How to Shape Health Care Technology We Can Afford

Alan Sager, Ph.D.
Professor of Health Services
Director, Health Reform Program
Boston University School of Public Health
www.healthreformprogram.org

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I’m happy to acknowledge ongoing collaboration with my colleague, Deborah Socolar.

Preparing for new technology

I. Putting our house in order, so new technology doesn't pour gasoline on the inferno of soaring health costs

II. Channeling new technology in effective and affordable directions

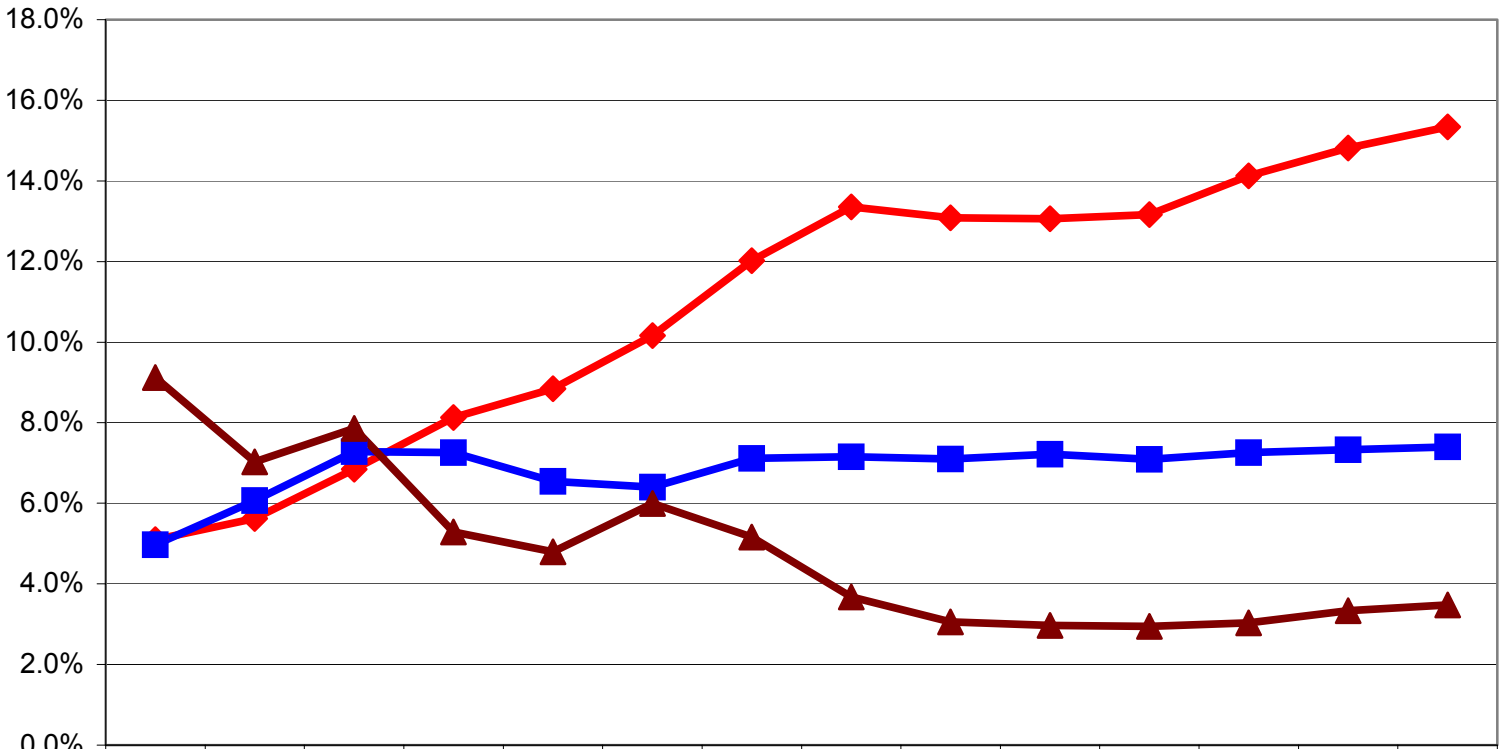
I. Putting Our House in Order

A. Problems and Causes

1. Soaring Costs

- $1.67 trillion (USA) and $48 billion (Mass.)
- Mass. 30% per person above nation
- We'd save over $8.5 billion yearly on personal health care in Massachusetts if we spent at USA average

