The World's Strangest Health Care--And How to Fix It

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Lexington at Home
Cary Memorial Library

15 January 2017

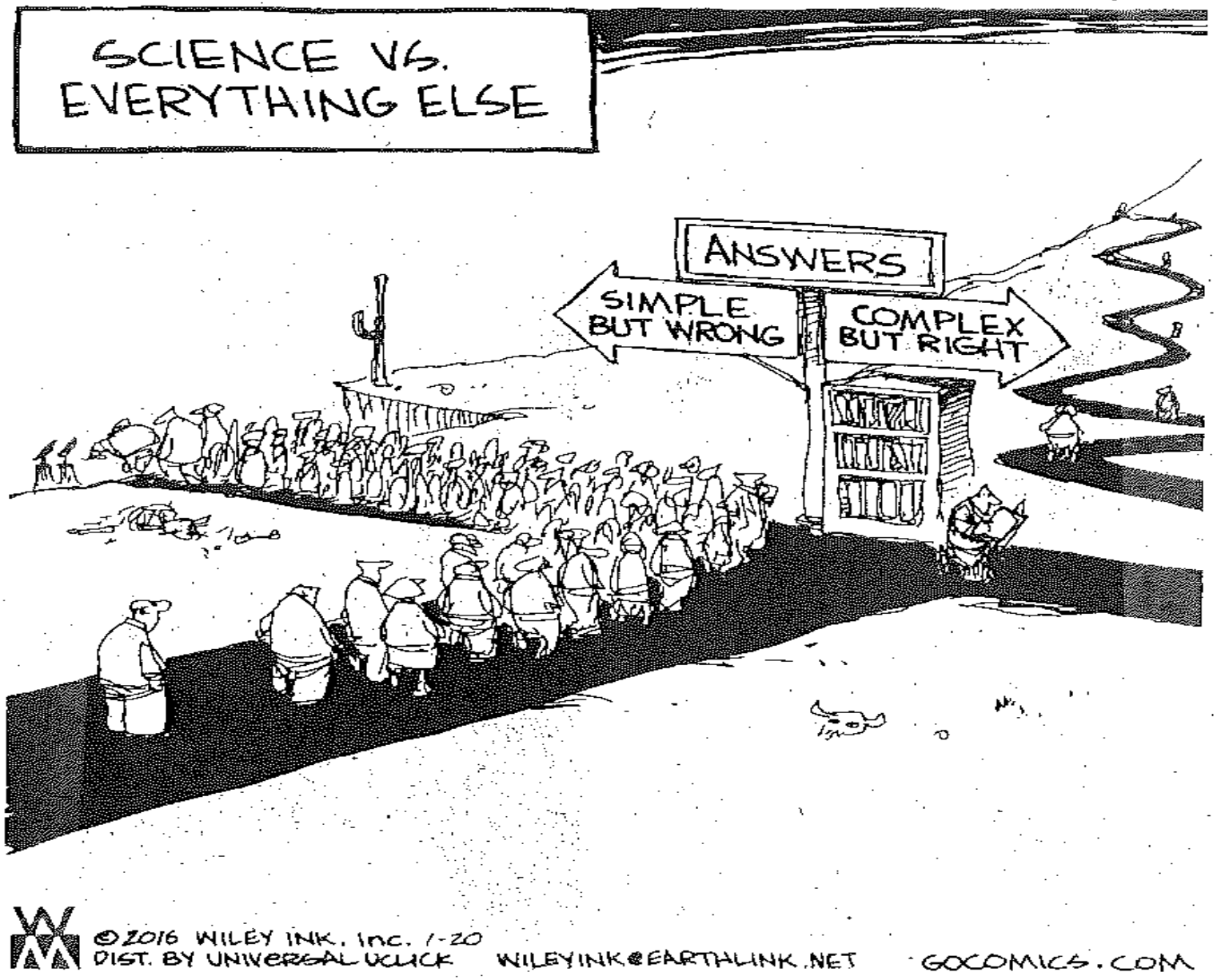
Four ideas

1. The goal? Medical security
2. How are we doing?
3. Causes of problems
4. Possible remedies

1. Medical security – the goal

1. **Confidence we'll get needed, competent, kind, and quick care without worrying about the bill**
2. Three elements
   a. Financial coverage and actual **access** to care
      - ✓ Primary care
      - ✓ Acute hospital
      - ✓ Meds
      - ✓ Long-term care and behavioral/mental health
   b. Cost control—more affordable health care
   c. Appropriateness (the right care) and **quality** (provided competently and safely)

2. How are we doing?
and
3. Causes of problems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SCIENCE VS. EVERYTHING ELSE
ANSWERS
SIMPLE BUT WRONG
COMPLEX BUT RIGHT
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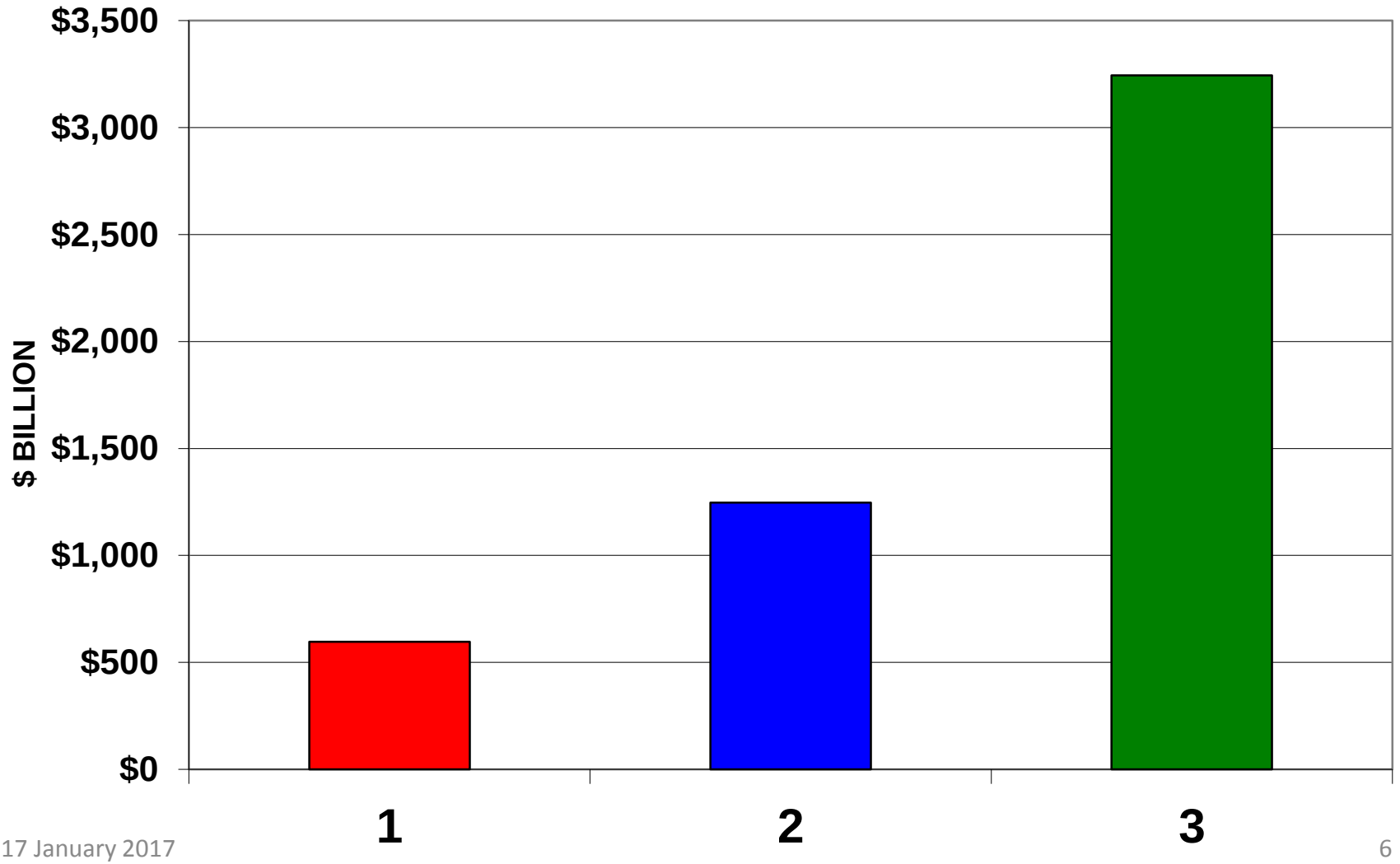
How big in 2015?

