WINNING AND RETAINING DURABLY AFFORDABLE HEALTH CARE FOR ALL

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Disclaimer: As always, I write and speak only for myself,
not on behalf of Boston University or any of its components.

This paper rests heavily on collaboration with my colleague, Deborah Socolar, M.P.H., Director, Health Reform Program, Health Services Department, Boston University School of Public Health.

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Thank you.

Good afternoon.

I. THE PROBLEM

At roughly $1.3 billion this year, or over $4,500 per person, U.S. health spending is enough to finance the care that works for all the people who need it. Our spending per person remains more than double that of other wealthy nations that cover all their people and live longer. And it is three times the British level.

We need to take stock.

Health spending is rising by about $100 billion yearly, yet almost all of it is going to buying more care—or more costly care—for people who are already insured.

Here in Massachusetts, a working group has just recommended a cautious approach to improving coverage. That reminds me of the story of the difference between a recession and a depression. A recession is when your neighbor is fired. A depression is when you are fired.

Also here in Massachusetts, a ballot initiative calling for universal coverage has just been defeated by a 52-48 margin. The opponents offered frightening arguments and even more frightening numbers—most of them of the flimsiest sorts—along with $4-5 million in advertising to win their narrow margin.

Having won the vote, the opponents of the ballot initiative are now accountable for the future of Massachusetts health care. Sadly, they have no program. Not for cost control. Not for universal coverage. Not for improving quality of care. The opponents of the ballot initiative were united only by their opposition to reform, stemming from fear of its costs.

Some of the opponents were and are anxious to hold down insurance premiums—but how will they do so?

Some are anxious for more money for business as usual—for hospitals, drug makers, and others—but where will they find the money?

Yet health spending in the United States has been rising rapidly again, shrugging off the ideologically comforting but temporary restraints of managed care, price competition, and hospital closings.

Yet the aging of the population has barely begun. The first of the boomers will hit 55 next year and 65 in 2011.

Yet hospital financial distress is deepening. In many parts of the nation. ER closings and diversions are growing in frequency. (Though it does seem that, at least in Boston, the hospitals in the best financial condition are the ones on diversion the most often.) Hospital closings reinforce dangerous and divisive patterns of care. (See St. Louis, Missouri and Washington, D.C. maps appended to this paper.) Efficiency does not predict survival, but being a teaching hospital or having more money in the bank do predict survival. This might be called not survival of the fittest but survival of the fattest.

Yet, in my state, one-quarter of all nursing homes are bankrupt.

Yet, our nation continues to enjoy the best economy in the history of the world.

Yet, we have eight million more uninsured people than we did a decade ago.

Yet, 70 million Americans lack insurance for prescription drugs—one in four—and, with drug spending rising by 15-20 percent annually, it will double in four or five years.

II. A FEW CAUSES—of the problem and of our failure to solve it

Consider how remarkable it is that we spend so much and leave so many unprotected.

Consider that re-directing about six months' spending increase toward universal coverage instead of higher prices or more money for business as usual would be enough to win financial entitlement for all Americans. Further, caregivers would still receive that additional money.

First, various parties have failed to make a commitment to covering everyone, partly because some of us think we can't afford it—and because some of us fear that it will hurt us or our families.

Second, caregivers prefer more money for business as usual over redirecting the same additional money to assuring universal financial coverage—even though they will end up with about the same money in the end. Some patients with good coverage today somehow fear that extending coverage will dilute the value of their own insurance or raise its price. No one seeks higher taxes.

Third, universal coverage seems always to take the back seat, or to be strapped on the roof rack. Most Americans apparently thought that we could not afford to improve coverage even during the mid-1990s, when cost increases were temporarily slowed by a combination of price competition, managed care, and hospital closings.

During the early 2000s, most Americans apparently think that we can't afford to improve coverage now because costs have begun to skyrocket again—revealing the savings from price competition, managed care, and hospital closings to have been—apparently—a short-lived and one-time phenomenon.

Fourth, we have focused hopes for reform excessively on the federal level. A variety of creative state innovations lost steam when the Clintons launched their vain reforms in 1993, and they continue to be discredited politically by the

Clintons' failure.   Today, confidence in government, in the abstract, is at a low level.   But support for concrete programs appears to be much better.

- The failure of price competition, and the inability of government regulation to protect patients against the wounds to quality inflicted by financial incentives to under-serve.
- The failure of managed care.
- The failure of hospital closings.

