Overcoming Anarchy in U.S. Health Care to Win Affordable Access to Needed Care for All Americans and to Simplify Our Professional Lives

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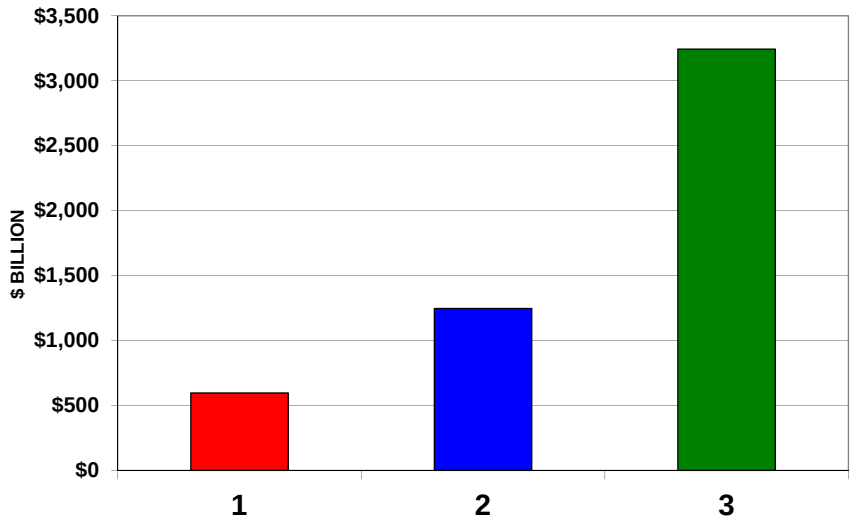
How big in 2015?

Which is total U.S. health spending? education? defense?



$3,500,000,000 year/365 ≈
$9,600,000,000 daily ≈

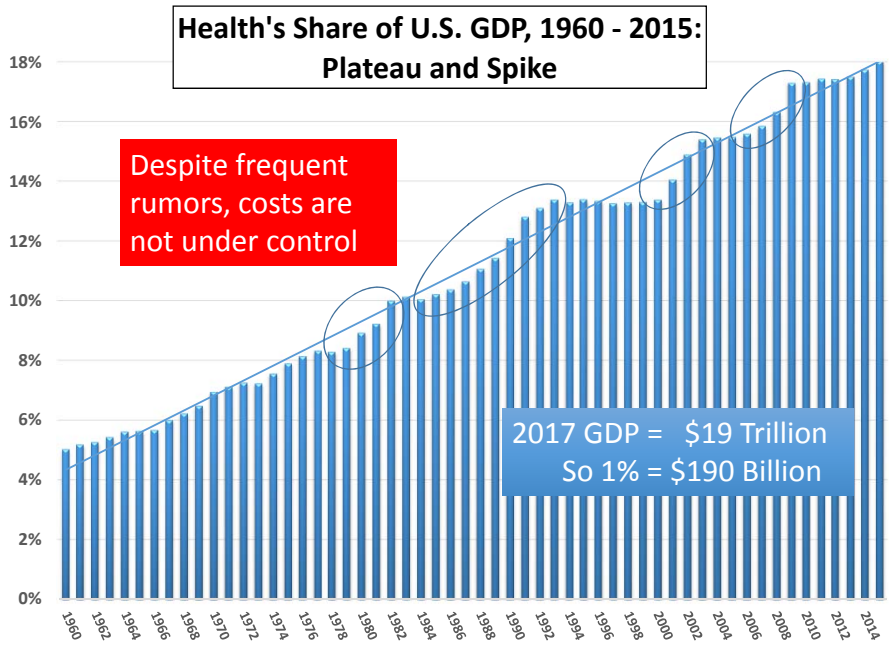
≈

3 ideas

1. Anarchy
2. Sidestepping anarchy
3. Confronting anarchy
   a. Hospitals
   b. Doctors
   c. Meds
   d. LTC

1. Anarchy

- A competitive free market doesn't and can't function well enough in health care
- Competent government action isn't generally possible in U.S. health care today
- Absent either, anarchy reigns
  - Costs uncontrolled
  - Efforts to control costs fail but their residue frustrates both caregivers and patients
  - Accountability is rare and finger-pointing is common



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Medical security – the goal

- **Confidence we'll get needed, competent, kind, and quick care without worrying about the bill**