HEALTH, EDUCATION, AND DEFENSE SPENDING, U.S., 1960 - 2003, AS PERCENT OF GDP

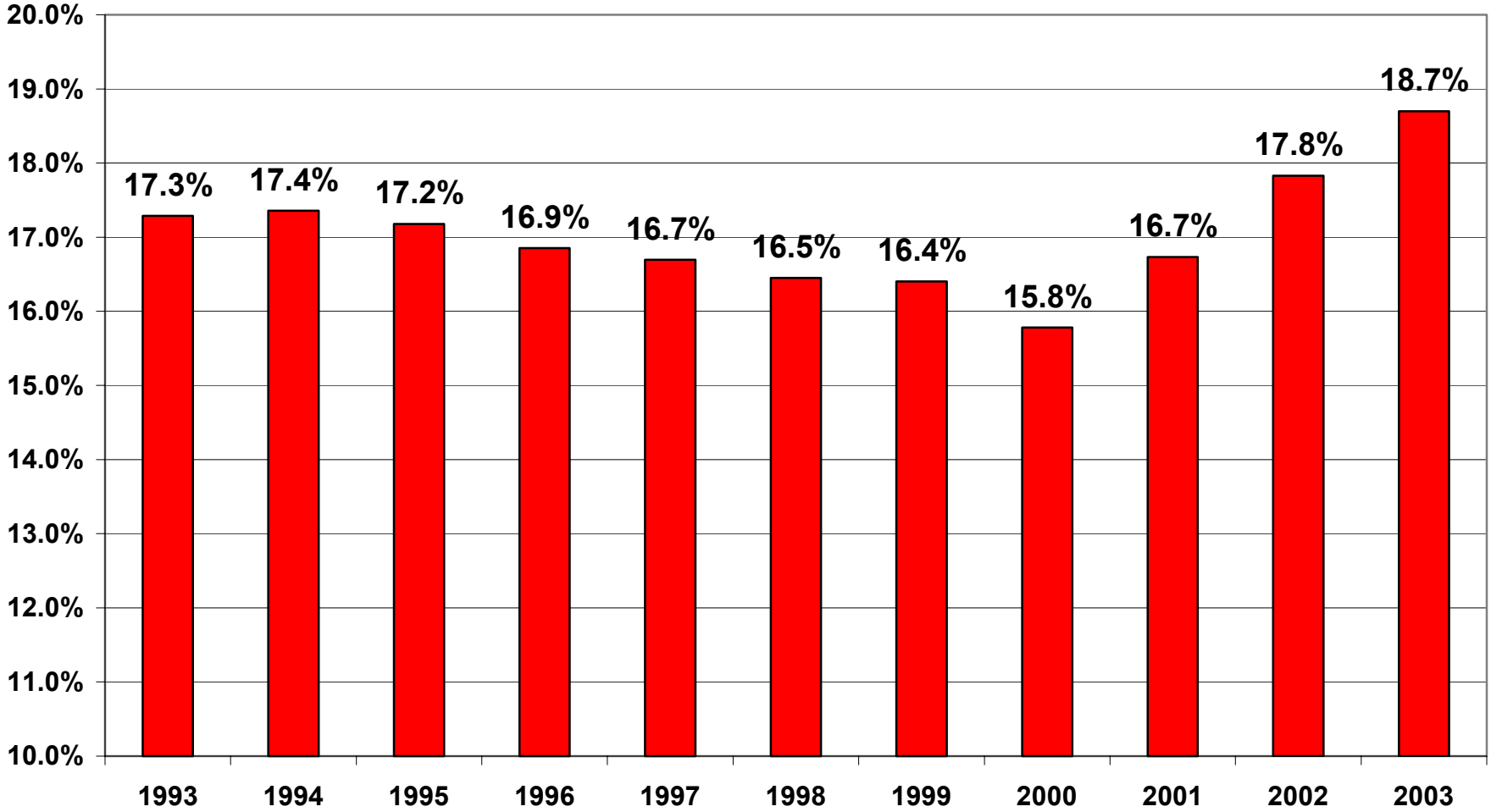


SPENDING % OF GDP

	1960	1965	1970	1975	1980	1985	1990	1995	1998	1999	2000	2001	2002	2003
HEALTH	5.1%	5.6%	6.8%	8.1%	8.8%	10.2%	12.0%	13.4%	13.1%	13.1%	13.2%	14.1%	14.8%	15.3%
EDUCATION	5.0%	6.1%	7.3%	7.3%	6.5%	6.4%	7.1%	7.2%	7.1%	7.2%	7.1%	7.3%	7.3%	7.4%
DEFENSE	9.1%	7.0%	7.9%	5.3%	4.8%	6.0%	5.2%	3.7%	3.1%	3.0%	2.9%	3.0%	3.3%	3.5%