Fifth, the failure of private sector cost control efforts—price competition, managed care, and hospital closings—has emptied the traditional private sector's warehouse of new ideas. Consequently, health reform now depends on government action. Without a functioning free market, the alternative to competent government action is anarchy. Some imagine that health planning and regulation failed to contain costs in the 1970s. The reality is that they were barely tried.

III. SOLUTIONS

It will be useful to pursue four general approaches to winning durably affordable health care for all:

- reverse the roles of competition and regulation
- get ready
- financing reforms
- delivery reforms

1. Reverse the roles of competition and regulation.

We need to use the right tool to perform each task.

We have been competing by price and regulating to protect quality from the harms inflicted by price competition, but that has not work to control costs durably or safely. Instead, we should compete by quality and regulate spending.

Government contains cost by limiting revenue. Competition among trustworthy organizations protects quality.

2. Get ready

<u>Plan against the full range of contingencies</u>. Tell many stories about the future that might offer reasonable opportunities, and be ready to seize each of them.

<u>Innovate, design, test, evaluate, and re-design</u>.

<u>Most important—Develop and test new ideas now</u>. Today, the legislation that can work can't pass, and the legislation that can pass can't work.

Tomorrow. Ah, tomorrow. Some people expect that a health care crisis will generate the political support required for thoroughgoing reform. Another irony. Then, we may have the political support, but we still won't know what to do if we have not designed and tested new financing and delivery methods well in advance, and learned what methods actually work medically and financially—and are actually acceptable to key stakeholders.

Unless we have designed, tested, redesigned, and retested all the elements of health reform, the looming health care crisis—something we might call medical meltdown—will discredit the smartest reformers. Be careful what you wish for, lest you get it, one old saying goes.

In a crisis, the political support for reform may be high enough to allow passage of interesting new legislation, but this support will almost certainly materialize at a time of less money, great worry, and demands for quick solutions. Americans are not a patient people.

We must cease paraphrasing Winston Churchill's remark that he could always trust the Americans to do the right thing—after they tried everything else.   That worked in two world wars—though barely in time—despite years of military neglect and unpreparedness in the U.S.

But when reforming U.S. health care, it will be very hard to do the right thing after years of neglect and mistakes. It will be much easier to do the right thing after years of innovation, testing, and evaluation.

<u>Innovation, testing and evaluation will require state action</u>. It is in the states that the stakes are lower. Programs tailored to local circumstances of health problems and health resources, with local political support, can get off the ground. We need health reform Kitty Hawks before we can launch health reform Apollo programs.

Among the many reasons to be angry with the Clintons for their reform fiasco of 1993 is that they did not know what they were doing. They embarked on a huge adventure, with little evidence that it would work. They made one of the mistakes of very smart people. They believed that good ideas are enough. Worse, they imagined that workable federal health reform was possible without experimenting first in the states.

There are many conventional but useful explanations for the Clintons' failure: they ignored reporters; they worked in secret; they ignored physicians; they relied too much or too little on competition.

But the more useful explanations, I think, were that they downplayed the known political opposition to employer mandates (remember President Dukakis?); they did not know how to run a purchasing cooperative for all people—particularly one that would redistribute substantial amounts of money—because none had ever existed before; they did not have the needed data on state and regional health spending that was needed to estimate geographic redistribution; and they under-estimated the differences among the states in their politics, their health costs, and their population shares lacking health insurance.

<u>One specific way to get ready: Spur innovation through state programs. Learn what works</u>. Try many different things. Congressman Tierney has introduced legislation calling for substantial federal funding for 10 states to plan and implement innovative methods of financing and delivering health care for all.

Most of the interesting and important state-level reforms must be authorized by federal law. We badly need a coordinated program through which states can apply for ERISA waivers and complementary Medicare and Medicaid waivers.

Working state-by-state is complicated and messy, but it is much complicated and messy—and much safer—than attempting national reform without much of an idea about what actually works. Many states lack the resources to plan, implement, manage, and evaluate reforms. But the states most likely to innovate

will have the resources. And the states most willing and able to innovate should not be held back by those that are not willing and able.

Human relations. Some of the people who caused today's problems will be sidelined temporarily during a crisis, but most will still be on the field, worried, angry, and often ready to cause trouble. Their opposition must be anticipated. They must be won over when possible. At least, they must be persuaded to be willing to try something new.