Which is total U.S. health spending? Education? Defense?

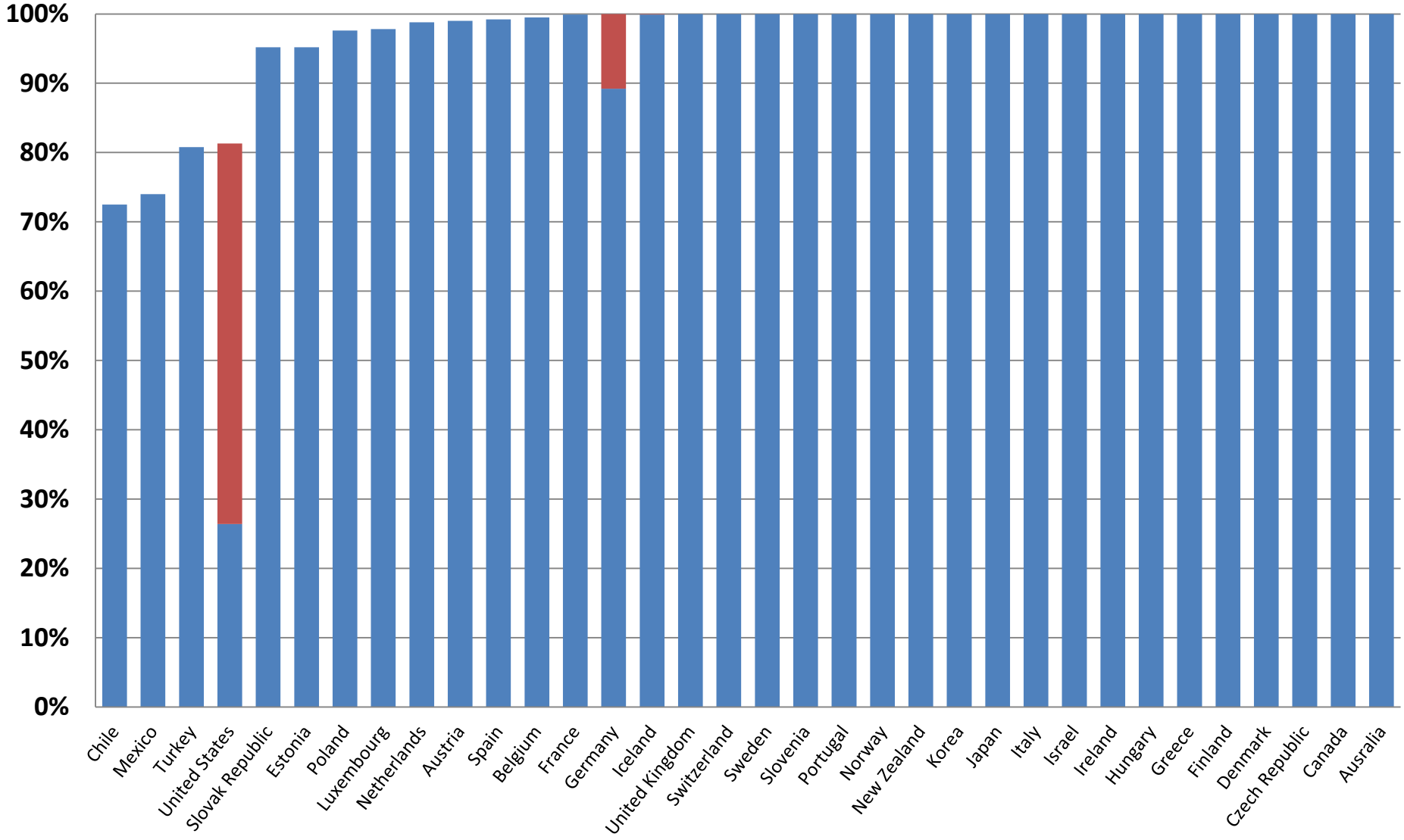


$3,600,000,000 year/365 ≈

$9,800,000,000 daily ≈

≈

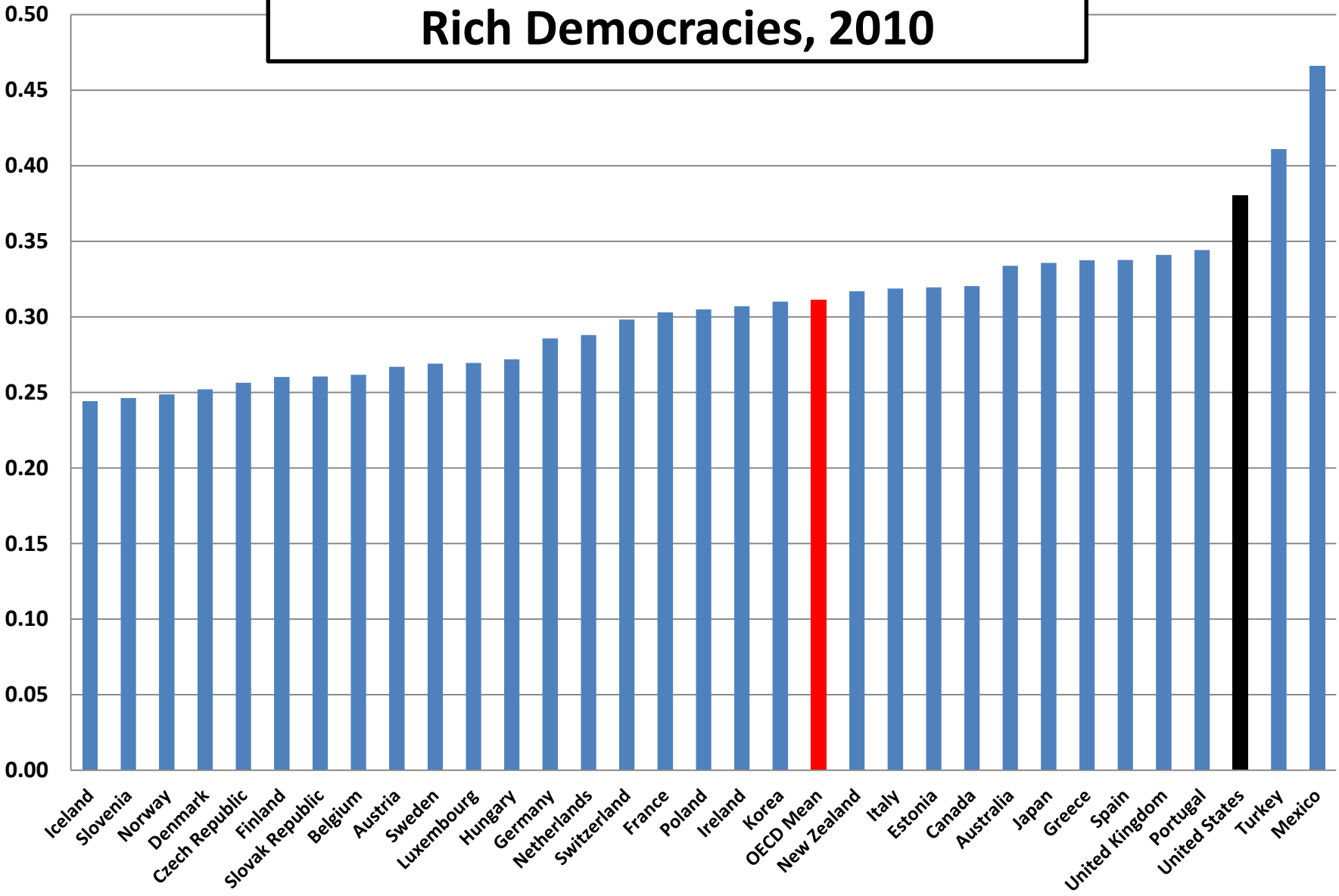
Share of People with Health Insurance, Rich Democracies, 2011



Why is the U.S. the only rich democracy that fails to cover all people?