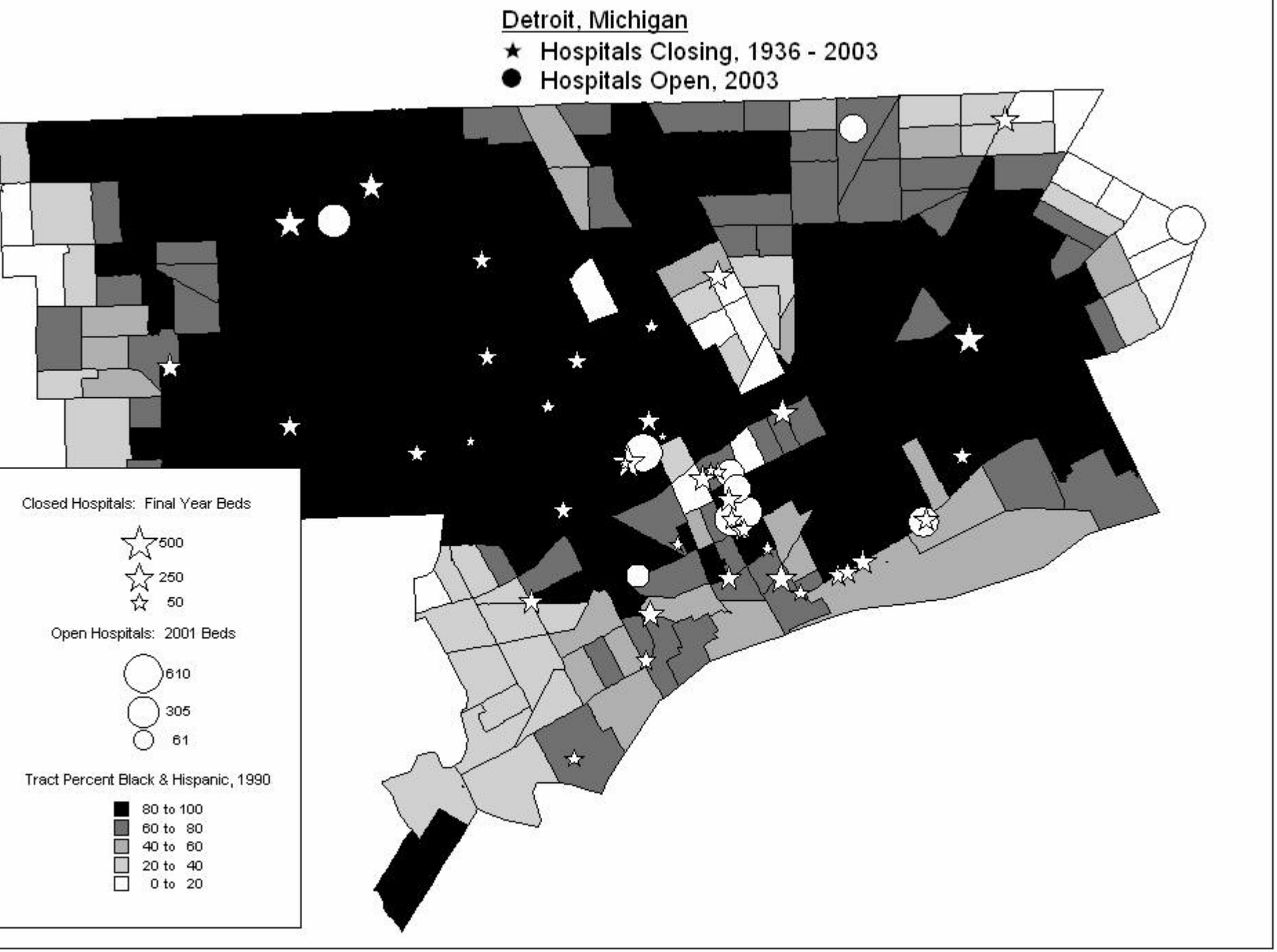
YEAR

MASSACHUSETTS HEALTH CARE'S SHARE OF PERSONAL INCOME, 1993 - 2003



Causes of soaring costs

a) Lack of effective/acceptable cost controls
  - Competition inside health care has failed.
  - Competition from other nations is unlikely.
  - Traditional managed care—financial incentives or regulations—have not been durably effective.
  - Hospital closings—survival of the fattest


Detroit, Michigan
Hospitals Closing, 1936 - 2003
Hospitals Open, 2003
Closed Hospitals: Final Year Beds
500
250
50
Open Hospitals: 2001 Beds
610
305
61
Tract Percent Black & Hispanic, 1990
80 to 100
60 to 80
40 to 60
20 to 40
0 to 20