For the success of reform will depend on many of these very people. Hospital administrators and trustees. Doctors. Nurses. Nursing home owners. Drug makers. HMO managers.

3. Financing reforms

Raising the money. I suggest a new slogan, pooled payor, in place of single payor. Pool all existing financing streams in one reservoir. This avoids doubling the federal income tax, which is just about what would be required to replace all of today's private health care spending with public dollars. (See the Appendix on traditional single payor financing.) It thereby avoids the political grief of creating many financial losers with memories inevitably much longer than those of the equally numerous winners.

And it also avoids the financially regressive and politically suicidal reliance on mandating employer financing of traditional health insurance. Premiums for that insurance run $3,000 or more for individual coverage and $7,000 or more for family coverage. That is a fixed cost per employee, one that particularly burdens employers of low-wage workers and employers whose labor costs are a high share of total costs. Employers who do not offer such insurance today simply lack the money to buy it.

Pooled payment should be accompanied by freezing private health insurance at this year's level. Government should require maintenance of effort in nominal dollars per person.

Then, raise taxes only for two things:

- to cover the share of annual spending increases that private insurance would no longer be asked to pay (since private insurance premiums would be frozen in nominal dollars), and
- to replace most out-of-pocket payments, because that is necessary to reduce financial barriers to access and to simplify administration.

Gradually phase in payments by employers and employees who do not now pay, by adding a payroll tax, against which existing health insurance payments are a credit.

Paying caregivers in simple and generally acceptable ways.

- Hospitals need flexible budgets, with guaranteed revenues keyed to the financial needs of efficiently operated institutions. Fixed costs are assured. Variable costs are paid as incurred, so hospitals are not penalized for serving fewer patients or more intense case mixes.
- Many or most doctors probably should be paid by salary, but in ways that oblige them to spend carefully finite budgets. They deserve good supervision, leadership, and motivation, and should be rewarded for serving their patients well.
- Drug makers need to be paid in ways that are affordable, that cover their legitimate costs, and that spur much greater investment in breakthrough research. Wealthy nations should provide the bulk of their revenue. They should sell to poor nations at marginal cost (manufacturing cost).

My colleague, Deborah Socolar, and I have elsewhere called for a prescription drug peace treaty.[1] This would entail:

- A price cut of 42 percent
- Assured replacement of all lost revenue through higher private market volume (in response to lower prices) and assured public purchase of medications for patients who can't afford even the discounted prices. Extra payment for the marginal cost of manufacturing and distribution. So profits are sustained, as are all of today's funds for research.
- Keying future profits to developing breakthrough drugs. Squeeze out drug makers' current annual waste of some $27 billion on copy-cat research and excess administrative/marketing structures so bloated that they make health insurance look like a model of efficiency.
- Anticipate the drug makers' hysterical advertising campaign against reform. ("The lights go out in the labs, and there is no R&D," according to Tracy Baroni, senior director of policy for the Pharmaceutical Research and Manufacturers of America (PhRMA), the drug industry's lobbying arm.[2] We call that PhRMA's fog of fear.

  Dissipate the fog of fear by showing that the drug makers are the real enemies of research.

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[1] Alan Sager and Deborah Socolar, *A Prescription Drug Peace Treaty: Cutting Prices to Make Prescription Drugs Affordable for All, and to Protect Research,* Boston: Health Reform Program, Boston University School of Public Health, 5 October 2000, http://dcc2.bumc.bu.edu/hs/ushealthreform.htm

[2] Cited in Deborah Baker (Associated Press), "Many in Southwest Lack Drug Benefits," *Albuquerque Journal,* 7 September 2000. Ms. Baroni was testifying before the New Mexico legislature's Health and Human Services Committee.

The longer their stonewalling on high prices and unequal coverage succeeds, the angrier Congress will become when it finally acts. And an angry future Congress might irresponsibly cut drug makers' revenues in ways that damage research.

Don't doubt that the anger will materialize, with drug spending doubling every four or five years.

This year, the drug makers are wasting some $27 billion that could have been devoted to breakthrough research—

- some $10.6 billion on copycat research that does relatively little good to patients but does allow several drug makers to cash in on one drug maker's bright idea; and
- some $16.7 billion in waste on excess marketing, advertising, and administration.