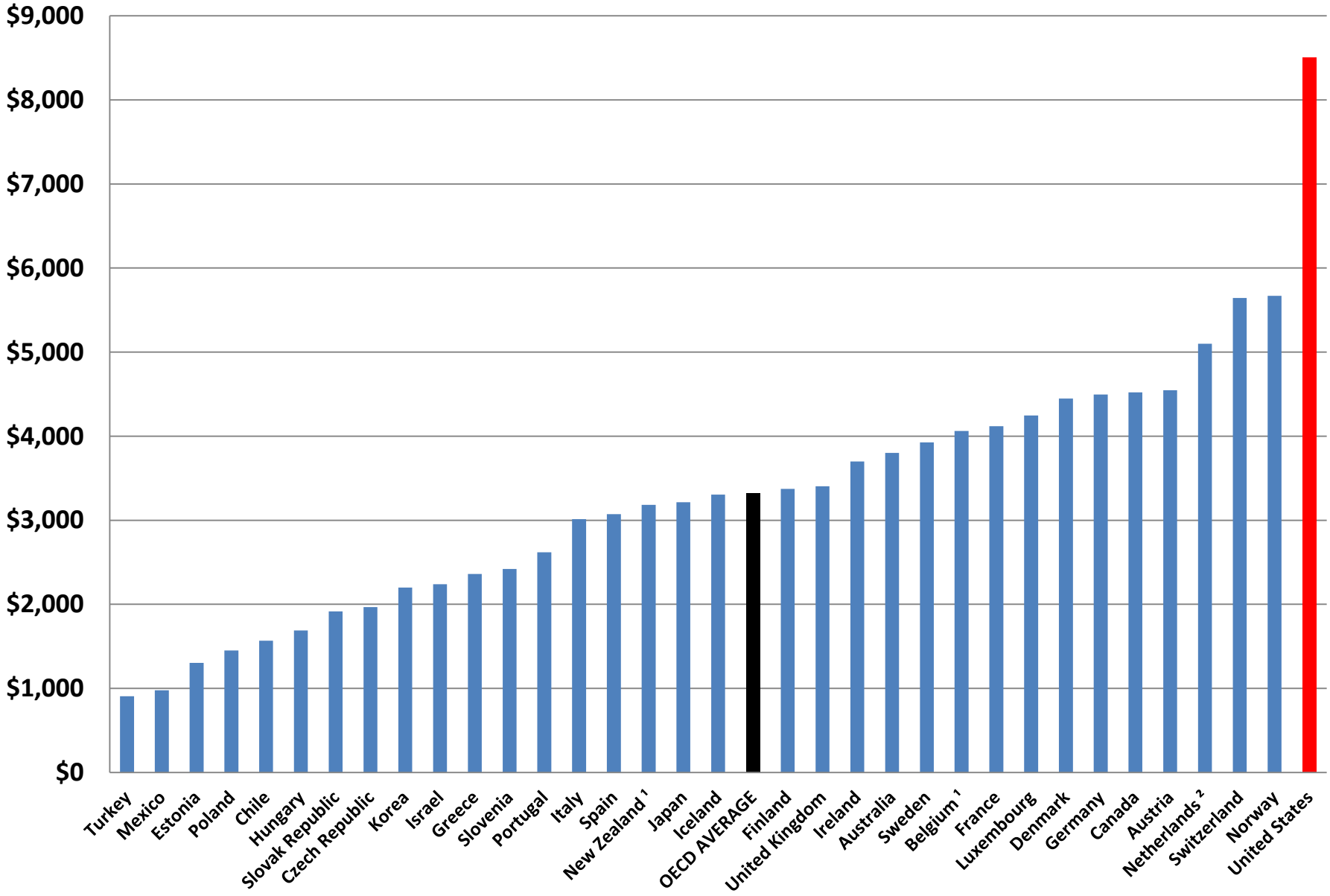
- ✓ High costs of today's care + income inequality → must transfer ↑$s from rich to poor
- ✓ Accident of relying on private health insurance through the job to provide coverage to ½ of us
- ✓ Weak political commitment to covering all
- ✓ Political power of hospitals, doctors, drug makers—who want higher revenue