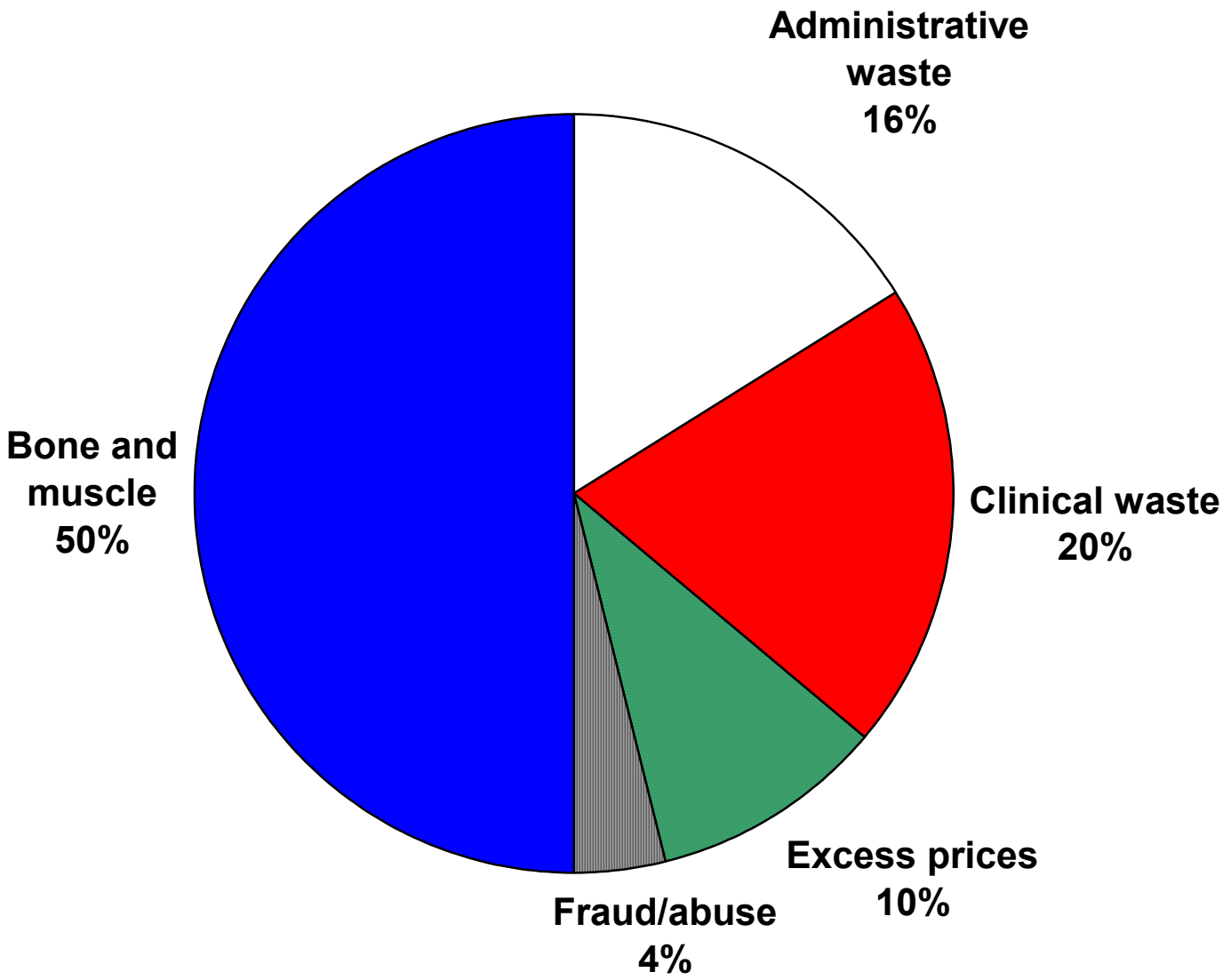
WHICH VARIABLES PREDICT CLOSINGS, 1997-2003?

1990 variable	significance
Intercept	0.216332
Beds	0.000004
Area % black	0.048675
Area % latino	0.403682
Area income/capita	0.270617
Hospital total financial margin	0.158566
Hospital cost/patient	***0.761498***
Hospital fund balance/patient	0.022449

b) One-half of health care dollar goes to

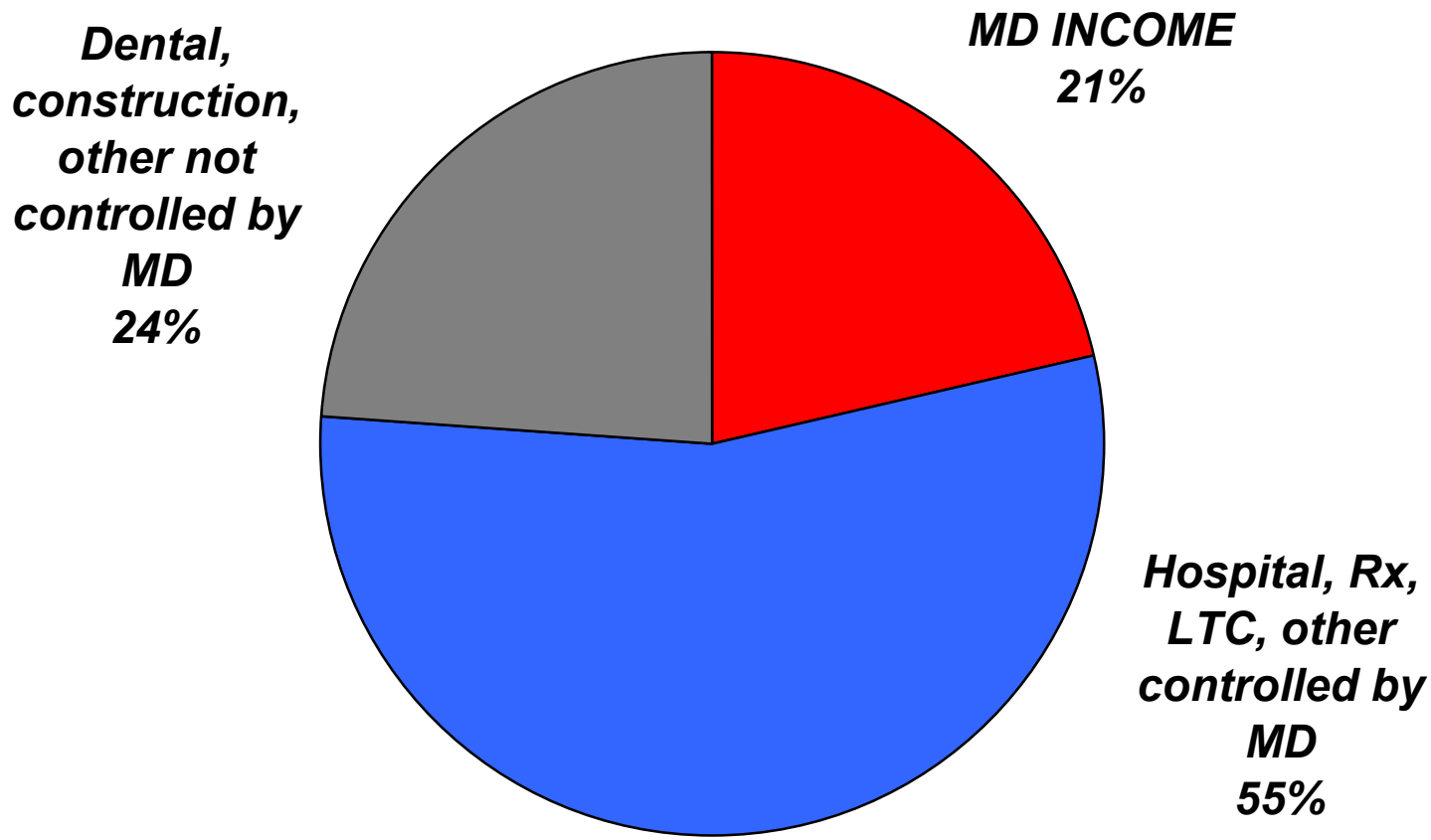
- Clinical waste
- Excessive prices
- Unnecessary administration
- Outright theft

