Getting Ready to Address Massachusetts Health Care Realities

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Caucus of Women Legislators
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This talk rests on nearly two decades of professional collaboration with Debbie Socolar, fellow-director of the Health Reform Program. Many of the points in this talk are documented in reports and testimony published on our web site, www.healthreformprogram.org.

A. Introduction

In health care, as elsewhere, the bill that can work usually can't pass and the bill that can pass usually won't work.

Together, we now spend over $1 billion weekly on health care in Massachusetts.

Costs soar.

The number of people without insurance rises.

As citizens, we wring our hands.

As employers, we try to trim our obligations.

As a legislature, the General Court is not yet able to do much to make health care sustainable—durably affordable for all. The pressure just isn't there yet.

But when the pressure gets great, you won't know what to do. Unless.

Unless each legislator thinks much more seriously and steadily about
- ✓ Health care problems,
- ✓ Their causes, and
- ✓ Real solutions.

This goes way beyond this year's debate over single payer versus employer mandate versus gubernatorial posturing.

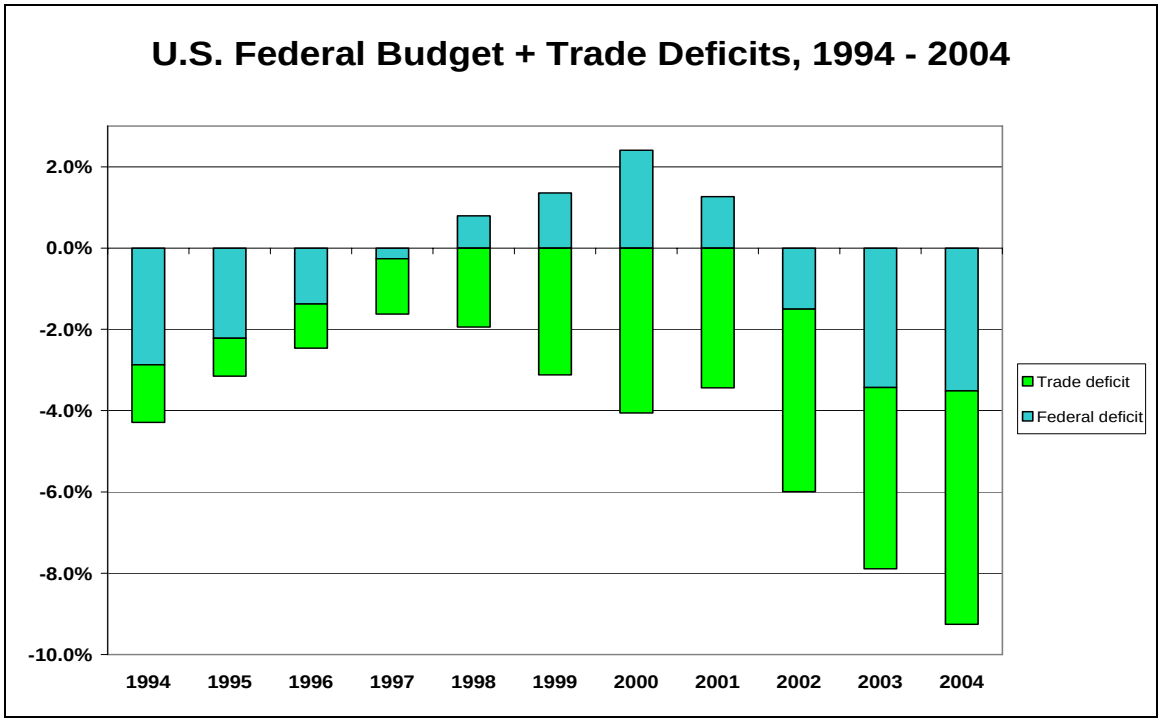
It goes to covering everyone and financing health care for all out of existing spending, which is already more than adequate to do the job.