Gini Coefficients (Income Inequality), Rich Democracies, 2010

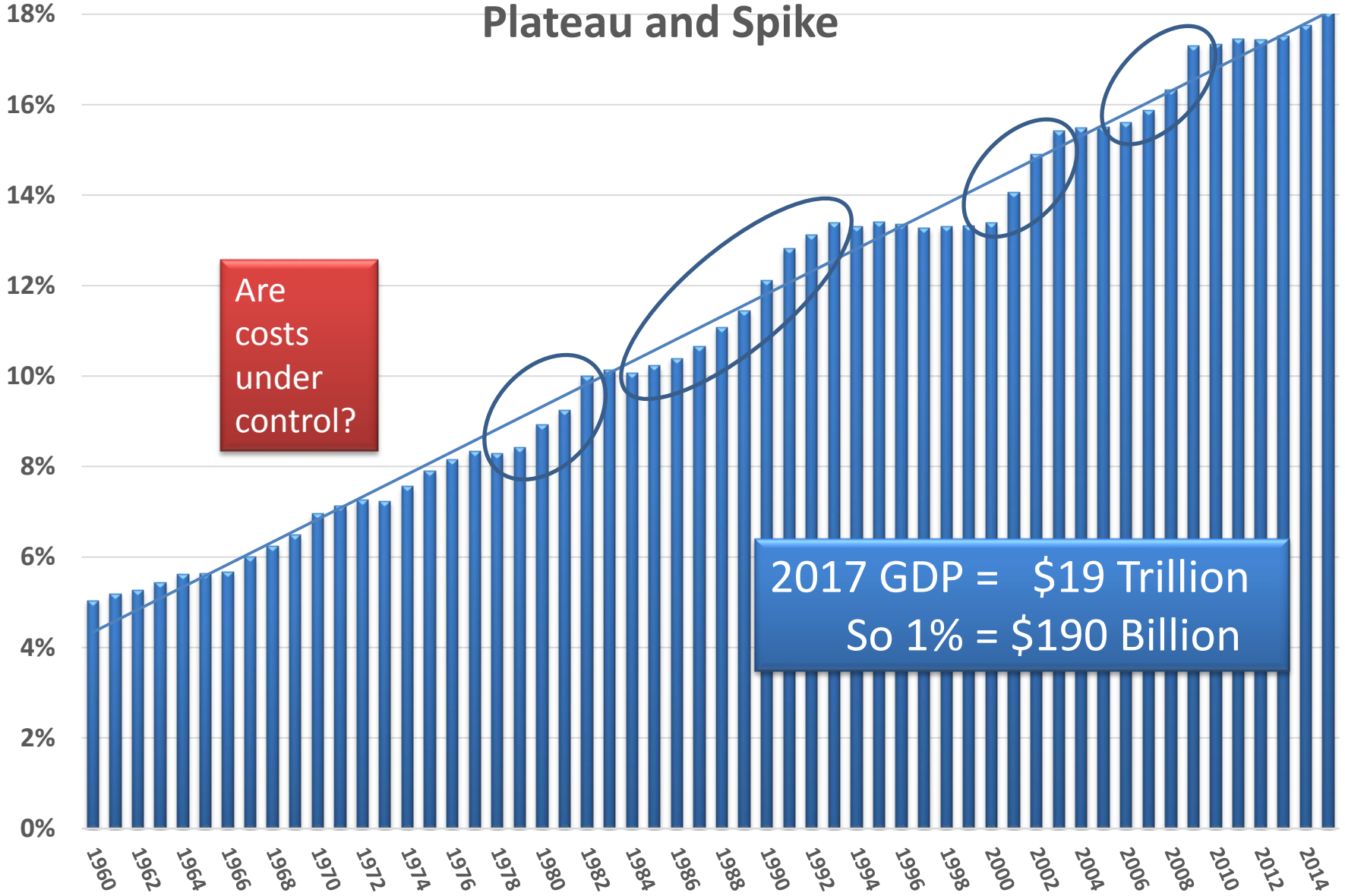



LEAD TRUCK

Health Spending per Person, OECD, 2011, Purchasing Power Parities



Health's Share of U.S. GDP, 1960 - 2015: Plateau and Spike



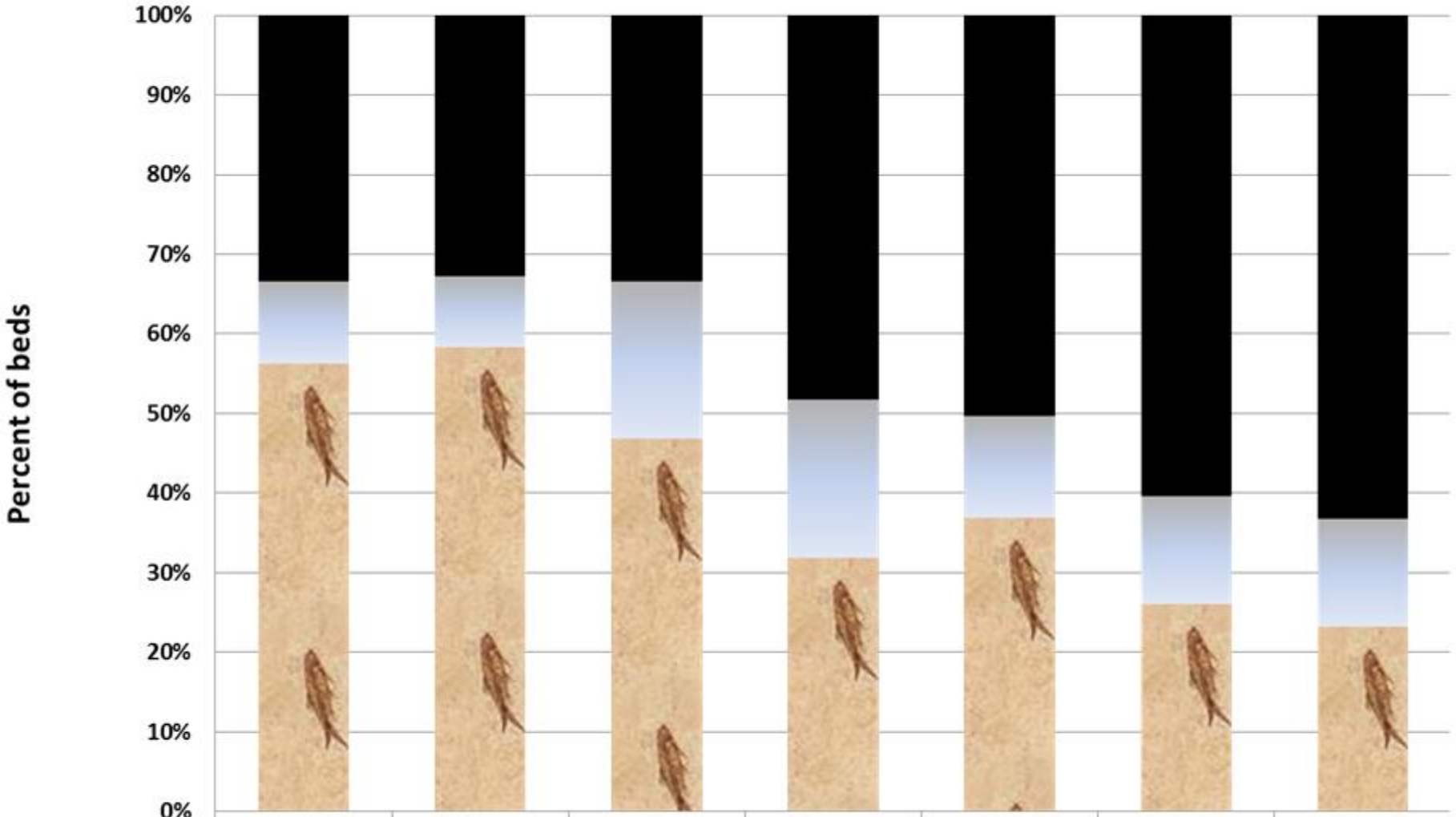
Why are U.S. costs highest in world?

- ✓ Enormous waste
- ✓ Believe can have ↑ health care without ↓ all else
- ✓ Payers compete, don't unite and confront caregivers
- ✓ Refuse to do what other rich democracies do
  - Budget for health care
  - Budgets for hospitals + salaries for their docs
  - Caps on drug prices
  - Boost primary care
- ✓ Hope new technology will cut cost + boost quality
- ✓ Rely on "market forces"
  - Competing insurers
  - Raise out-of-pocket costs to force patients to shop for care by price

Why not target waste?