ESTIMATED HEALTH CARE WASTE



c) Doctors get 20% of health dollar and control another 55%. They know where most of the clinical waste is, but we haven't been able to hold them accountable for spending money more carefully.

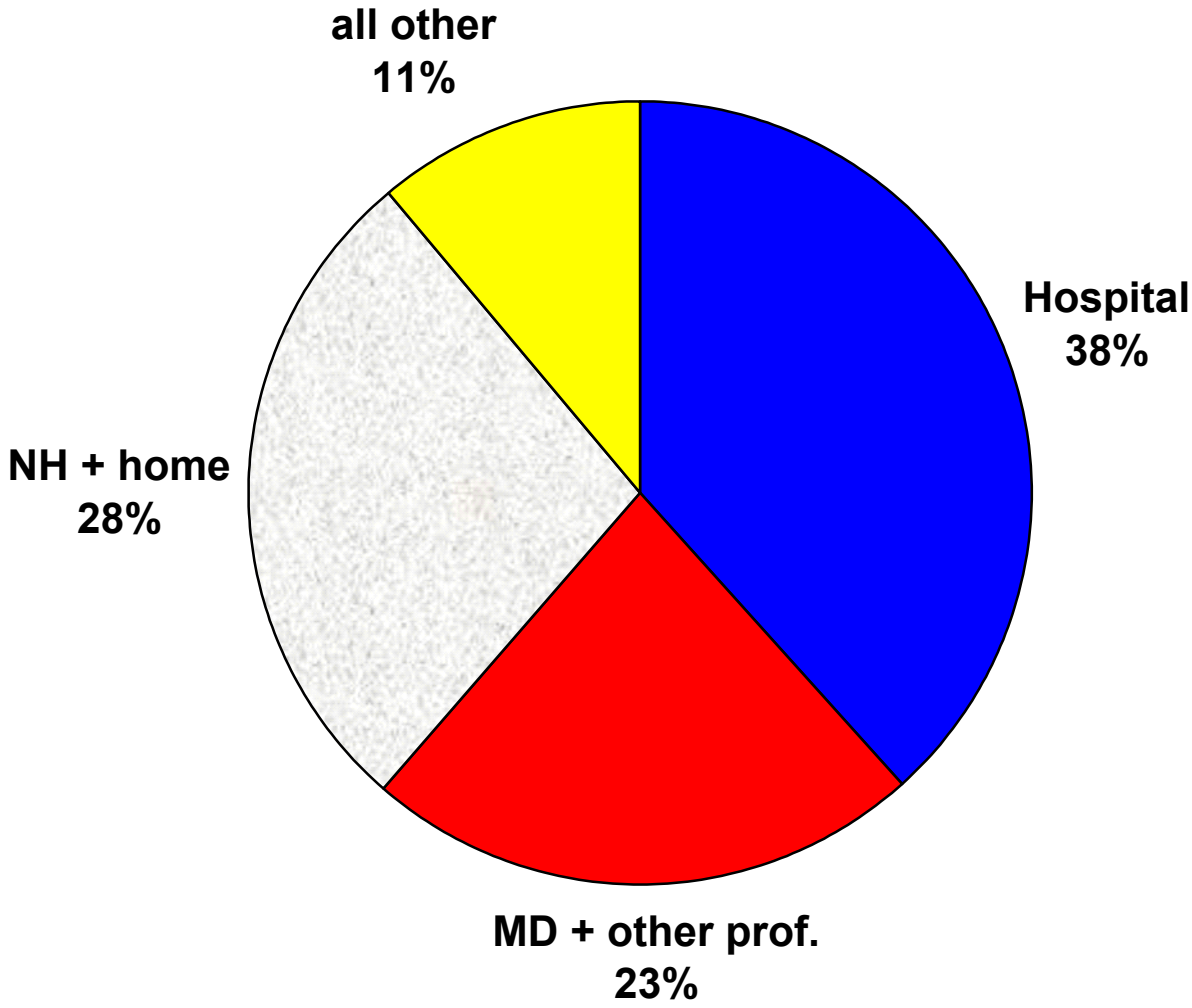
THREE PARTS OF THE HEALTH DOLLAR, 2003



d) More causes of soaring costs

- Hospitals
  - serving 40 percent of Massachusetts patients in teaching hospitals isn't affordable
  - statistically explaining high costs isn't the same as justifying them