4. Delivery reforms

Let managed care organizations compete by quality, not by price. All are non-profit and all are paid the same risk-adjusted price per patient. Hold size to 50,000 – 100,000, so many remain in business in each metropolitan area. Provide systems support and technical assistance so each can be operated efficiently. Each paid by flexible budget so each remains in business even if it loses members—because competition requires competitors. All must expend entire budgets annually. So the only reason to withhold care from one patient is to make money available to care for another patient who is in greater need.

Identify and stabilize all hospitals that are needed to protect the health of the public.

Draw up a list of needed hospitals. So many hospitals have closed already—and so many of the surviving hospitals will be needed to treat the aging baby boomers—that the burden of proof should be on anyone who wants to close any more hospitals.

Draw up a second list, of hospitals that are financially distressed. Provide each with technical assistance or emergency cash relief.

Looking down the road, ensure that each garners revenue sufficient to remain in business, as long as it is operated efficiently. Prepare hospital receivership laws to quickly protect vital human, organizational, and financial assets of hospitals that are being mis-managed.

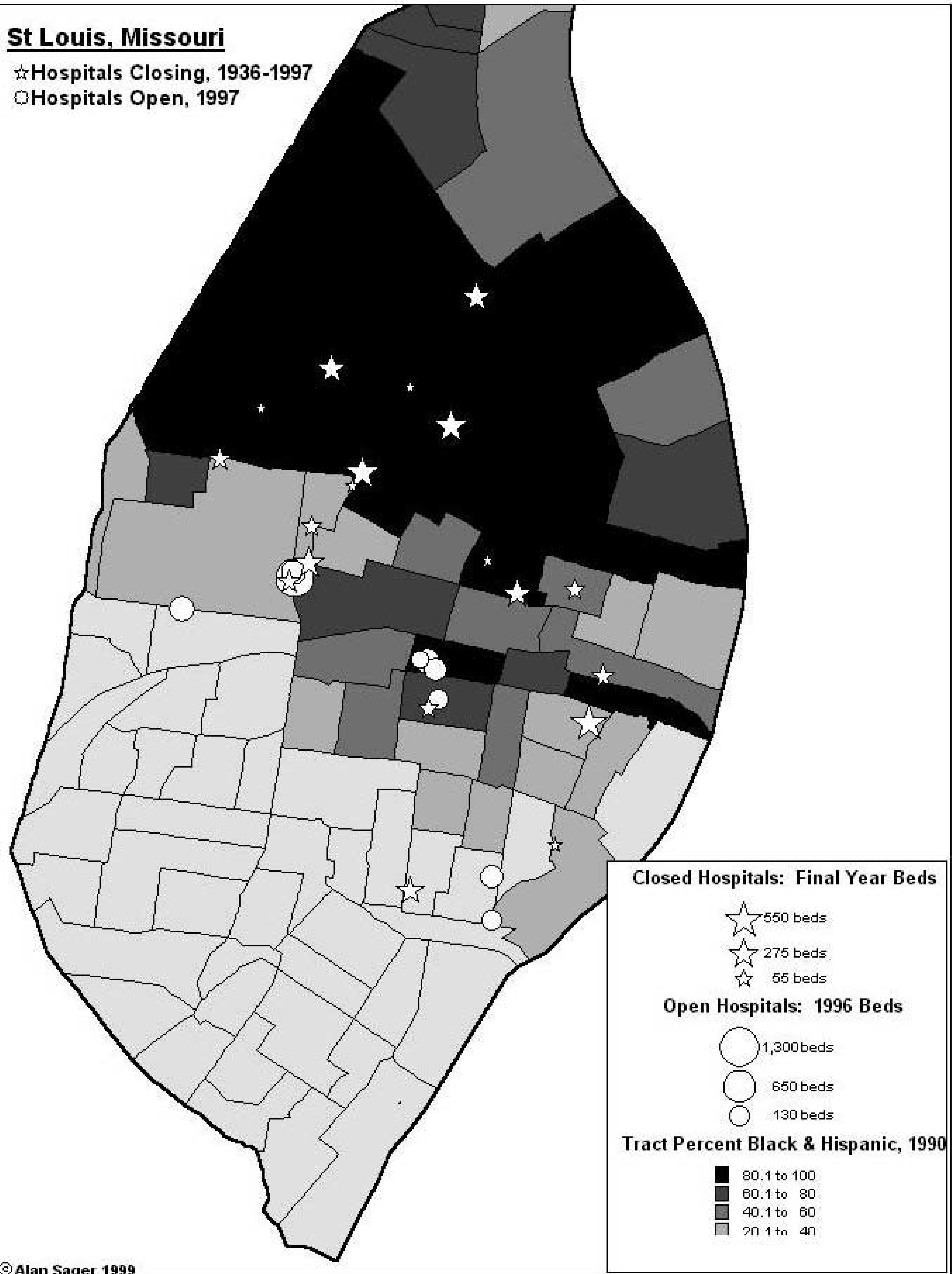
Identify and secure the right numbers and right kinds of physicians in the right places. This is a little tougher, even, than the hospital question. But the market is not giving us the right answers, so a measure of public intervention is called for here as well. Far too little work is being done in this area today.