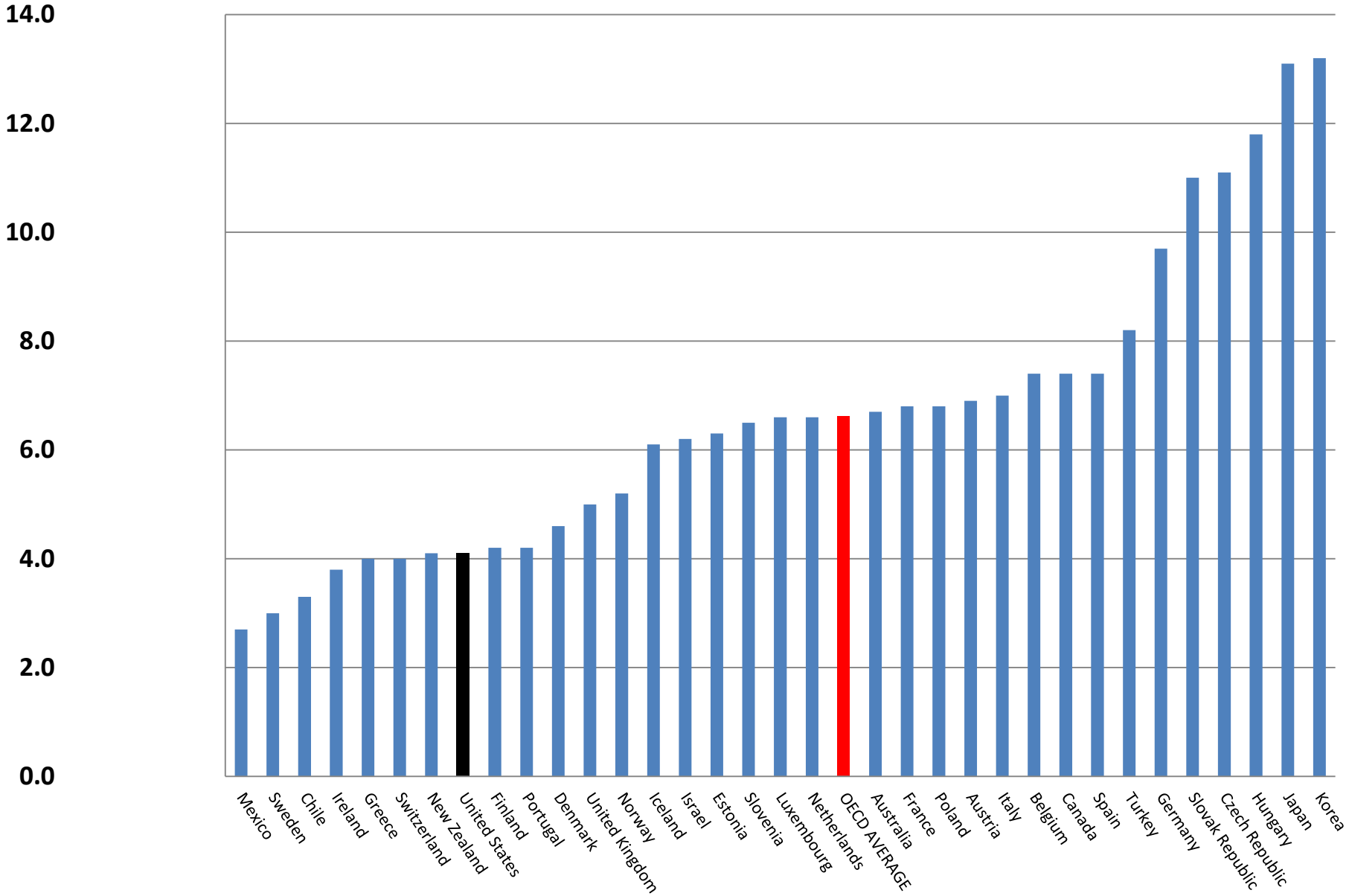
	Percent wasted health $s		
Source/type of waste	low est.	high est.	**middle est.**
Clinical waste	15	25	**20**
Administrative waste	10	20	**15**
Excess prices	7	15	**10**
Theft and fraud	1	7	**5**
Total	**33**	**67**	**50**

Percent of Beds by Medical School Affiliation, 1950 - 2010



	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%

Doctor Consultations per Capita, 2011 (or Nearest)

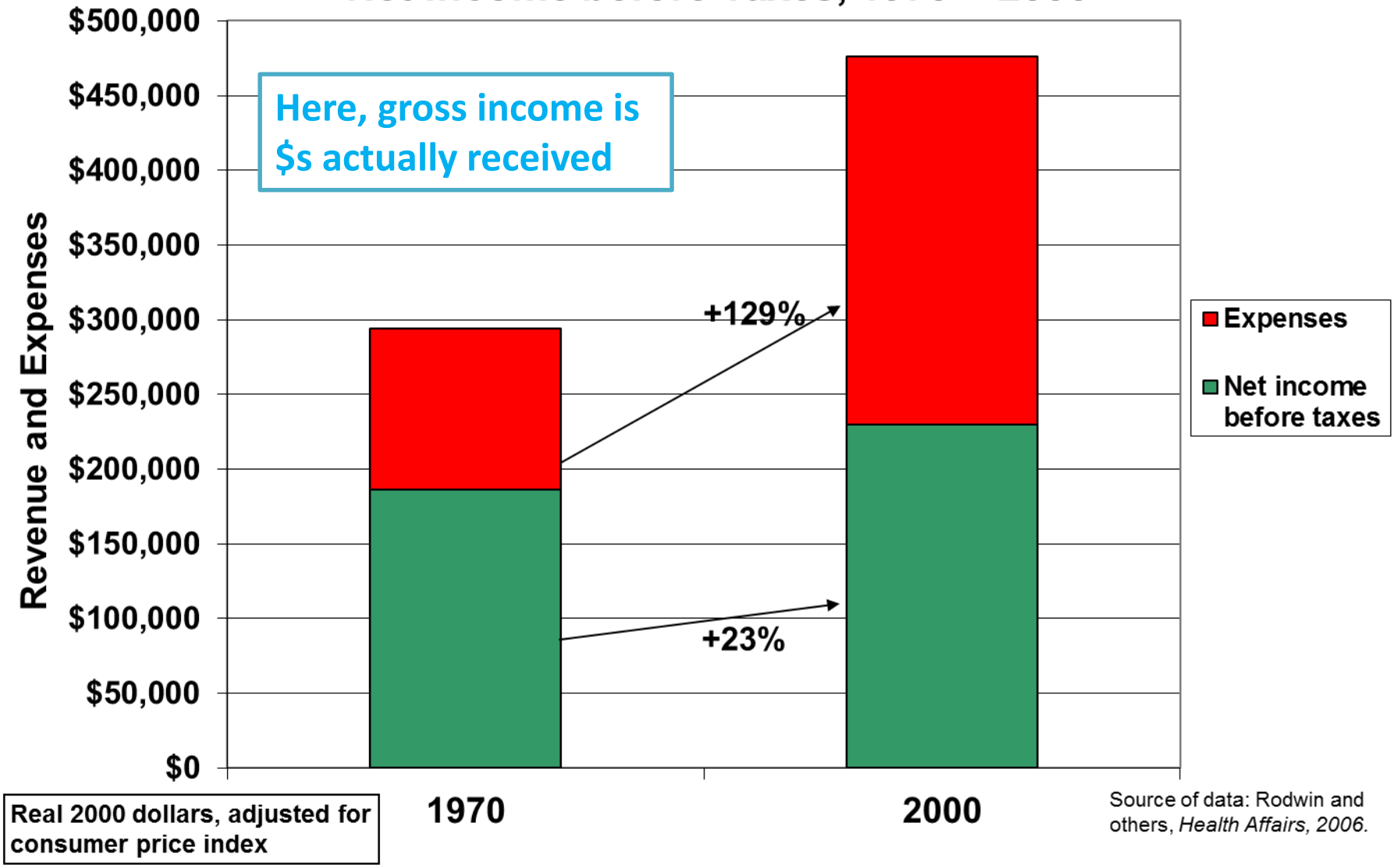


U.S. – OECD PCPs/1,000 People

	U.S.	OECD – 30-nation median
Practicing physicians/ 1,000 people	2.6	3.3
Share in primary care	1/3	1/2
PCPs / 1,000 people	**0.87**	**1.65**
→ Non-PCPs/1,000 people	**1.73**	**1.65**

Source: OECD, Frequently Requested Health Data, October 2012, http://www.oecd.org/els/health-systems/oecdhealthdata2012-frequentlyrequesteddata.htm; Health United States, 2011; and various estimates of PCP share in other nations.

U.S. Physician Average Gross Income, Expenses, and Net Income before Taxes, 1970 + 2000



Source of data: Rodwin and others, *Health Affairs, 2006.*

Technology that reduces cost, enhances quality, both, or neither

- Consider a $1,800 personal computer in 1983.
- Specifications?
- What forces → cheaper and much more powerful machines today?

Osborne 1	
Introduced:	April 1981
Price:	US $1,795 = **$4,640 in 2016 $s**
Weight:	24.5 pounds
CPU:	Zilog Z80 @ 4.0 MHz
RAM:	64K RAM
Display:	built-in 5" monitor
	53 X 24 text
Ports:	parallel / IEEE-488
	modem / serial port
Storage:	dual 5-1/4 inch, 91K drives
OS:	CP/M

Source: http://oldcomputers.net/osborne.html.