- Doctors
  - Nation's highest MD/capita ratio (and continued faster growth than U.S.A.) though some real shortages and much talk of out-migration persist
- Long-term care

ALLOCATION OF $8.5 BILLION IN HIGHER MASS. PERSONAL HEALTH SPENDING, 2003



2. Caregiver financial stress and distress

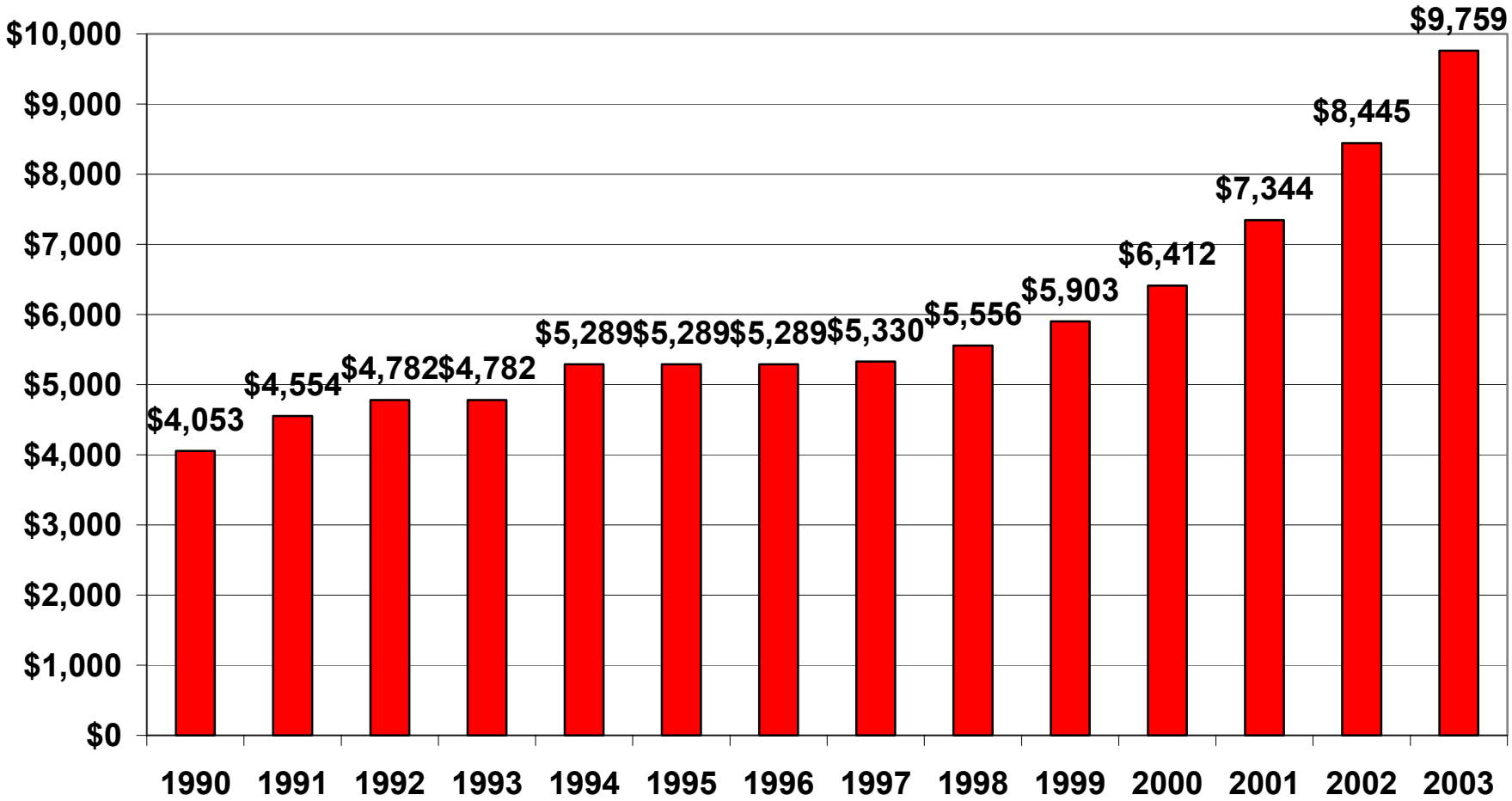
- More money for business as usual is not a sustainable business plan
  - Hospitals
  - Physicians
  - Nursing homes
  - Drug makers