It goes to learning how to negotiate peace treaties with doctors, with hospitals, with nursing homes, and even with drug companies.

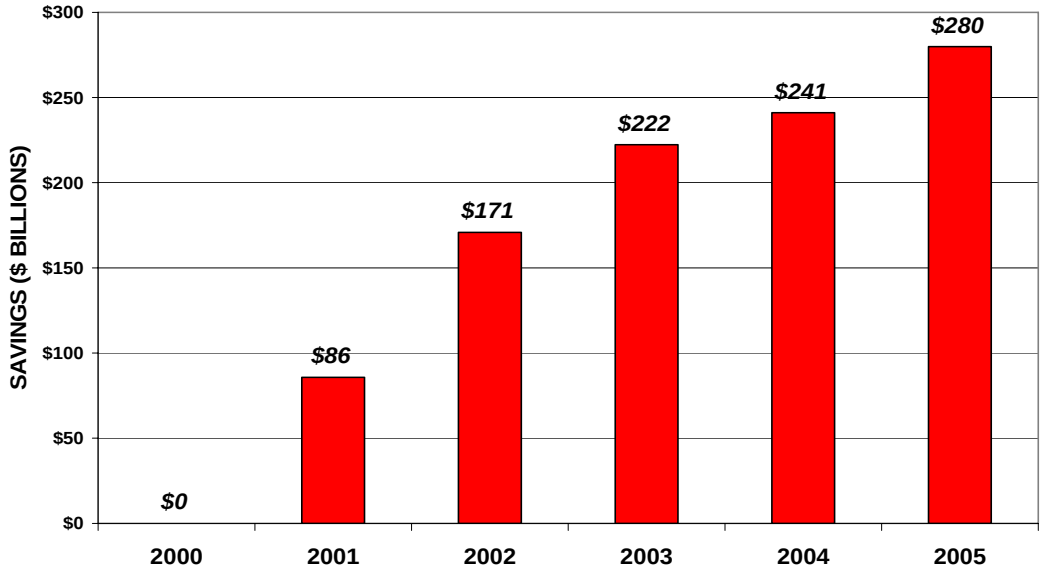
B. We all need to get ready—
Health care business as usual won't work when the economy melts down

Health care in the U.S. and in Massachusetts is addicted to more money for business as usual—3-5 percent annual growth in real spending per person.

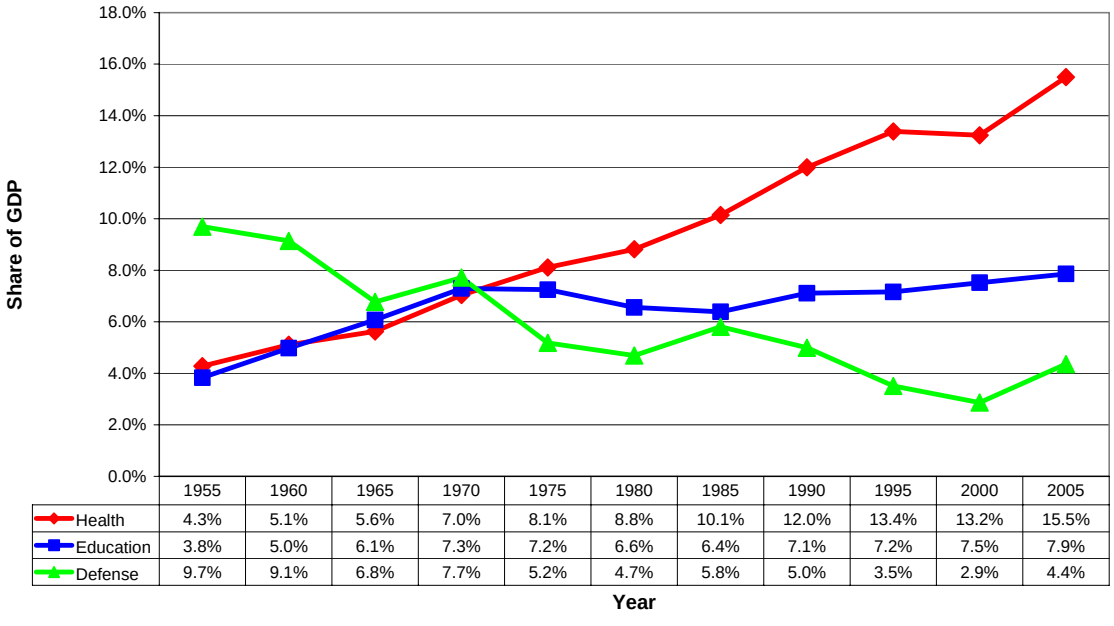
But the U.S. economy is living on borrowed time, borrowed money, and borrowed Toyotas. This year might really be 1927. Consider the trade deficit's and federal deficit's share of GDP over the past decade, rising to almost 10 percent last year.