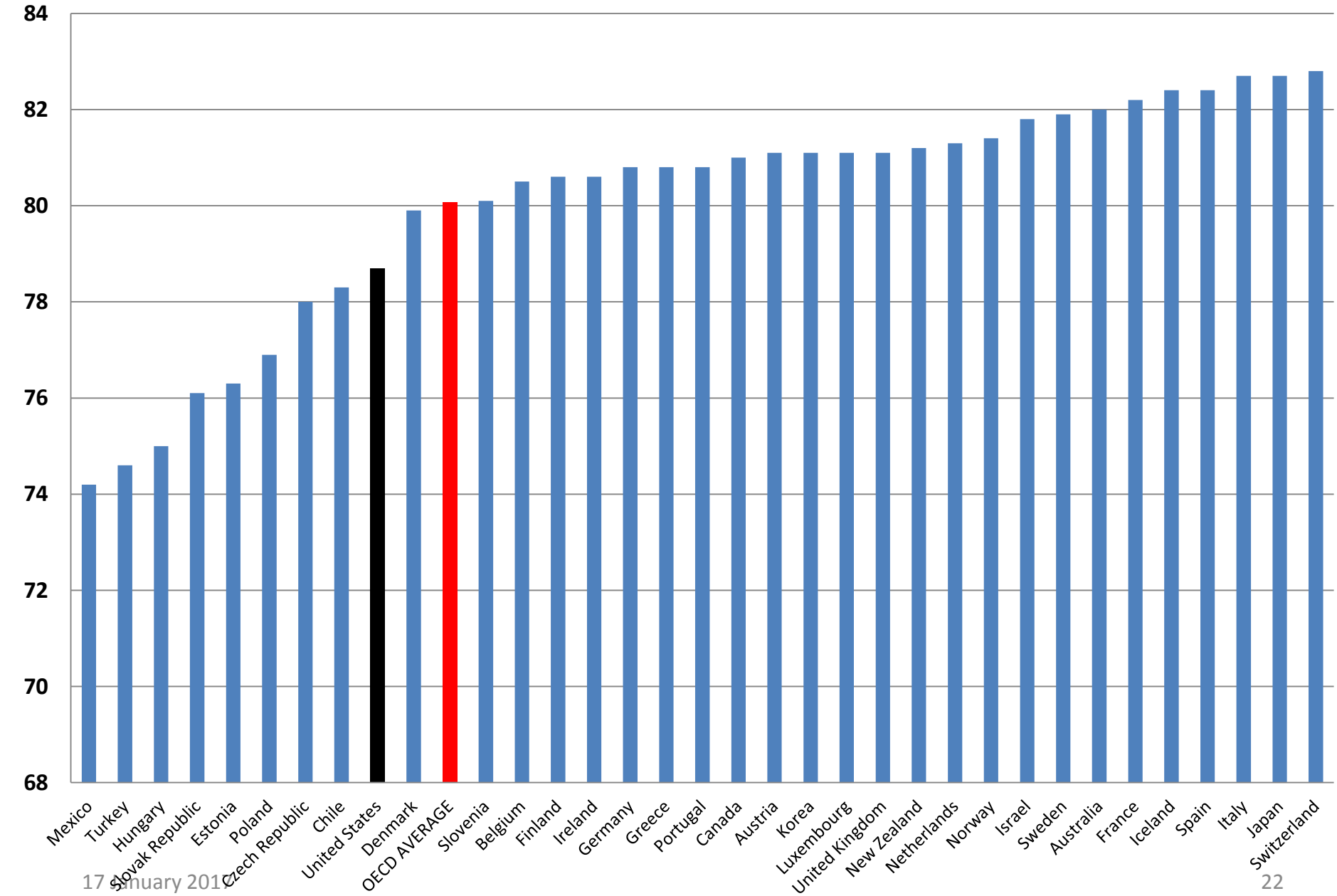
Civilian Jobs Outside Health Care per Job Inside Health Care, 2000 –

2000	2007	2009	2012
11.2	**8.9**	**8.0**	**7.8**

In 2000, we had 44% more jobs outside health care, for each job inside health care, than we do today.

Sources: *HUS 2010,* Table 105; Current Population Survey, Employment and Earnings, http://www.bls.gov/opub/ee/2013/cps/annavg18_2012.pdf.

Life Expectancy at Birth, Rich Democracies, All People, 2011



Why are U.S. outcomes so poor despite (or because of) high spending?

- ✓ Disorganization of care
  - ✓ Very weak primary care—family doctor—who knows us and who coordinates care
- ✓ Very uneven access
- ✓ Focus on ceiling (best care for some) and not floor (lowest quality we tolerate for anyone)
- ✓ Shift of care to teaching hospitals
- ✓ Iatrogenic harm – care that kills
- ✓ Reliance on patients to shop by quality—and price

4. Possible remedies

- ✓Government regulation and planning
- ✓Market competition
- ✓Professionalism and financial neutrality
- ✓Address social determinants—or health care itself?
- ✓A few specifics – family doctors, affordable meds, and secure long-term care

Two kinds of balanced results

- Better access, cost control, and quality/ appropriateness
- Political and financial balance—so patients, payers, caregivers, and others are reasonably happy

a. Failure to achieve balance through government action, politics

- Weak political will to limit U.S. cost—why?
  - Caregiver power—they seek more money
  - Cost of insurance through job is usually invisible to workers
  - Americans hope for all the health care someone else is willing to pay for
- Instead
  - Government touts succession of gimmicks—look busy
    - Hospital closings – accountable care – pay for value—boost OOPs
  - Ignore effective tools, used by other rich democracies
  - Avoid honest political negotiations

Which cost controls are effective? Politically feasible?

	Politically feasible	Politically infeasible
Effective	✓	• Cap spending • Payers pool revenues • Budgets for hosps • Set doctors' fees to yield targeted incomes • Single payer?
Ineffective	Traditional market and government action	No worries!

b. Free market's seduction

- When market works, it works very well, and without visible human or political interference
- Invisible hand rewards greed **and** yields 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**– it respects the distribution of purchasing power
    - If some people lack purchasing power, government can redistribute income so all people can demand care
- When market works, it seeks equilibrium
  - Some people prefer market for ideological reasons
  - Other people think government can't work well in health care
    - So they think that market is only practical way to contain cost, improve quality, or get right caregiver configuration

Market failure

Freely competitive market requires 6 things.

Not one of the 6 is close to satisfied in health care (***darn!***)

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 or can't be met—is bound to disappoint

- Without free market, pursuit of profit won't yield either efficiency or the care we want and need
  - When the 6 aren't met, invisible hand picks your pocket
  - Market rhetoric can then serve as smokescreen for bad behavior and dangerous outcomes
  - Caregivers may compete for a while by price and quality
  - But they often merge, because that's a lot easier and less worrying than competing. And then can raise price.
- Competition means complexity + confusion for doctors, hospitals—and for us

Government applies a double standard to market failure, one for hospitals and another for humans

- Allows mergers by hospitals and drug companies, enabling them to boost prices
- Pushing competition, government
  - Raises out-of-pocket (OOP) payments, thereby creating barrier between sick people and the health care they need
  - Forces us to choose among complicated Medicare Part D drug plans or ACA plans
  - Forces doctors to cope with multiple insurer rules

Blame high cost on patients' unhealthy behavior + over-use of care because we had good insurance

- "Moral hazard" credible or moralistically satisfying to some
  - Good insurance → bad behavior + use of unneeded health care
    - Recreational surgery and MRIs?
- Smoking and drinking (U.S.A. relatively low)
- Obesity (U.S.A. costliest before we gained weight)
- Blame is smokescreen or distraction
  - Government and insurance companies look busy
  - Points finger at us → ↓pressure for real action to contain cost
    - Raise money differently? Pay caregivers differently? More family doctors?
- Attacks weakest party to bear burden

Cost-sharing Terms are Very Difficult for Consumers

- ☐ Deductible
- ☐ Copay
- ☐ Coinsurance
- ☐ Benefit Limit
- ☐ Out-of-Pocket Maximum
- ☐ Balance Bill

Separate deductibles for drugs or other services
Individual vs. Family
Aggregate vs. Embedded
Allowed Amount
Visits, days
In- vs. Out-of-Network

BlueCross BlueShield of North Carolina

An independent licensee of the Blue Cross and Blue Shield Association.