- Four pillars of medical security
  a. Financial coverage and actual **access** to care
  b. Cost control, affordability
  c. Appropriateness (the right care) and **quality** (provided competently and safely)
  d. Right doctors and hospitals in right places (almost no attention to this)

Rising costs undermine medical security

- Health costs are problem everywhere—especially in U.S. and Mass.
- U.S. costs > double rich democracy average
  - Mass. 36 percent above U.S. average
- U.S. income inequality highest among rich democracies
  - Mass. among highest in U.S.
- Raising taxes on richer Americans is only way to finance care for poor
- Higher cost and rising income inequality make that harder every year
- Both the market and government have failed to contain cost

Free market's seduction

- When market works, it works very well, and without visible human or political interference
- Invisible hand rewards greed **and** uses it to yield 2 big benefits
  - i. **Efficient** caregivers earn higher profits
    - Rewards efficiency with higher profits or with survival
    - Insurers or HMOs or hospitals compete by price and quality
      - Prices and costs will fall, quality will improve, or both
  - ii. Market provides the care that **patients demand**

Free market's seduction

- When market works, it seeks equilibrium—self-regulates!
  - Some people prefer market ideologically
  - Others, pragmatically
    - Or by default, believing government can't work well in health care, leaving market only choice

Market failure

Freely competitive market requires 6 things.

Not one of the 6 is close to satisfied in health care

1. Lots of small buyers and sellers, so market makes price
2. Autonomous, independent providers and consumers
3. Easy entry and exit
4. Buyers and sellers have good, balanced information about price, quality
5. Prices track cost, so buying by price and quality rewards efficient satisfaction of consumer demand
6. Don't trust anyone

Unrequited love: Insisting on market—when its 6 requirements aren't met—is bound to disappoint

- Without free market, pursuit of profit can't yield either efficiency or the care we want and need
  - Market rhetoric can then serve as smokescreen for bad behavior and dangerous outcomes
  - Hospitals compete briefly by price and quality
    - But they often merge, because that's a lot easier and less worrying than competing—and then can raise prices

Failure to achieve equilibrium, balance through government action, politics

- Weak political will to limit U.S. cost—why?
  - Caregivers understandably seek more money
  - Cost of insurance through job is usually invisible to workers
  - Americans seek all the care someone else is willing to pay for
  - No recognition that more money for health = less for all else
- Instead
  - Government touts succession of gimmicks—look busy
    - Hospital closings – accountable care – pay for value—boost OOPs
  - Ignores effective tools, used by other rich democracies
  - Avoids honest political negotiations

Failures of market and government → anarchy

Neither has succeeded in

- Containing cost
- Covering all Americans
- Boosting appropriate and high-quality care
- Improving the configuration of physician, hospital, long-term, mental, dental, or pharmaceutical care

Manifestations of anarchy in U.S. health care

1. Misdiagnosis of main sources of high costs
   - Many choose to think one main source is volume, but it's really price
- Shooting at wrong target
  - ACOs aim to reduce volumes of care
  - So do higher out-of-pocket costs
- Both have been widely adopted without evidence of efficacy or safety
- U.S. care use below rich-democracy medians
  - 2/3 of median for doctor visits
  - 4/5 of median for hospital discharges

Manifestations of anarchy

2. Payers create narrow networks to win lower prices in exchange for higher volumes
- Network adequacy regulated on paper but not monitored in practice
- More patients forced out-of-network
  - Furious at high charges

3. Efficient hospitals are neither more profitable nor more likely to survive

Manifestations of anarchy

4. Medicare Advantage plans

- Imagined to compete by price and quality to cut cost
- But have found it's easier to boost revenue by gaming the risk-adjustment
  - Their excess take from Medicare is perhaps $10 billion yearly

5. Too many different rules for doctors to follow

- Payers vary in
  - covered services
  - prices paid and OOPs
  - quality measures
  - documentation
  - formularies

Manifestations of anarchy

6. Mass. law capping yearly health cost growth but lacking effective enforcement tools
7. Hospitals merge to advance their "ability to compete"
8. U.S. insurers and employers rely on PBMs to contain drug spending
9. Federal pressure to buy EHRs that aren't inter-operable or (often) clinician-friendly
10. Payers seek to micro-manage physicians and hospitals with pay-for-value rewards and punishments
11. Multi-hundred-page regulations on dozens of topics—regulations that can't be enforced
12. For four decades, try to close hospitals to save money, but close more efficient ones, so more care is given in costly surviving teaching hospitals

