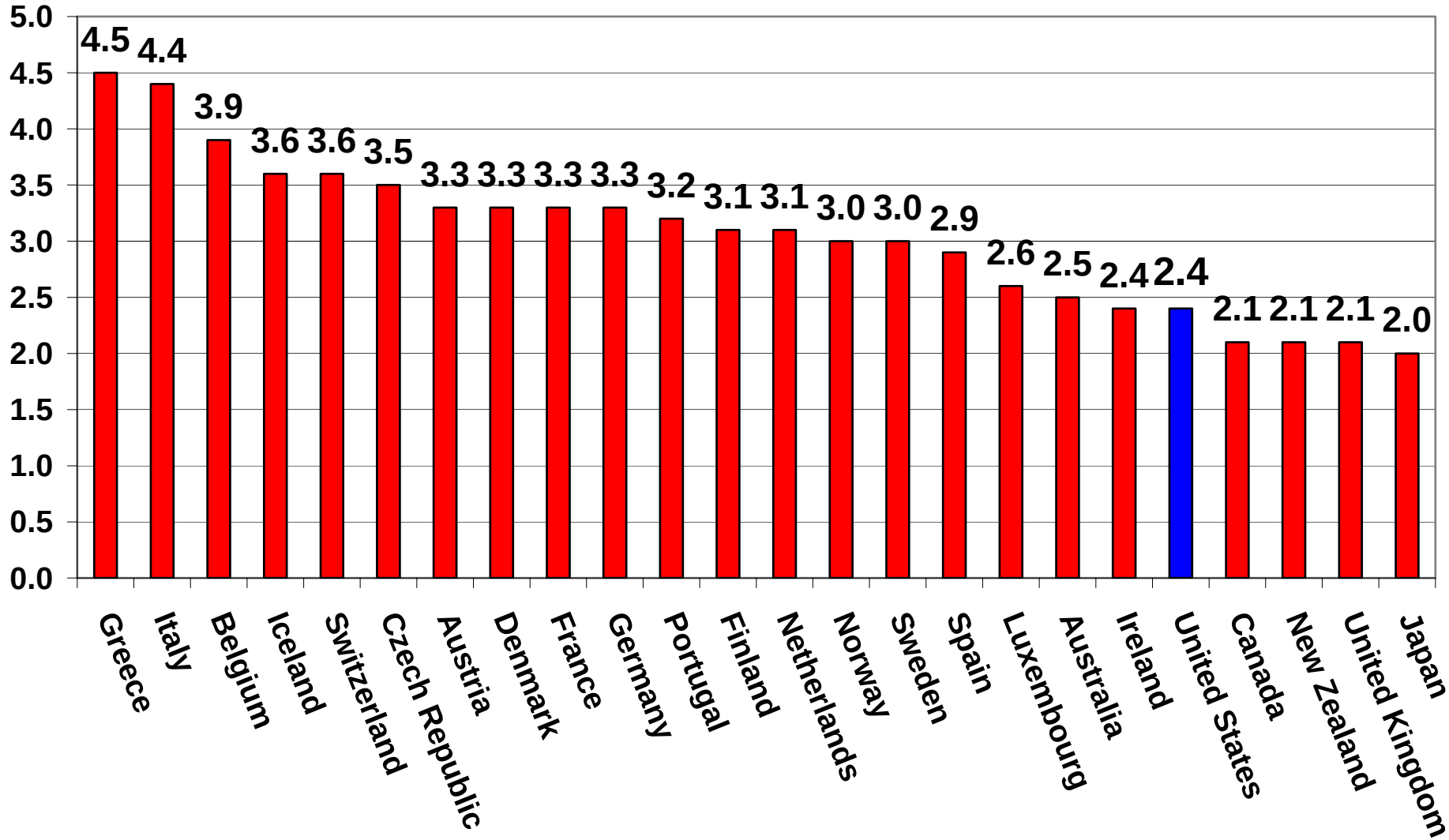

Detroit, Michigan
Hospitals Closing, 1936 - 2003
Hospitals Open, 2003
pitals: Final Year Beds
500
250
50
lospitals: 2001 Beds
610
305
61
ent Black & Hispanic, 1990