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



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%

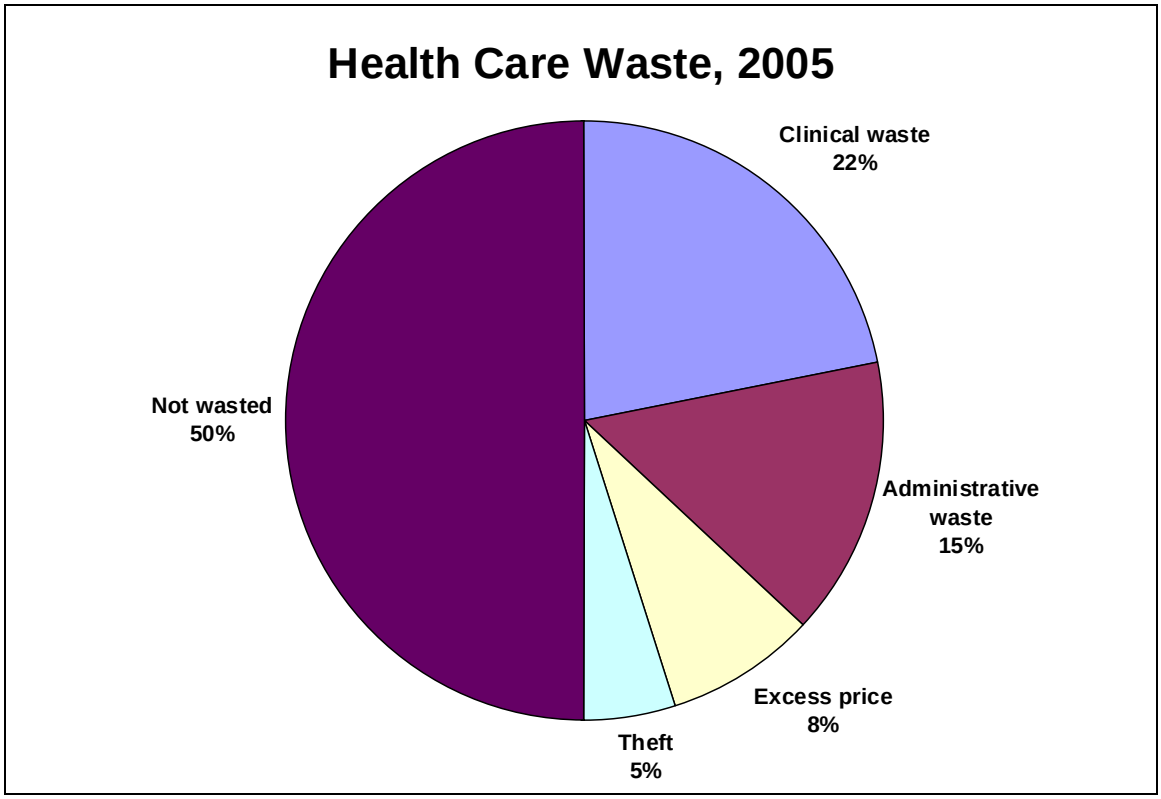
C. The easiest problem to solve

Fortunately, health care is the easiest problem to solve in the U.S. Not easy, just easier than all of the others. Because we already spend so much.