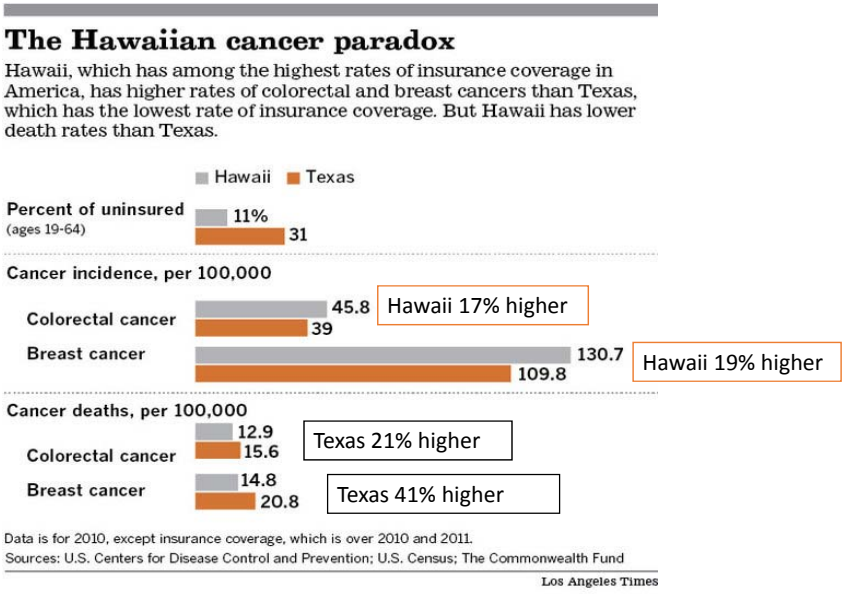
2. Attempts to sidestep anarchy

a. Boost OOPs – skin in game? – tax on sickness – people (especially poor people) use less care → targets volume but price is bigger problem

b. New technology – why doesn't it cut health costs?

c. Focus on behavioral, economic, social, environmental determinants
   - Were we willing to pay to address SDOHs, would that improve health?
   - No sign that $s to address social determinants will be forthcoming soon in U.S.
     - Do some people seize on SDOHs to dodge paying for other people's medical care?
     - Will MassHealth ACOs cut prices paid to hospitals, doctors, and nursing homes to generate money to address SDOHs?
       - Will that impair Medicaid patients' access to care?
   - Does this justly under-value medical care?

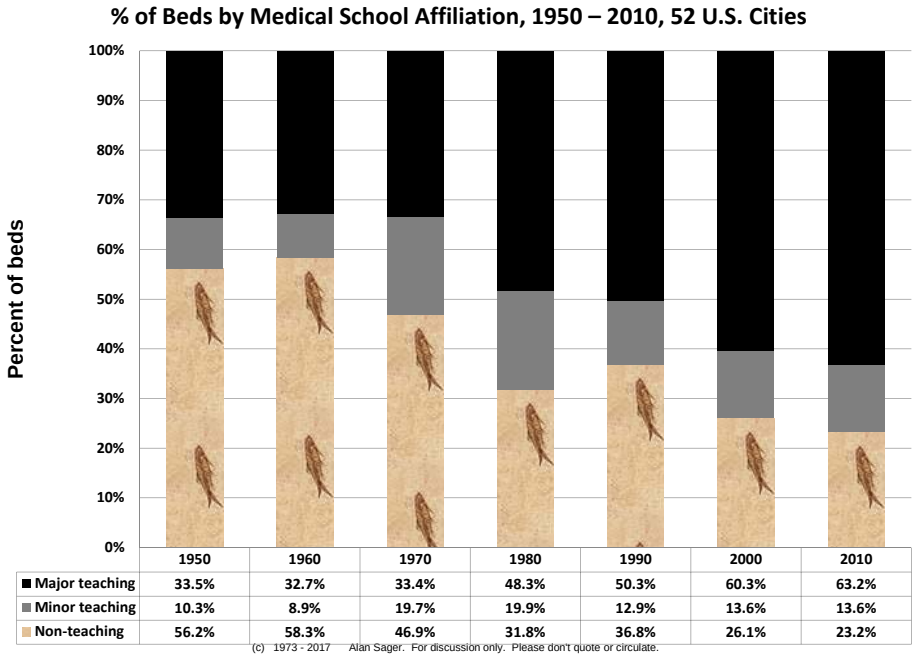
Does affordable access to health care matter?