Washington, District of Columbia
★ Hospitals Closing, 1936 - 2003
● Hospitals Open, 2003
Closed Hospitals: Final Year Beds
420
210
42
Open Hospitals: 2001 Beds
870
435
87
Tract Percent Black & Hispanic, 1990
80 to 99.8
60 to 80
40 to 60
20 to 40
0 to 20
© 2003, Alan Sager

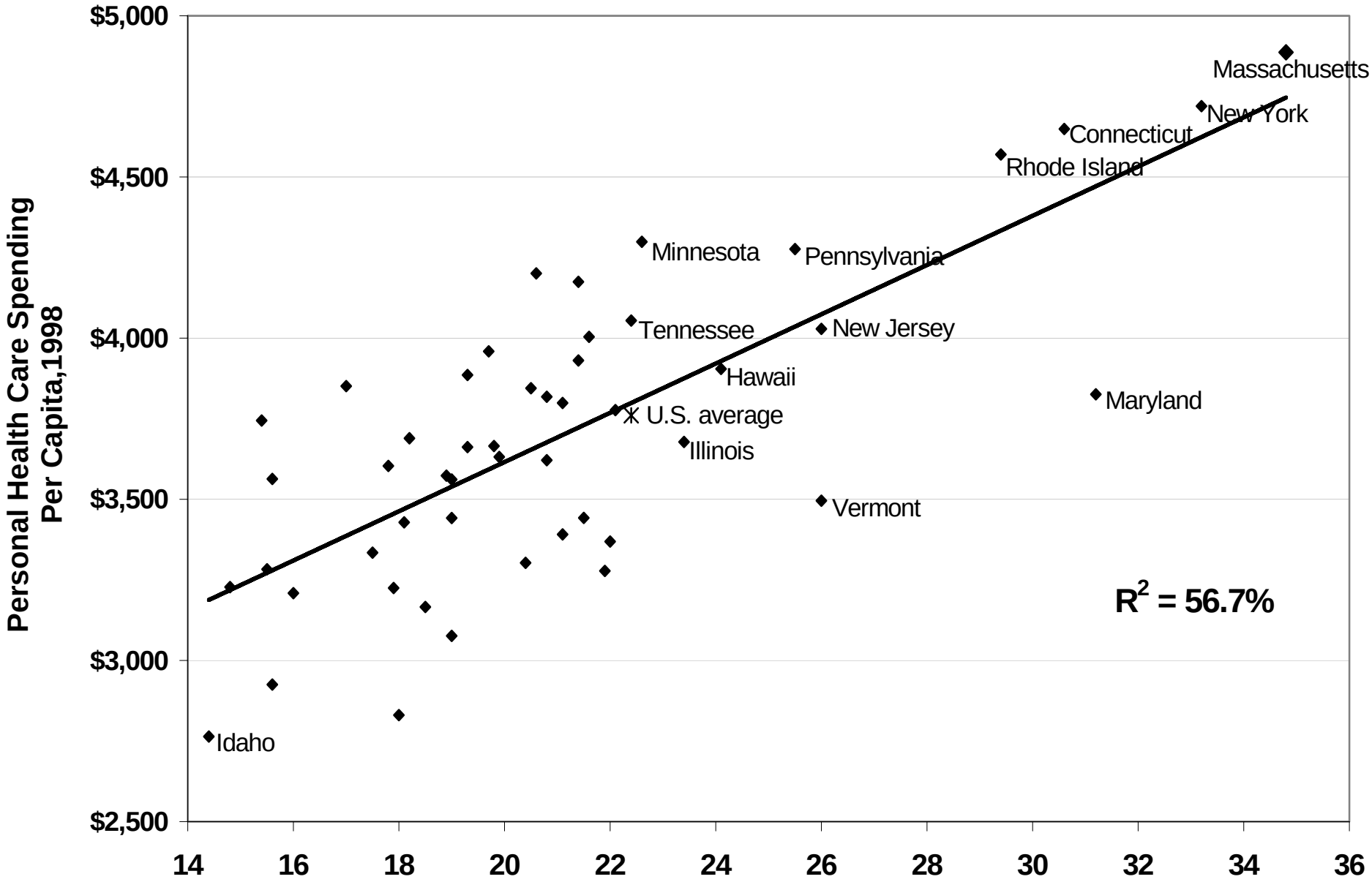
WHAT PREDICTS MAJOR LEAGUE BASEBALL TEAM RELOCATIONS, 1950 – 1970?