3. Shrinking coverage and access

- 40-50 million Americans with no insurance
- 70-75 million with no drug coverage

- Most payers try to shift risk/minimize obligations
- Higher private premium costs and soaring drug costs spur de-insurance.
  - Using patients as kamikaze pilots?
- Some in Congress hope to spin off Medicare to HMOs/PPOs and Medicaid to states

FAMILY HEALTH INSURANCE ANNUAL PREMIUM, STEADY BENEFIT PACKAGE, BIG EMPLOYER, EASTERN MASSACHUSETTS, 1990-2003



I. Putting Our House in Order

B. Possible Solutions

1. Set an honest goal for health care
2. Commit to medical security for everyone, within a budget
3. Squeeze out the waste and recycle it
4. Paying all needed caregivers fairly
5. No government + no market = anarchy
6. Contingency plans are vital
7. One hand for yourself and one for the ship

1. Honest goal

Candidates

a) Immortality
   - Pathology is remorseless; resources are finite.

b) Medical security
   - Confidence we'll get the care we need, from competent, kind, and trustworthy clinicians who have our best interests at heart and whose decisions are not swayed by financial self-interest
   - Awareness of the reality of trade-offs and of the need to spend carefully.
     - If we don't get something, the reason is that we don't need it, or someone else has a stronger claim on the resources. Or the money's needed to keep ERs open.

2. Medical security for all within a budget

Everyone is covered +

Dollars are now finite =

The system is bounded so everyone must be fairly served with available revenue.

But it's one thing to cut revenue and another to actually keep costs at or below that revenue.

3. Squeeze out waste and recycle it

- Cutting waste frees up the dollars to cover everyone without exceeding capped revenue.
- *Make the easier choices first. That leaves us with fewer hard choices.*
- A few of the techniques
  a) Prescription drug peace treaty
  b) Professionalism within a budget
  c) Stop paying for what doesn't work

a) Prescription drug peace treaty:

"The world won't be safe for better meds if they're not affordable."

- Drug makers' business plan (doubling U.S. revenue in every 5-6 years) is not sustainable. "We know we're defying gravity."
- So
  - Cut U.S. prices by 1/3 (revenue drops $50 B)
  - Replace ALL LOST REVENUE via higher private and public demand (3 billion prescriptions → 4 billion)
  - Compensate for tiny added production cost
- Choice: suffer, pay much more, or reform

b) Professionalism within a budget

- Make trade-offs in a trustworthy manner
- One watertight compartment with MDs' money—they allocate by competence, energy, kindness
- Second compartment for hospital, Rx, LTC dollars that MDs marshal. Physicians spend this money to take care of everyone, and must make it last all year. They can't gain financially from decisions. Must make clinical trade-offs. Doctors can spot waste and excise.
- Needed:
  - Evidence on what works and what's worth the money
  - Management systems—moving beyond herding cats
  - How big should the clusters of doctors, dollars, and patients be? What is manageable and promotes responsibility?
  - Appropriate rewards for good behavior
- Managed care: the next generation

c) Stop paying for things not proven to work

- Re-focus efforts away from primary care and prevention to where the big dollars are and therefore where waste can be squeezed out.
- Some 75% of medical care has never been well evaluated.
- Consider scraping and washing inside knees for osteoarthritis—no subjective or objective benefits over placebo
  - 600,000 laparoscopic surgeries yearly
  - @$5,000
  - = $3.25 billion of solid waste
- How many are still being done?

4. Pay all needed caregivers fairly

- Stop rationalizing the excessive share of patients in costly Massachusetts teaching hospitals. Shape affordable care.
- Identify and sustain each needed hospital.
- Fair payment to physicians without attracting still more to state.
- Shaping affordable LTC and mental health remains hardest problem.

5. No market + no government = anarchy

- No well-functioning market in health care, except for eyeglasses/contacts
- Government deals mainly with crises or visible and concrete abuses, and it's understandably hard for government to act absent consensus or crisis.
- Continuous engagement: state government needs a business plan for all of health care.
  - Start with stabilizing needed hospitals and nursing homes.
  - Move to designing/testing ways to cut waste and ensure affordable care for all.

6. Contingency plans

- Dig the well before we're thirsty because crisis is worst time to start paying sustained attention to reform options
- Much of New Deal actually worked, despite frenzied enactment during 100 Days—because laws were tested in states
- Successful businesses and the military (usually) have contingency plans. There are few in health care.

7. One hand for yourself and one hand for the ship

II. Channeling New Technology in Effective and Affordable Directions

A. Perceived threats

- Everything's out of control already or soon will be
  - Trade and budget deficits at 8% of GDP
  - Health now 15% of GDP and rising
  - Boomers lurch toward Medicare eligibility
  - Not enough nurses
  - Seems impossible to craft affordable Rx benefit
  - LTC crisis
  - **And** new technologies will vastly add to cost

B. Possible responses

1. Throw patients from the lifeboat.
2. View new technology as tool, not force of nature.

- Develop and use new technology that promises to be equitably and durably affordable.