Especially in Massachusetts, which has the world's costliest health care. (Please refer to separate one-page chart on "A few Massachusetts health care realities, 2005.")

- $1 billion weekly for health, 27 percent above U.S. per-person average.
- Many fewer hospital beds/1,000 people than nation as a whole.
- Lots more physicians and nurses
- Heavier reliance on HMOs
- Relatively few people uninsured (though numbers growing)
- 5-th worst income inequality among the states

But one-half of health spending is wasted.

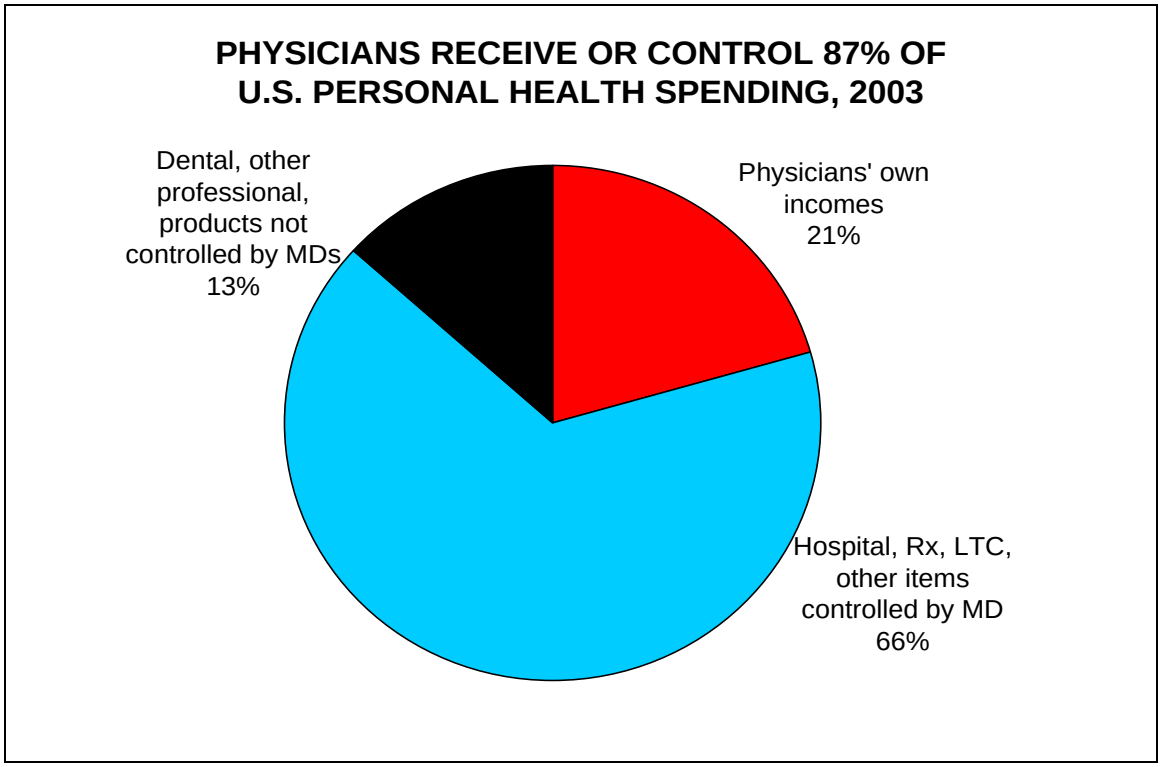


D. Types of waste and their causes

- ✓ Clinical—unnecessary care owing to financial incentives to over-serve, defensive medicine, and lack of knowledge of what care is needed and works
- ✓ Clinical—incompetent care owing to failure to use existing knowledge, and impairment of the caregiver
- ✓ Administrative—owing to need to determine eligibility, complexity caused by multiple payers/multiple rules, and especially to the enormous mistrust between both doctors and payers, and hospitals and payers.
- ✓ Excess prices—of prescription drugs, much durable medical equipment, and some salaries.
- ✓ Outright theft and fraud

E. Squeezing out waste, capturing it, and recycling it to protect under-insured and uninsured people

Step 1—commit to covering everyone and paying all needed caregivers fairly and adequately, using only the money that's already available.