In conclusion, there is considerable reason for worry. The solutions of the past have failed and the idea warehouse is empty of promising solutions that enjoy good currency in today's political debates. Costs are rising again, carrying insurance premiums higher. Drug spending is out of control. Hospitals are closing. Many doctors are worried.

But also in conclusion, there is great reason for optimism. Our health spending is staggeringly high. (How ***do*** we manage to spend so much without covering everyone?) We have the doctors and the dollars—and the competence and the compassion—to provide all the health care that works to all the people who need it.

That makes winning affordable health care for all the easiest job in the United States. Not easy—just easier than any of the others.

Thank you very much.


St Louis, Missouri
☆Hospitals Closing, 1936-1997
○Hospitals Open, 1997
Closed Hospitals: Final Year Beds
550 beds
275 beds
55 beds
Open Hospitals: 1996 Beds
1,300 beds
650 beds
130 beds
Tract Percent Black & Hispanic, 1990
80.1 to 100
60.1 to 80
40.1 to 60
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January 1999

Washington, DC

☆ Hospitals Closing, 1936-1997

○ Hospitals Open, 1997

Closed Hospitals: Final Year Beds

330

165

33

Open Hospitals: 1996 Beds

780

390

78

Tract Percent Black & Hispanic, 199

Range	Tracts
80.1 to 100	(115)
60.1 to 80	(17)
40.1 to 60	(15)
20.1 to 40	(8)

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Appendix

Traditional Single Payor Financing versus Pooled Financing

The traditional single payor approach would raise taxes to replace all private insurance and out-of-pocket payments. (Almost by accident, I discussed this for a half-hour with Jerry Brown when he was running for president, in January or February of 1992. He said something like, "they're out of their minds if they can even *think* about a tax increase as large as that. It's the craziest thing I ever heard.")

In 1997, private health spending was estimated at $585,312,000,000, or 53.6 percent of total health spending, which was $1,092,385,000,000.[1] The estimated figure for private health spending for 1998 is $614,468,000,000. The projection for 1999 is $654,409,000,000.[2]

Fully 91.5 percent of the private payments are made by individuals or businesses—32.0 percent out-of-pocket and 59.5 percent through private insurance. (Philanthropy accounted for 6.0 percent .)

If we reasonably assume that traditional single payor plans would seek to replace all of this private spending with public tax dollars, a tax increase of roughly $644 billion would have been required in fiscal year 1999.[3]

Raising some $644 billion in fiscal year 1999 would have meant an *89.3 percent rise in federal income tax receipts*. Or, if you prefer a broader approach to revenue generation, raising the $644 billion would have required a *39.2 percent increase in all federal revenues* (including personal and corporate income tax, Social Security and Medicare taxes, inheritance taxes, excise taxes, customs duties, and all the rest).[4]

We suggest that it would be useful to consider an alternative. That would be to start health care financing reform by raising federal taxes only to cover today's out-of-pocket costs. The resulting tax increase would still be substantial—some $206 billion—but that is less than one-third of $644 billion.