- Race of residents living nearby
- Not attendance
- Not place in standings
- Not age of stadium

Active Physicians per 1,000 People, 2002



Physician Supply and Health Spending by State



6. Causes of failures to prepare

- Caregivers
  - Too busy demanding more money for business as usual, gaming revenue, marketing to attract more patients.
  - Not my job
  - It's scary to think about drops in real spending
  - Nothing I can do now will affect my chances of weathering the storm—except, perhaps, boosting my margin through marketing and through streamlining caregiving
- Payers
  - Too busy trying to save money
  - Not my job
- Government: Belief that larger market will keep economy strong, and that health care market's survival of fittest governs caregivers' future

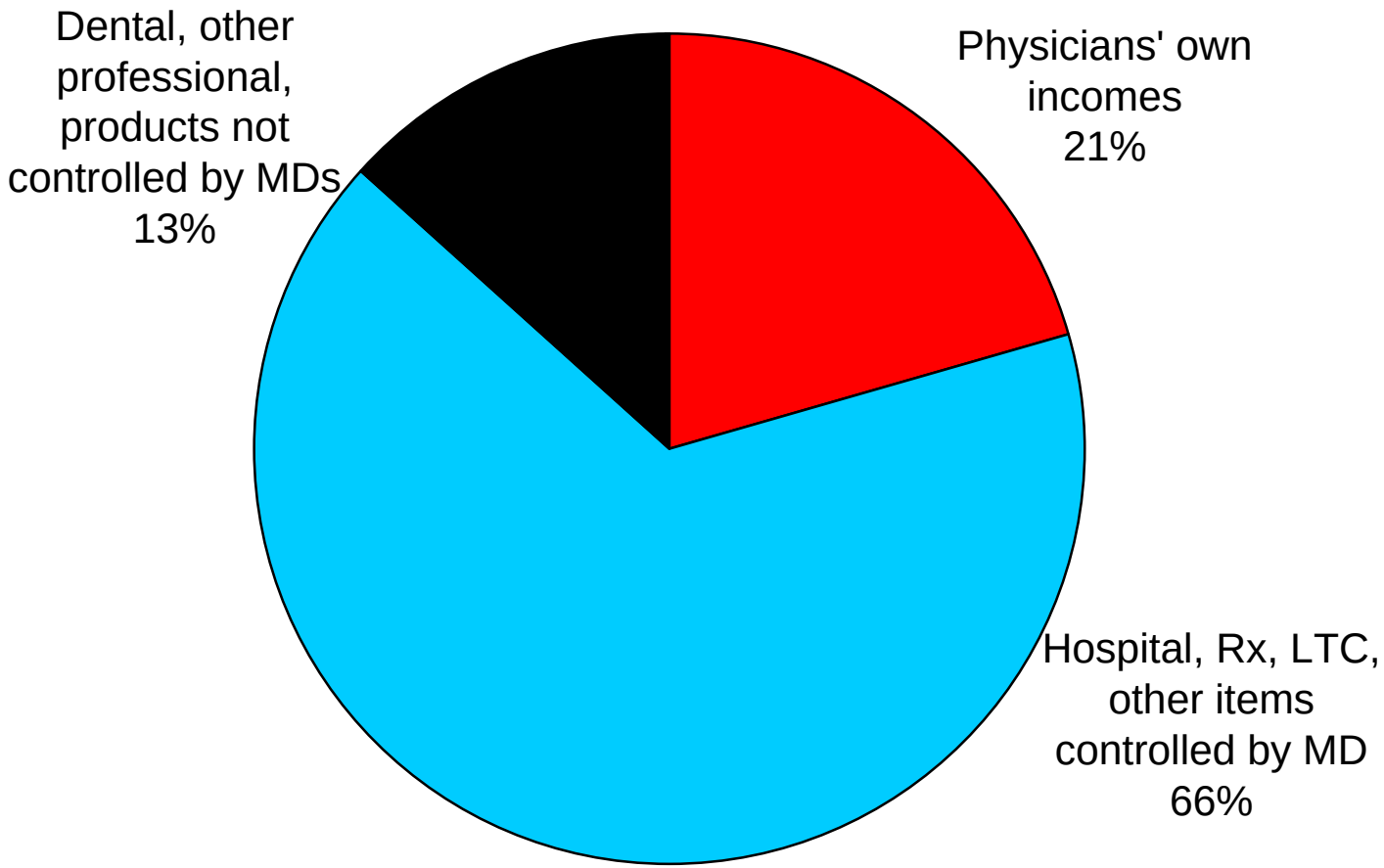
D. SOLUTIONS THAT ADDRESS CAUSES

1. Costs
2. Coverage
3. Caregiver configuration

1. Containing Costs

- Physicians role in cutting waste is essential
- A broad political deal must be translated into legislation, whose elements are tested in advance
  - If doctors agree to spend finite, budgeted money responsibly and stretch the dollars to cover finite enrolled patients,
  - Then we will cut 90 percent of all financial paperwork and 100 percent of the threat of malpractice suits
- Sustained commitment to effective and affordable care for all—a change in physicians' values supported by societal and professional pressure
- The 87 percent of personal health spending that doctors control goes in two watertight compartments
- Payment methods and caregiver supply are essential, but so are commitments to care for all, cost control, and spending money carefully.

PHYSICIANS RECEIVE OR CONTROL 87% OF U.S. PERSONAL HEALTH SPENDING, 2003



- Payments to doctors must respect doctors' own needs and affordable patterns of care for all. We can afford to respect both.
- Doctors' gross incomes may average about $500,000, but suppose they retain only about $200,000. That's about 8 percent of total health spending. This 8 percent is what we have to put in doctors' hands in ways that allow us to assuredly trust them to deliver affordable high-quality care for all.
- Let's not get hung up on the 8 percent.