Step 2—recognize that doctors control about 87 percent of health dollars. They must therefore be at the center of any real reform. Doctors' gross incomes are about 20 percent of each health dollar, but they only retain about 8 percent after paying practice expenses. But how we get this 8 percent into their hands powerfully shapes the flow of the remainder of the 87 cents that they control.

In the past, payers and managed care organizations have found it hard to work with doctors and instead tried to regulate doctors, bribe them, coerce them, or otherwise attempt to manipulate them and their behavior. One reason is that doctors simply resisted controls that took away the blank checks they'd been given in the fat years of the 1950s and 1960s.

In the future, we need to negotiate a peace treaty with doctors—a clinical, financial, and political peace treaty.

Step 3—these are some of its possible provisions—

- ✓ Clusters of doctors might accept budgets to care for groups of patients.

- ✓ The budget for each cluster would be poured into two separate water-tight compartments, one to pay doctors and the other to pay for the medications, lab work, radiology, inpatient care, and other services that only doctors can authorize.

- ✓ Doctors have to decide among themselves how to divide up the money in their own compartment—with rewards based mainly on some combination of competence, energy, and kindness.

- ✓ Doctors then have to carefully use the money in the second compartment to care for their patients. They have to spend all of this money. They can't benefit by scrimping. They can't spend more than they have.

- ✓ The budgets for each cluster of physicians would be adjusted for patients' illness, disability, and other risk factors.

- ✓ Because these arrangements liberate doctors to spend money carefully to do as much clinical good as possible with the inevitably scarce dollars that are available, they are clinically and financially trustworthy. That is, doctors face no financial incentives to over-serve or under-serve. Although some policing will inevitably be required, most of the paperwork that is common today—paperwork attributable to mistrust and also to complexity—will be eliminated.

- ✓ In exchange for taking on this job, doctors would cease to be liable to be sued for malpractice. Instead, income that patients lose from sub-optimal medical care would be replaced from new social insurance funds. All medical costs

would be covered by the universal coverage financing. Compensation for added costs of pain and suffering would be decided by separate legislation.

Step 4—none of this will be easy to do. But this is a lot more meaningful than throwing up numbers on a PowerPoint presentation or tossing ever more money into Massachusetts health care.

Building durably affordable health care for all will require much more than legislation—it will require lengthy conversations between state government leaders, physicians, payers, and patient advocacy groups. We have to stop alternating between throwing money on health care and dropping bombs on health care. We have to coordinate our work to contain cost and cover everyone.

Step 5—each stakeholder will have to identify what's vital and what's peripheral. What it must have, and what it's willing to compromise on, in the interest of winning affordable care for all.

Now follows a picture of the U.S.S. *Constitution,* which was launched in 1797 and is now moored in the Charlestown district of Boston, Massachusetts.

Its mainmast is 220 feet (67 meters) high. To furl and unfurl the sails, sailors would climb rope ladders and edge out on the yards (horizontal timbers attached to the masts) and tie and untie knots. They did this in storms, when the ship was rolling and pitching wildly, in total darkness, and in rain or snow. Discipline helped sailors do this. So did professional pride and group cohesion. Perhaps most important, sailors knew that the ship could easily be destroyed during storms if the sails were not adjusted properly. Accordingly, the sailors' motto was "one hand for yourself and one hand for the ship."