Explanation of Benefits

December 01, 2011 *This is not a bill.*

Subscriber information

First: John A
Last: Doe
ID: W1234567891
Blue Options Plan

Need more information?

Find answers online at ***mybcbsnc.com***

Customer Service (Monday-Friday, 8 a.m. - 9 p.m. EST) 1-888-234-2416
Servicio al Cliente (Lunes – Viernes, 8 a.m. - 9 p.m. EST) 1-888-234-2416

Additional Information

Please save this form for your tax records. Your balance may not reflect any prior payments made by you or another insurance company.

The information listed in the "Benefit Year Summary" section indicates the most current benefit period information on your plan as of the date o this notice. The "Amount Satisfied" will reflect the total amount applied throughout your plan's benefit period, which may include amounts applied before and after any changes in benefits or dependents covered throughout the current benefit period.

Para obtener asistencia en español, comuníquese con el departamento de servicio al cliente al número que aparece al respaldo de su tarjeta del seguro.

Benefit Year Summary - For benefit period starting 01/01/2011

Blue Options Plan	In-Network Deductible		Out-of-Network Deductible		In-Network Out-of-Pocket		Out-of-Network Out-of-Pocket	
	Plan's Maximum	Amount Satisfied	Plan's Maximum	Amount Satisfied	Plan's Maximum	Amount Satisfied	Plan's Maximum	Amount Satisfied
John A	$700.00	MET	$1,400.00	$0.00	$3,210.00	$0.00	$6,420.00	$0.00
Jane B	$700.00	$0.00	$1,400.00	$0.00	$3,210.00	$0.00	$6,420.00	$0.00
Joe C	$700.00	$0.00	$1,400.00	$0.00	$3,210.00	$0.00	$6,420.00	$0.00
Family	$2,100.00	$700.00	$4,200.00	$0.00	$9,630.00	$0.00	$19,260.00	$0.00

These benefits require you and/or your family to reach payment maximums, labeled "Plan's Maximum," before your plan pays a greater share of the cost. These maximums can be reached in two ways: when you've satisfied your individual maximums, or when your family has met its maximums. Payments made by members are credited both to their individual Amount Satisfied and to the family's, up to the individual maximum amount. Individual maximum requirements are waived when your family maximum is reached. The amount satisfied column will read "Met" if an individual or family maximum is satisfied.

Patient: John A. Doe #: W1234567891

Medical Services Detail	Your Provider Billed	Member Benefit			Amount Your Provider May Bill You					Reason Code (See below)
Claim #: 01-102510-046-40		Allowed Amount	Member Savings	Your Plan Paid	Copayment	Deductible	Coinsurance	Other Liability	TOTAL	
Provider: JOHN SMITH **Date(s):** 11/21/2011-11/21/2011	$875.00	$600.00	$275.00	$0.00	$0.00	$600.00	$0.00	$0.00	$600.00	
	Service: MEDICAL CARE									
Provider: JOHN SMITH **Date(s):** 11/21/2011-11/21/2011	$150.00	$100.00	$50.00	$0.00	$0.00	$100.00	$0.00	$0.00	$100.00	
	Service: LABORATORY									
Provider: JOHN SMITH **Date(s):** 11/21/2011-11/21/2011	$50.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$50.00	$50.00	ENB
	Service: SUPPLIES									
Total for Claim # 01-102510-046-40	**$1,075.00**	**$700.00**	**$325.00**	**$0.00**	**$0.00**	**$700.00**	**$0.00**	**$50.00**	**$750.00**	

Blaming patients is toxic

- ACA + employers boost deductibles, co-insurance, co-pays
- ACA insists that market requires weakening patients' insurance coverage
  - Force us humans to have "skin in the game"
  - Shop by price and quality
- Popular with some
  - Employers, who save on premiums,
  - Young or healthy workers, who also like lower premiums and hope to avoid OOPs by not getting sick
- Results
  - Indiscriminate cuts in use of care, both needed and not
  - Higher OOPs are a tax on sickness and using care
  - People with more chronic illness have lower average incomes

Raising OOPs – dumb cost controls and dumb politics

- ✓ Theory
  - Give ~~patients~~ consumers information about price, quality +
  - Make them pay more out-of-pocket
  - And they'll shop carefully
- ✓ Reality
  - Data on price are hard to find, irrelevant
  - Data on quality are worse
  - Main question is who needs what care—how can non-clinicians judge that
- ✓ So telling us to shop by price + quality = telling kids to go play in traffic
- ✓ Patients will rebel against manipulation, inability to afford care, and debt