- Will single payer really contain cost? Why do we think doctors, hospitals, drug makers, nursing homes, dentists, and others will keep their costs under the ceiling of total national or regional revenue provided?
- Doctors' decisions commit the dollars. We have to ensure that these decisions are made with an eye toward affordable care for all

Physicians' strategic role

- Cutting clinical waste is a retail business, one that must be supported by
  - better evidence on what works
  - data on actual marginal costs (not prices or average costs) of all common types of care
  - methods of paying doctors that are much more financially neutral but that require doctors to marshal finite dollars carefully—and that reward them for doing so
  - need to justify denial of care to patients and families in legitimate ways
  - MD commitment to care for all

A big political deal

- Not voluntary, but translated into legislation
- If doctors agree to spend finite budgeted money responsibly and stretch the dollars to cover everyone,
  - we will end 90 percent of all financial paperwork and 100 percent of the threat of malpractice suits
- Test elements in advance

A practical example

- U.S. has about 2.5 active patient care doctors per 1,000 people
- So 50 doctors (primary + most big specialties) could take on about 20,000 patients.
- 2005 personal health spending per person will be about $5,600, and 87 percent of this = $4900
- The 50 doctors would have almost $100 million to marshal to finance and deliver one year of care to 20,000 patients. (Some would be reserved for reinsurance.)

Practical models, not microsimulation modeling

- We need arrangements that organize and deliver care in trustworthy ways, arrangements that doctors are happy to embrace or at least accept.
- Doctors' political endorsement of care for all and cost control is essential to passing the law and to making it work from month to month.
- We don't need more modeling to estimate how much a single payer or other universal coverage program would save or spend.
- We do need to scare doctors (and hospitals and others) with the real prospect of less money for business as usual, and then we need to reassure them that we can work out some durably beneficial arrangements.

Why 50 doctors per group?