Understandably, each stakeholder in health care fights for its own interests. Caregivers seek more money for business as usual. Each payer tries to pay less

or to shift costs to another payer (especially, today, to patients). Advocates of improved financial coverage often seek higher spending to advance their aim.

This strategy has worked reasonably well for most parties until now. It may work a little longer, but probably not much. Each stakeholder therefore needs to give much more serious thought to what is essential to its own long-term self-interest and to ways to reconcile that self-interest with the needs of other stakeholders—and with the nation's need for affordable and high-quality health care for all Americans.

Unaffordable health costs and the fragile U.S. economy pose great risk of a medical meltdown, which would cost tens of millions more Americans their coverage, and drive huge numbers of caregivers out of business, destroying invaluable medical resources and leaving all Americans vulnerable. The nation is unlikely to avoid such a medical meltdown unless physicians, hospitals, drug makers, and other caregivers recognize the value of securing financial stability for themselves—and for health care across the country—in return for wholeheartedly taking on the job of covering all people with the dollars available.

If you think this is unrealistic, it is actually hospitals', drug makers', and other caregivers' demands for more money for business as usual in health care that are unrealistic. So are hopes of solving our access problems with more money.

For example, just recall the fate of the 1988 Universal Health Care Law, c. 23 of the Acts of 1988, signed here on 21 April among balloons, national news cameras, and the bright hopes of the Dukakis presidential campaign. Hospitals got $3 billion in added revenues, phasing in immediately, and universal health care got a lot of promises and ultimate repudiation. Coverage expansion that is not joined at the hip to cost control will be steadily eroded.

F. Affordable medications

Winning affordable prescription drugs for everyone in Massachusetts might not be a bad place to begin.

The choice is among suffering and dying prematurely for lack of needed medications, paying still more money to the world's drug makers, and genuine reform.

This year, U.S. prescription drug spending of over $250 billion provides the world's drug makers with about one-half of their world-wide revenue. An impressive accomplishment by only 5 percent of the world's people. Yet some 70 million of us have no prescription drug insurance, others have meager coverage, and rising drug spending boosts insurance premiums.

In Massachusetts, retail prescription drug spending this year will be about $4.2 billion. When additional spending in hospitals and nursing homes is counted, the total approaches $5 billion. We spend about as much on medications as the total of Denmark plus Sweden—nations with double our population.

Yet some one million of us have no prescription drug insurance.

To cover all people in Massachusetts, we could throw more money at the drug makers. They say they want it—to finance more research, of course. But we can't afford it. And they don't really need it.

There's a better way.

State government could negotiate a package deal with each drug maker. If you sold $400 million of your products in Massachusetts last year, for example, we'll give you $416 million this year, allowing 4 percent inflation. And we'll pay you the added manufacturing and distribution cost of all increases in volume. But you have to fill all prescriptions written for Massachusetts patients.

In this way, the drug maker is financially whole. Its profits and dollars to finance research don't fall. But everyone in Massachusetts now gets the medications he or she needs. Total spending rises by the actual cost of manufacturing, distribution, and dispensing. But these are not very expensive. That's because once the research is completed and the factory is built, the marginal or incremental cost of making more pills is tiny. Distributing and dispensing aren't very costly, either.

The most convenient and effective way to do this is to channel all drug purchases through a single buyer. Indeed, all financing could be carved out of existing private and public insurance plans and directed to the single buyer.

The low marginal cost of prescription drugs means that the goal of providing affordable medications for all people is within our grasp. For reasons I won't detail here, providing affordable medications for all people is also one of the best foundations for boosting investments in breakthrough research—something the drug makers talk about a great deal, but where their actual performance falls well short of their words.

And Massachusetts has the prescription drug buying power of a medium-size European nation, if we pool all of our purchasing together. We should be able to negotiate a peace treaty with drug makers.

G. Hospital survival

Interestingly a political coalition has coalesced to support higher across-the-board Medicaid payments to all hospitals and a mandate that many employers provide health insurance. Sounds a little like 1988.