1. Throw patients from the lifeboat

- Abandon equitable insurance and let benefits vary with ability to pay
  - Less need to worry about social cost of technology
  - Fits with Congress's risk-shedding model
  - Socially divisive and probably socially destabilizing

2. Tech tool

- View technology as a tool to use actively, not as a force of nature to enjoy (like a sunset or adequate rainfall) or endure passively (like a flood or earthquake)
  a) Technology development
  b) Technology dissemination

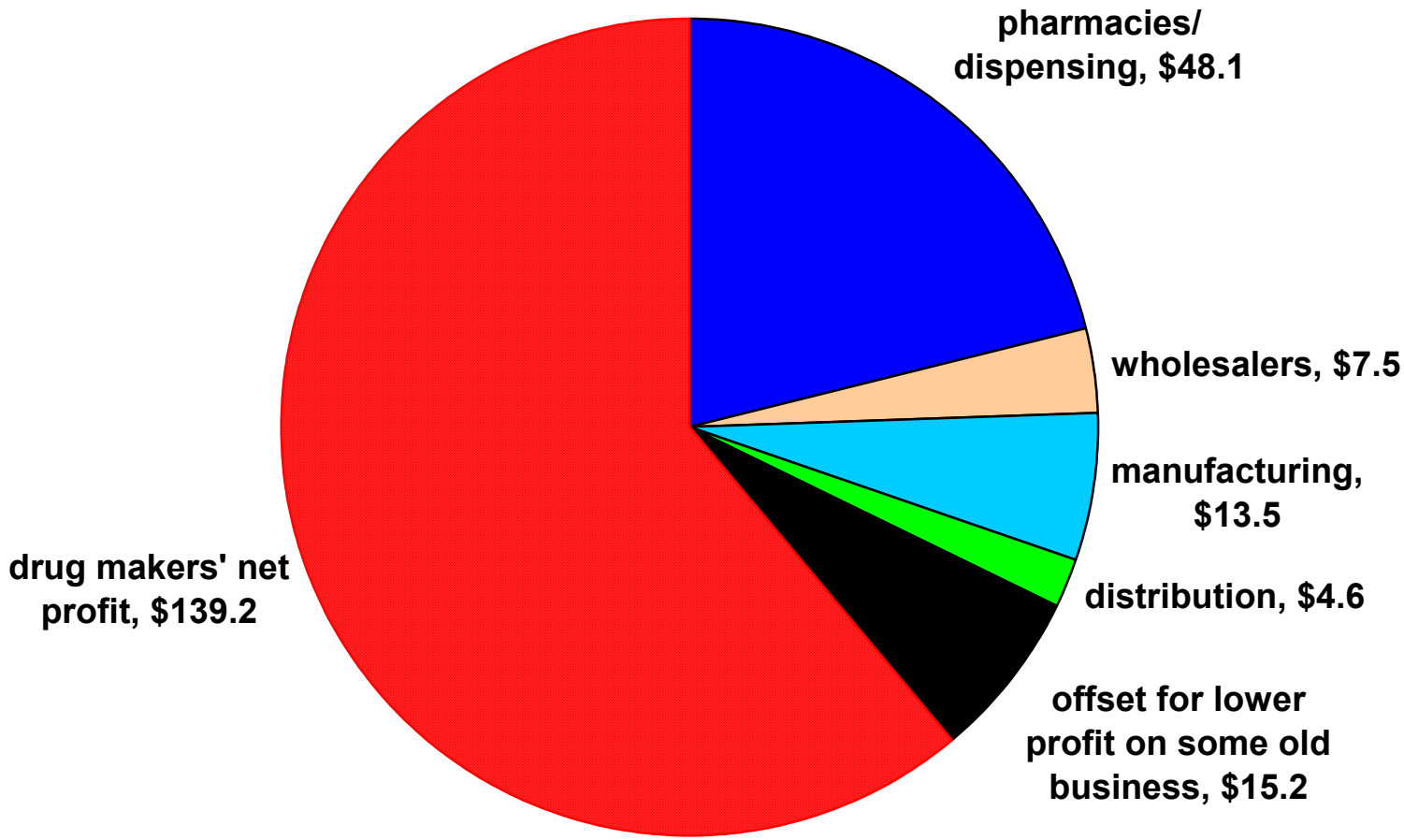
a. Technology development

- Stop whining about the cost of new technology; do something about it.
  - Substitute: channel more new technology toward developing cheaper ways to do things we already know how to do,
    - A pill for coronary artery plaque to substitute for angioplasty and CABG
    - A Nobel Prize for saving money
  - Generally, spend more on meds. Chemicals yes, plumbing no.
    - But price of meds has to reflect real cost. Don't grossly over-pay for the meds—as a Medicare Rx benefit is poised to do.
    - And slash research on copycats (40% of drug makers' research dollars).
  - Scrutinize downstream affordability of doing new things at greater cost.

WHERE THE MEDICARE DOLLARS GO:

PROFITS AS A SHARE OF SPENDING ON NEW DRUG PURCHASES

$ Billion



b. Technology dissemination

- Link to development—pre-commit (encumber) downstream care costs
- Be honest about trade-offs
- Decide in light of benefits, costs, and equity
- Decide in context of
  - Constrained revenue
  - Social solidarity/medical security for all
  - Professionalism within a budget