3. Confronting anarchy and enhancing medical security by focusing on some of the actual caregiving on which we're spending $3.5T this year

a. Hospitals
b. Doctors
c. Meds
d. LTC

The care we get—and its cost—depend heavily on the caregivers we've got



	1950	1960	1970	1980	1990	2000	2010
Major teaching	33.5%	32.7%	33.4%	48.3%	50.3%	60.3%	63.2%
Minor teaching	10.3%	8.9%	19.7%	19.9%	12.9%	13.6%	13.6%
Non-teaching	56.2%	58.3%	46.9%	31.8%	36.8%	26.1%	23.2%

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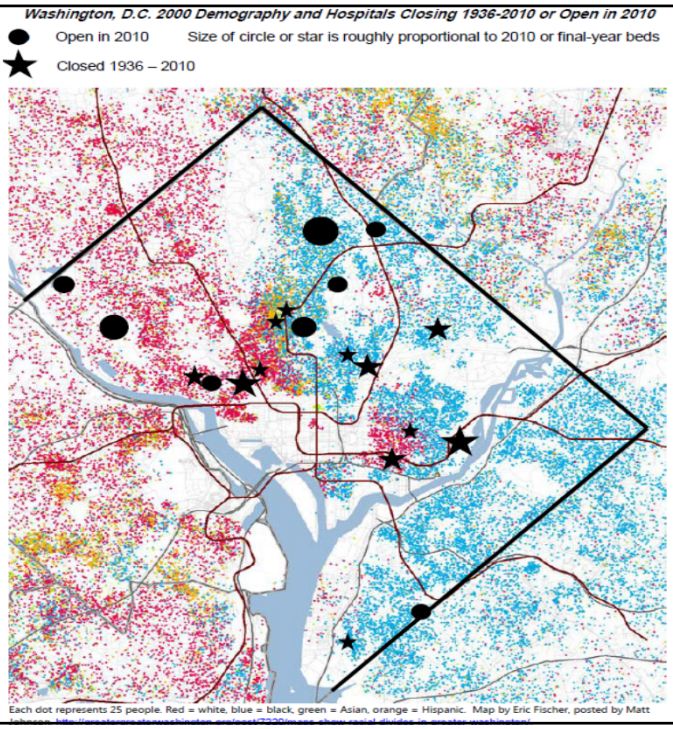
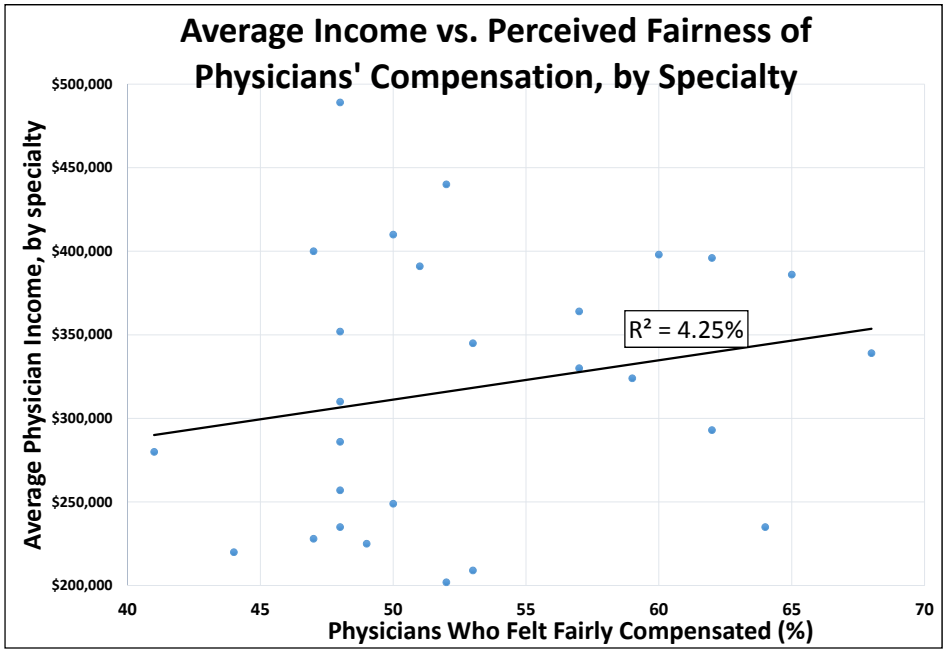
And—hospital care in 52 U.S. cities in 2010 was 22 percent costlier than it would have been had the 1980 configuration of hospitals persisted