There are a few problems. One is that about one-half of the increase in Medicaid payments would apparently go to the 20 most prosperous hospitals in the state—most of them large and powerful teaching hospitals. It would do little to stabilize needed, efficient, but endangered community hospitals. Then, when these other hospitals ask for money to help themselves survive, they'd be told that it's all spent.

Half of our state's hospitals have been closed since 1960—all of them non-teaching community hospitals. Many of the survivors are endangered. And Massachusetts is tops in the nation in the share of patients served in costly teaching hospitals.

Closing beds doesn't save money, partly because less costly hospitals are closed and partly because unused beds are unstaffed and fixed costs are either fixed or fully depreciated. Besides, our state is well below the national average in beds per 1,000 people. And we'll need to re-open or rebuild thousands of beds (at a capital cost of $1 billion or more per 1,000 beds rebuilt) over the next two decade, just to address the medical needs of our aging citizens. Clearly, surge capacity is also needed to cope with crises. For all these reasons, we should assume that each surviving hospital is needed until proven not to be needed. The burden of proof should fall on those who would boost or tolerate still more closings.

It is therefore essential to identify and stabilize all of the hospitals and emergency rooms needed to protect the health of the public. Currently, neither state government nor the hospital association are willing or able to identify these hospitals.

We should pay each hospital enough money to finance high-quality care and keep the hospital open, as long as it's operated efficiently. We should pay hospitals by flexible budgets, which remove the financial incentive to provide too much care or too little care. Every diagnosis should be equally profitable, so hospitals don't scurry to build programs to over-serve profitable cardiac or bone surgery patients, while other patients languish.

Until these steps are taken, we should establish a state hospital stabilization fund, financed by an assessment of one-quarter of each hospital's patient care revenue and one percent of other revenue. In 2003, this assessment would have generated $57 million, almost four-tenths of one percent of hospital revenue and

about equal to six percent of the $924 million in hospital surpluses or profits state-wide.

All of this money would be returned to hospitals—those that need additional revenue to stabilize their operations and finance high-quality care.

This stabilization fund should be operated in concert with a new hospital receivership law, one that would allow relevant stakeholders to petition a court to place any needed but endangered hospital in receivership. This would provide a legal and financial structure to sustain that hospital.

H. Affordable long-term care for all

The $52.7 billion we'll spend on health care in our state this year is enough to finance the acute care services that work for the people who need them.

But I'm not confident that all long-term or chronic care services can be covered with this money. Many of our fellow-citizens suffer long-term care disabilities associated with old age, frailty, confusion and cognitive impairment, developmental problems, and emotional or cognitive problems. Improved financing is essential to helping all of these individuals. But it probably won't be enough. In many instances, it is just very costly to raise money to determine eligibilty and organize services to pay a caregiver to help another person.

Over the past 30 years, there's been surprisingly little in the way of innovation in long-term care service delivery or financing.

We need to tinker with a host of different arrangements. Some involve pooling acute and long-term care dollars. Others involve new ways of mobilizing families, neighbors, religious congregations, fraternal organizations, and other small communities to deliver long-term care. Still others involve better use of adaptive technologies.

Much of long-term care involves quality of life.

Considering long-term care—which usually focuses on our last days on earth—leads us back to the beginning of this talk.

I. Medical security

Making Massachusetts health care durably affordable requires much more serious thought about what we are buying with our health care dollars.

Pathology is remorseless and resources are finite. In this sense, we can never spend enough on health care. Health care is not really about saving lives, though we often use that phrase in daily conversation. Health care can't save lives. That's a theological question, not a medical one. Health care does delay death, relieve pain, and overcome disability. It is therefore useful to think harder about the aims of health care. Why do we spend $1 billion weekly on health care in our state?

I'd propose medical security as the aim—confidence that we'll get competent and timely care from compassionate caregivers, without having to worry about the bill when we're sick, and without having to worry about losing our insurance health coverage ever.