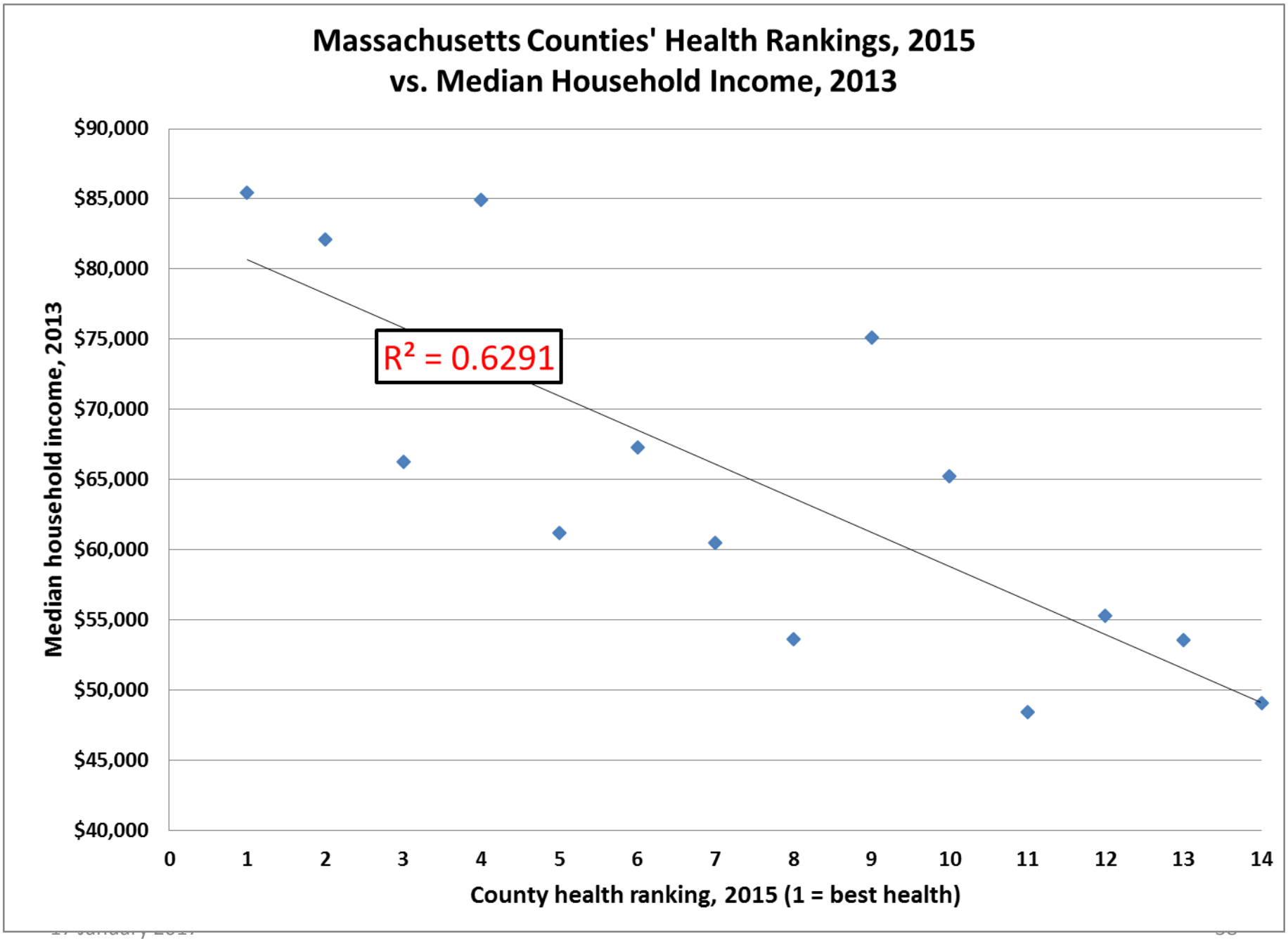
c. Alternative to government and market

- Doctors might act as professionals to diagnose and treat us carefully—spend money carefully
- Non-profit hospitals might act as fiduciaries
  - If they try to spend big but finite budgets carefully
- So could non-profit HMOs like Kaiser
- Both doctors and hospitals might aim for as much health as possible with dollars available

→What conditions are <u>necessary</u> to allow us to place trust in professional or fiduciary behavior?
  - Are those conditions <u>attainable</u>?

d. Pay more attention to “social determinants of health”

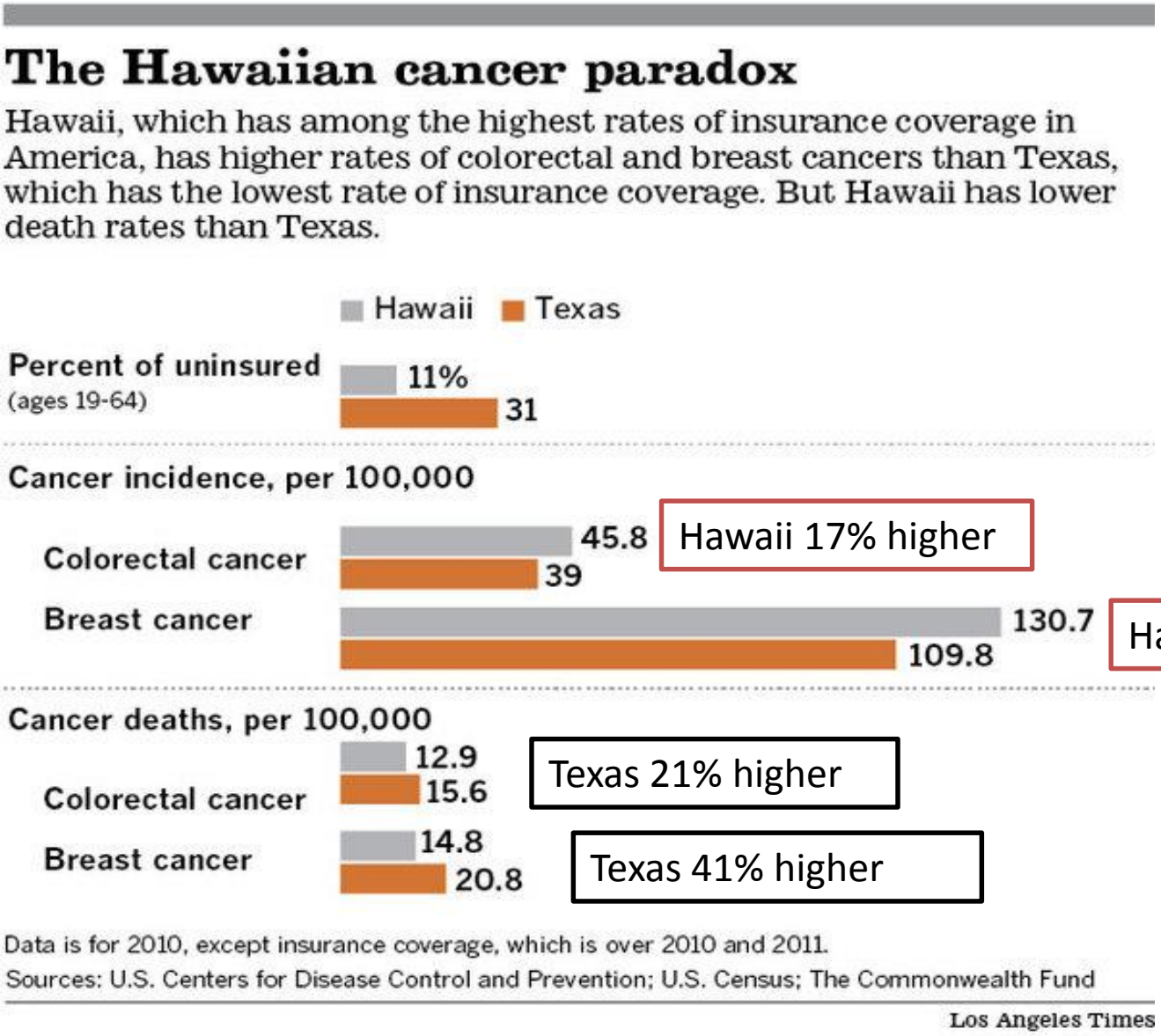
- Economic – jobs, income, savings
- Social – education, stress reduction
- Behavioral – smoking, drugs, alcohol
- Environmental – air, water, toxins like lead


Massachusetts Counties' Health Rankings, 2015
vs. Median Household Income, 2013
$90,000
$85,000
$80,000
$75,000
$70,000
$65,000
$60,000
$55,000
$50,000
$45,000
$40,000
Median household income, 2013
R² = 0.6291
0
1
2
3
4
5
6
7
8
9
10
11
12
13
14
County health ranking, 2015 (1 = best health)

Why focus on medical care?

1. Economic, social, behavioral factors hard to change
   - Especially absent political willingness to pay to address them
   - And that's partly because health care sponges up so much $
2. Overwhelming share of $3.6T in health spending goes to medical care of individuals
3. I think ≈ ½ of this money is wasted
   - You might want to squeeze out some wasted money, capture it, and recycle some of it to boost access to health care
   - And use some to remedy economic, social, or behavioral factors
   - You might want to spend some of it on public health
4. **If health care can't delay death or overcome pain or disability, it can at least avoid bankrupting the patient—or sponging up money we could use for other things**

Does affordable access to health care matter?



A few specifics—
Family doctors

- ✓ Force med schools to recruit students who like both science and patients
- ✓ Pay family doctors more and double their numbers
- ✓ 300,000 family doctors * $300,000 each

  = $90B

  = 3% of health spending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Cut Rx prices

- ✓ Get cost of research and profit out of price of pill by paying prizes for valuable new meds
- ✓ Break up the big vertically integrated drug makers and focus on better financing of research
- ✓ Nominal OOPs only - $3/generic and $5/brand

LTC

- Need lots of help for a long time → ↑ $s
- Congress afraid of cost of good Medicare LTC
  - Fears bottomless financial pit
- Families now provide 80% of LTC
- Must combine more public money with more voluntary help to assure safe, adequate, dignified LTC—preferably at home

17 January 2017

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