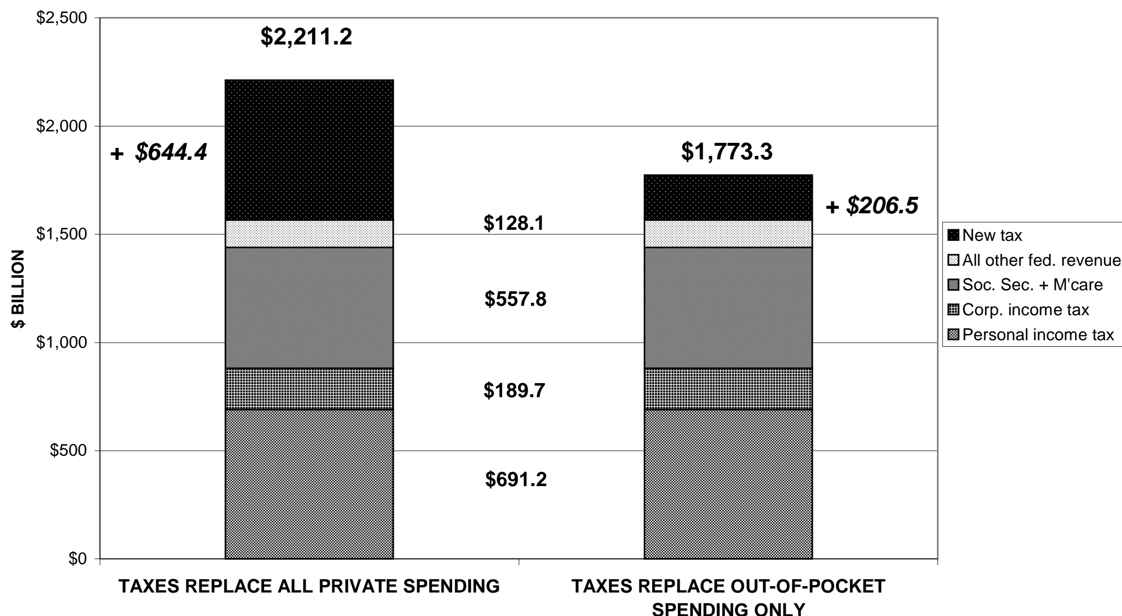
The figure on the next page shows the effects of a $644 billion federal tax increase or a $206 billion tax increase on top of current federal revenue.

Private employers would be required to maintain their effort in paying for coverage.[5] But they would write their checks to the single payor trust fund, not to an insuror or HMO. Maintenance of effort would be defined by 1999 health insurance cost per worker, in 1999 dollars. These payments would gradually lose purchasing power over time. Just as gradually, taxes would be raised to replace the lost purchasing power. (One path might be a payroll tax against which employers' payments would be credited.) This way, we avoid the political

grief of a $644 billion tax increase. Had this approach been taken in 1974, when Kennedy and Nixon debated the way to cover all Americans, over 80 percent of health spending would be financed publicly today, I have calculated.

How would all the money be assembled in one place, to win the benefits of a single payor plan? Today's private insurance funds would be pooled with Medicare, Medicaid, other persisting public revenues, and the new federal tax in a single trust fund. Several different streams of money would flow into the trust fund, but only one stream would flow out. (This parallels what individual Canadian provinces have long done. There, federal taxes, provincial taxes, and—sometimes—private insurance premiums are combined to finance universal coverage.)

Now, some would say that we should not worry about a giant tax increase—even one that would almost double the income tax— since private spending would be cut by a greater amount. The problem here is that the winners are not the same as the losers. The winners would smile vaguely and forget. The losers would hate forever. This testifies to the asymmetry between pain and gain. Similarly, it is said, the average person has roughly three times as many bad dreams as good dreams.



[1] Office of the Actuary, Health Care Financing Administration, “1997 National Health Expenditures,” www.hcfa.gov/stats/nhe-oact/nhe.htm.

[2] Sheila Smith, Mark Freeland, Stephen Heffler, and others, “The Next Ten Years of Health Spending: What Does the Future Hold?” Health Affairs, Vol. 17, No. 5 (September-October 1998), pp. 128-140, exhibit 1. I calculated the 1999 estimate by taking the 1998 figure and adding 6.5 percent (the authors’ projected average annual rate of increase from 1998 to 2001).

[3] This figure is one-quarter of the calendar year 1998 private spending and three-quarters of the calendar year 1999 private spending.

[4] Federal income tax revenues in FY 1999 were estimated at $721.6 billion and total federal revenue at $1643.3 billion. See Office of Management and Budget, “Federal Receipts,” Analytical Perspectives, Budget of the United States, FY 1998, p. 39 (www.access.gpo.gov/su_docs/ budget98).

[5] Employers would have to maintain their effort, measured in nominal, 1999, dollars per employee.

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