- This seems large enough to afford solid clinical support (especially about efficacy and cost of care) and administrative support
- But it's small enough for doctors to know and monitor one another, and to knock heads to develop standards they're comfortable with
- And small enough for everyone to see the practical consequences of clinical decisions
- And, particularly, small enough to spot someone who's incompetent, wasteful, lazy, or otherwise not with the program
- 50 might not be the right number; the Greeks debated for centuries about the right size for a self-governing *polis*. It might be useful to tinker.

Doctors use evidence and knock heads

- Each network of doctors gets evidence on how to diagnose and treat—what care works and who needs it.
- Each gets evidence on actual marginal cost of each service. It might even pay for hospitals and drugs by their marginal cost (with fixed costs absorbed outside the budgets of doctor networks).
- Each network makes care decisions in light of evidence on efficacy and cost of treatments.
- Each must care for all enrollees with money available.

Risk adjustment

- Payments to each network would be adjusted for the age, illness, disability level, and other legitimate predictors of cost of care.

Individual enrollment

- Patients would enroll individually, not as families, so a family member could choose a network that contained his/her primary care physician
- This way, we avoid a few huge networks in each metropolitan area
- Each network could refer to and pay physicians out of their network, but would have to include that under their budget

Geographic accountability

- Networks should be geographically localized
- Each commits to taking anyone from a certain area
- Service areas overlap so patients do have reasonable choice.

Two watertight compartments

- One for money for doctors, which they must divide up among themselves in some fair proportion to competence, energy, and kindness
- The second is for the 67 percent of the personal health dollar that doctors control but don’t get—hospitals, meds, long-term care, and the rest.
- Doctors must spend all of the 67 percent, and can’t benefit personally from any conservative scrimping.

Paying doctors

- Aim is to generate fair, agreed income targets
- Salary possible, with moderate bonuses for adhering to evidence-based clinical standards, greater efficiency, better outcomes, better patient satisfaction, greater energy
- Or fee-for-service, modulated for these things
- Challenges
  - measure these things accurately and cheaply
  - provide feedback in acceptable ways, probably from a group of peers or a diplomatic, respected, and vigorous medical director

Monitoring

- Each network must be monitored to ensure fair patterns of service by age, income, race, ethnicity, religion, gender, and other potential axes of discrimination
- Patients with similar problems must be treated similarly
- Everyone must know that no patient ever gets or is ever denied care to enrich anyone—but only to liberate dollars to serve another patient who's in greater need and has a better chance of benefiting.

Appeals

- Each network will have an appeals mechanism
- Because doctors can't be enriched by withholding care, their patients should trust them, reducing foundation for appeals
- As much as possible, it would be helpful to avoid Oregon-style published lists of what's covered or not, as these lists induce anguish, politicization of decisions, and put care under a constant spotlight. We want a solid foundation for trust, not trials (before judges).

Less finance-related paperwork

- If physicians are paid in more trustworthy ways, they won't have to submit individual claims
- And they won't have to re-file rejected claims
- Movement from gaming the payment methods to working within inevitable constraints

Less waste, fraud, and theft

- When dollars are visibly finite and pathology remains visibly remorseless, it becomes obvious to everyone that
  - waste kills
  - fraud kills
  - theft kills
- People therefore start confronting colleagues and, if necessary blow whistles

Benefits to doctors who agree to do these things—a peace treaty

- A solid organizational and financial foundation for efficient evidence-based care for all people
- An end to constant worry about financial meltdown of health care
- True, this may be a second-best, but one that's possible
- Tort-based malpractice system is abandoned in favor of no-fault compensation for lost wages (cost of medical care is covered through the universal care system)
- Because doctors are paid in trustworthy ways, 90 percent of finance-based paperwork is eliminated—they pay themselves.
- Doctors get to practice evidence-based and efficient medicine, making the hard choices

Managed care for grown-ups

- Or Kaiser without walls.
- Managed by doctors, who have social obligations.
- Inherently more trustworthy since no one makes more money when patients get less care.
- The organizations are non-profit
- They don’t compete much. If they get too big, they should split in two.