It's essential to identify and stabilize the ERs and hospitals needed to protect the health of the public. Only one state has done that.

Doctors' decisions control 87% of health $

- Can any nation address its health care problems in the face of doctors' opposition?
- Excess paperwork stems mainly from
  - Complexity of demands from multiple payers
  - Payer – caregiver mistrust, gaming
- Can we make a deal?
  - Exchange reduced paperwork and genuine action on malpractice for—doctors undertaking risk-free accountability for cost control
  - Push thoughts about money into the background by addressing them head-on
  - Restore quality of professional life
  - Less administrative work and more time for patients



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Source: Medscape, "2017 Physician Compensation Report," cited in Emily Rappleye, "Which Medical Specialties Feel Unfairly Compensated," Becker's Hospital Review, 14 April 2017.

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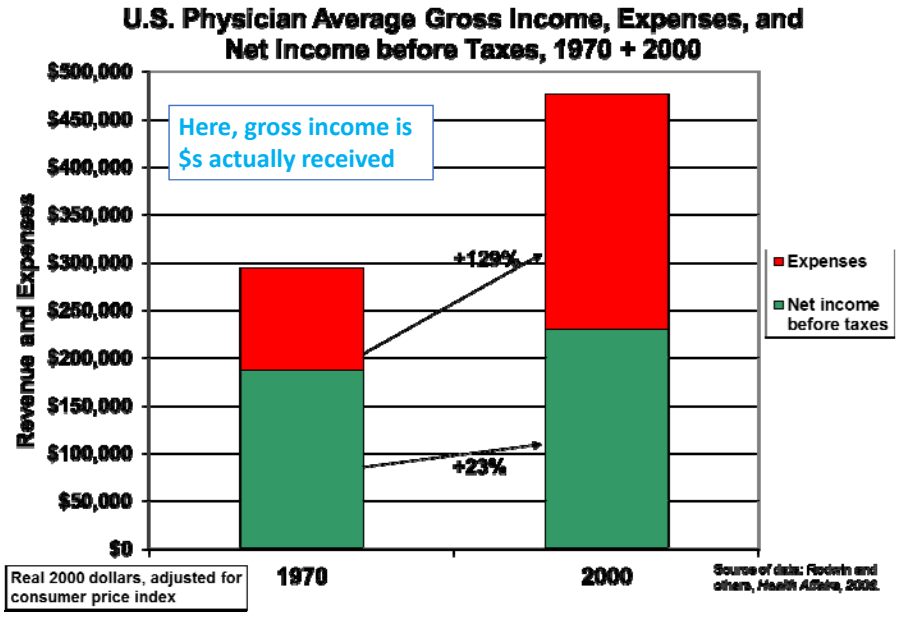

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Rebuild primary care base of health care pyramid

- ✓Induce med schools to recruit more students who like both science and patients
- ✓Pay family doctors more and move to double their numbers
  - ✓300,000 FTE family doctors * $300,000 each
    = $90B yearly
    = 2.6% of health spending
- ✓Doctors' panel size drops to about 1,000 patients
- ✓They have much more time to think, learn, coordinate, and build trusting relations with patients

Rx – The easiest problem to fix in health care

- U.S. gives the world's drug makers 40 percent of their revenue
  - We're 4.4 % of world's people
- We hate high drug prices but are told low prices will inhibit innovation
- High U.S. drug prices engender higher OOPs (patients hate them) and deter appropriate use of meds doctors prescribe
- We can spark more innovation—and get its cost out of pills' prices by
  - Awarding prizes for valuable new meds in exchange for patent rights
  - Licensing them for manufacture
  - Pricing them at retail at close to incremental manufacturing cost

What's this? Why is it on the last slide?