(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 •Single payer cuts in admin. waste	•squeeze clinical waste through bedside rationing **within budgets**, coupled with end of malpractice system •squeeze administrative waste by better payment methods—part of foundation for 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 promoting health savings accounts •give patients better information about need for care and caregivers' price and quality

QUESTION: Which method of containing cost would be *most effective* + *helpful*?

	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**

QUESTION: Which method of containing cost is *most likely to be relied on in next decade*?

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2. Coverage

- Bound tightly to cost control, else there's no vital pressure to contain cost, only remote abstractions like saving money for Medicare or your employer

Methods of improving coverage

	Small, Incremental	Big
Hike Cost	•Subsidize employer, employee purchase	•Medicaid expansions •Employer mandate •Individual mandate
Cut Cost	•High-deductible coverage/bare bones policies, supple-mented by Health savings accounts?	•Single payer? •Financially neutral, physician-directed closed systems?

QUESTION: Which method of improving coverage would be *most helpful and effective?*

	Small, Incremental	Big
Hike Cost	**A** Subsidize insurance purchase	**B** Expand Medicaid, employer or individual mandates
Cut Cost	**C** Bare bones insurance + Health savings accounts	**D** Single payer, or financially neutral MD-directed systems

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	Small, Incremental	Big
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Cut Cost	**C** Bare bones coverage + health savings accounts	**D** Single payer, or financially neutral MD-directed systems

3. Caregiver Configuration

a. Stabilizing needed hospitals
b. The right doctors in the right places
c. Affordable medications for all
d. Long-term care—never enough money to finance all that might be needed
e. Dentist shortage considerable—need to re-orient away from profitable sidelines and toward basic care for all

The right hospitals in the right places—payment and planning

CASE FOR INTERVENTION - 1

1. We lack a free market could to weed out the inefficient hospitals.
2. Even if we had a free market, it could only ratify purchasing power and doctor location—both maldistributed today.
3. Racial link with closings is unacceptable.
4. Massive bed shortages loom.
   - Average hospital census nationally now about 450,000—will rise to 770,000 by 2025.

CASE FOR INTERVENTION - 2

5. Cost of replacing closed hospitals has already begun to pass ~ $1 million/bed, $1 B/ 000 beds
6. Hospital today is usually worth more than promises tomorrow, especially when its survival depends on organizing needed care. Just look at central Brooklyn.
7. Jobs matter.
8. Burden of proof must shift—no hospital should be allowed to close without proof that it is <u>not</u> needed to protect the health of the public.

ACTION STEPS

1. Identify needed hospitals likely to close
   - Which hospitals (and ERs) are needed to protect the health of the public, today and tomorrow.
     - ✓ What types of hospitals and where should they be located?
     - ✓ Which hospitals are required to attract and retain needed doctors to each locality?
   - Identify hospitals that are likely to close in time to intervene
     - ✓ Track financial ratios annually
     - ✓ Use long-term predictive model

ACTION STEPS - 2

2. Raise public awareness of the risk to a needed hospital
   - Payers imagine hospital closings will save money. Hasn't happened yet, and isn't likely.
   - Trustees and CEOs deny problems until it's too late
   - They often act as if they thought, "If we can't save this hospital, we would be embarrassed if someone else did it."
   - They often believe that hospitals that can't compete in the market deserve to close.
   - They claim that going public would only undermine the hospital prematurely.

ACTION STEPS - 3

3. For temporary protection
   - Enact state hospital receivership law, allowing officials or citizens to petition a court to take control of a hospital and stabilize its finances.
   - Or urge governor to declare that closing Hospital X constitutes a “public health emergency,” allowing state to seize control of needed hospital and stabilize it.
   - Underpin either legal step with short-term financial relief through state trust fund financed by 0.25 percent of each hospital’s revenue, → about $1.25 billion yearly in U.S.
     – (and about $100 million in New York State)

ACTION STEPS - 4

4. To durably protect each needed hospital, establish all-payer rate setting to guarantee enough money to sustain efficient, high-quality operation

- In a free market, each payer would pay the same price.
- Without a free market, only a public structure can protect each needed hospital

b. Physician specialization and location

- The right doctors in the right places: payment and planning. A tough job in every nation.
- Public financing of all medical education will make it much easier for students to enter primary care
  - $40,000 * 16,000/year * 4 years =
  - $2.56 billion = 0.13 percent of 2005's total health spending of $1,936.5 billion
- Income convergence (not strict equality) will help greatly. It's essential.

c. Affordable medications for all

- Medical networks can’t cut drug prices.
- Need Rx peace treaty
- Payers persuade drug makers to cut prices in exchange for assured higher volume
- New York State could be single buyer for drugs.
- Total revenue unchanged, but now all needed prescriptions are filled
- To return profits to prior level, need only pay tiny marginal cost of producing added volume of pills

New York has adequate leverage

- Total 2004 Rx spending
- New York State $19.5 billion
- Canada $21.8 billion
- Australia ca. $9 billion
- France ca. $38 billion

d. Long-term care

- Talk of Medicare LTC benefit has ceased in wake of higher drug costs and MMA mess
- Fear of moral hazard—if you pay for the non-institutional care people want, they're likely to use it
- LTC is like a stone bridge whose halves hold up one another
- Need mobilize serious rise in voluntary aid and use that to secure containable increase in public financing—legislators won't have reason to worry that they have to fill a bottomless, receding pit—as families withdraw efforts in favor of new publicly paid help

How to mobilize volunteers

- Bank volunteered time
- Create parallel economy of good deeds
- Move good deeds across time and space
- Use banked time to buy time insurance, so need only save expected value of average lifetime of help
- Motivation meaningless—who knows why we do things? Mix altruism and self-interest
- Work through established social networks of neighborhood, fraternal organization, work/union, religious congregations
- Back volunteered time with guarantee of paid help if no further volunteers emerge—like backing paper silver certificates
- Need manage like any economy—to guard against inflation, for example

E. MOVING FORWARD

1. Economic contingencies and political panic
2. Getting ready

A few competing contingencies

- More money for business as usual
- Single payer begins to gain traction owing to increased awareness of higher costs, waste, loss of coverage, unsustainability of more-money-to-finance-business-as-usual
- A decade of stagflation, with steady erosion of coverage and growing financial distress for caregivers
- Economic discontinuity
  - dollar dives, deficit must be cut, IMF demands belt-tightening,
  - real dollars for health care drop by 5 percent annually for five years,
  - 100 million uninsured, 1,000 hospitals close, physicians driving cabs—

Preparing for contingencies

- Bioterrorism
- Avian flu and another flu vaccine folly
- Why not plan to prevent
  - Loss of 1,000 hospitals
  - 100 million uninsured American patients
- So—how to recession-proof our health care? A few hours of advance planning during a calm time—especially if we can get hospitals and other caregivers to participate—is worth a few weeks of frantic meetings during a crisis
- Crisis might not materialize. If not, what have we wasted?

Health Care's Capacity to Respond to a 5% Drop in Real GDP

- A substantial (5%) drop in real GDP, whether gradual or sudden, would probably boost pressure to slow the rise in health spending, or even to cut spending.
- In response to this pressure, physicians and hospitals might react flexibly and successfully to protect themselves and their patients. Or they might not.
- Carefully designed and tested arrangements to cover all and spend limited dollars carefully—to deal with threats—will make it much easier to stabilize U.S. health care.

The greater the crisis

- The greater the pressure for improved coverage, cost control, and caregiver stabilization
- And the less money to accomplish these
- Without a clear idea of how to proceed, tested in advance, it will be hard to respond safely and constructively during crisis
- When economic and political worries will magnify reliance on health care as a source of stability and reassurance (and when need for care is usually greater)

Aim of health care

- It’s hard to hit a target if you don’t know where it is
- Immortality isn’t the aim, honestly
- Medical security, instead
  - ✓Confidence we’ll get needed care
  - ✓From competent caregivers
  - ✓Without having to worry about bill when ill
  - ✓Without having to worry about losing coverage ever

Our easiest problem

- Winning affordable health care for all Americans is the easiest problem to fix in the U.S.
- Not easy—just easier than all of the others.
- They all require more money or more capacity.
- Health care doesn’t.