# Sustaining Massachusetts Health Care

***Women in Health Care Management***

Wellesley, Massachusetts
26 May 2005

Alan Sager, Ph.D.

Professor of Health Services

Director, Health Reform Program

Boston University School of Public Health

asager@bu.edu

617 638 4664

www.healthreformprogram.org

The ideas and evidence offered here were developed in concert with my fellow-director, Debbie Socolar.

# Overview

A. **Introduction: a few reasons for reform's inertia**
B. **Problems**
   1. Is our health care sustainable?
   2. Spending increases, national
   3. Coverage cuts, national
   4. Economic doubts
   5. Pressure points
C. **Causes**
   1. Economy
   2. Revenue sources
   3. Costs
   4. Coverage
   5. Caregiver configuration
   6. Failure to prepare
D. **Solutions that address causes**
E. **Moving forward**
   1. Economic contingencies and political panic
   2. Getting ready

# A. Reform's Inertia

1. **Clintons' failure**
   a. Conventional views
   - Their bill wasn't ready in time
   - Too complicated
   - Not pre-sold politically
   - Gingrich built on small business and insurer opposition to deny a victory to Dems
   - Diffused their energy—NAFTA
   - Didn't defend against Harry+Louise, "no exit" and other ungrounded attacks
   - Economy re-started

## b. Other views (mine)

- Never really tested—another abstract idea for 1/7th of the nation's goods and services
- What did the president know?
  - How would reform actually work, how to get care, from whom?
  - How would everyone be covered and who would pay for uninsured?
  - What regional budgets, boundaries, data on current spending?
- Clintons didn't know—that's why failed to rebut lying critics
- Total spending would rise owing to employer mandate + cigarette tax
- Employer mandates really are regressive
- States differed greatly in cost and coverage problems, receptivity to trying something new
- Doctors' opposition
- Once appearance of health cost crisis passed, few fervently favored Clintons

## 2. Single payer stagnation—why?

- Have models or studies of savings convinced anyone? Not yet, so maybe we need different types of studies.
- Administrative waste sounds too glib to explain so much waste—what about clinical waste?
- More administrative waste is associated with mistrust than with complexity
- How will it work the morning after? Patient uncertainty, worry—will I be able to keep getting care I'm used to?
- Will it really contain cost? Why do we think doctors, hospitals, drug makers, nursing homes, dentists, and others will keep their costs under the ceiling of total national or regional revenue provided?
- By what methods will caregivers be paid?
- Most doctors oppose single payer—what can change?
- How do caregivers make transition from "enrich yourself" market thinking to spending carefully?
- It feels too easy, mechanical, brittle, bloodless
- World's dumbest bumper sticker

- **3. Cost – coverage conundrum**
- We spend enough to care for everyone but there's little constituency for cost control
- And there are few mechanisms to stretch today's dollars to cover everyone
- Most cost controls have failed badly
- Few perceive benefit from containing cost
- Incremental coverage improvements (Kerry, employer mandates) rely on boosting spending even higher (get everyone in and then we'll contain cost)
- Hard to imagine passage without economic crisis/new politics, but we won't have the money then to increase health spending.

# B. PROBLEMS

1. Is our health care sustainable?
2. Spending increases, national
3. Coverage cuts, national
4. Economic doubts
5. Pressure points
   - By state—spending and coverage differences
   - Capacity to generate revenue—inter-payer differences
   - By sector—which areas of health care are most vulnerable?

# 1. Is our health care sustainable?

- Definitions
- Predictions

# Sustainability Defined

- Maintaining something, keeping it in existence, supplying it with necessities

- Enjoying political and financial support adequate to finance and deliver health care as usual—business as usual—in the decade ahead with no more than moderate adaptations.

# 3 Viewpoints on Sustainability

1. Physicians, hospitals, other **caregivers**—will we be able to garner revenue needed to survive and steadily improve both quality of patient care and our incomes?
2. **Payers**—will we be willing and able to supply the revenue that caregivers expect and patients require?
3. **Patients**—will enough of us be protected against health costs, and be able to obtain needed, competent, and timely care?

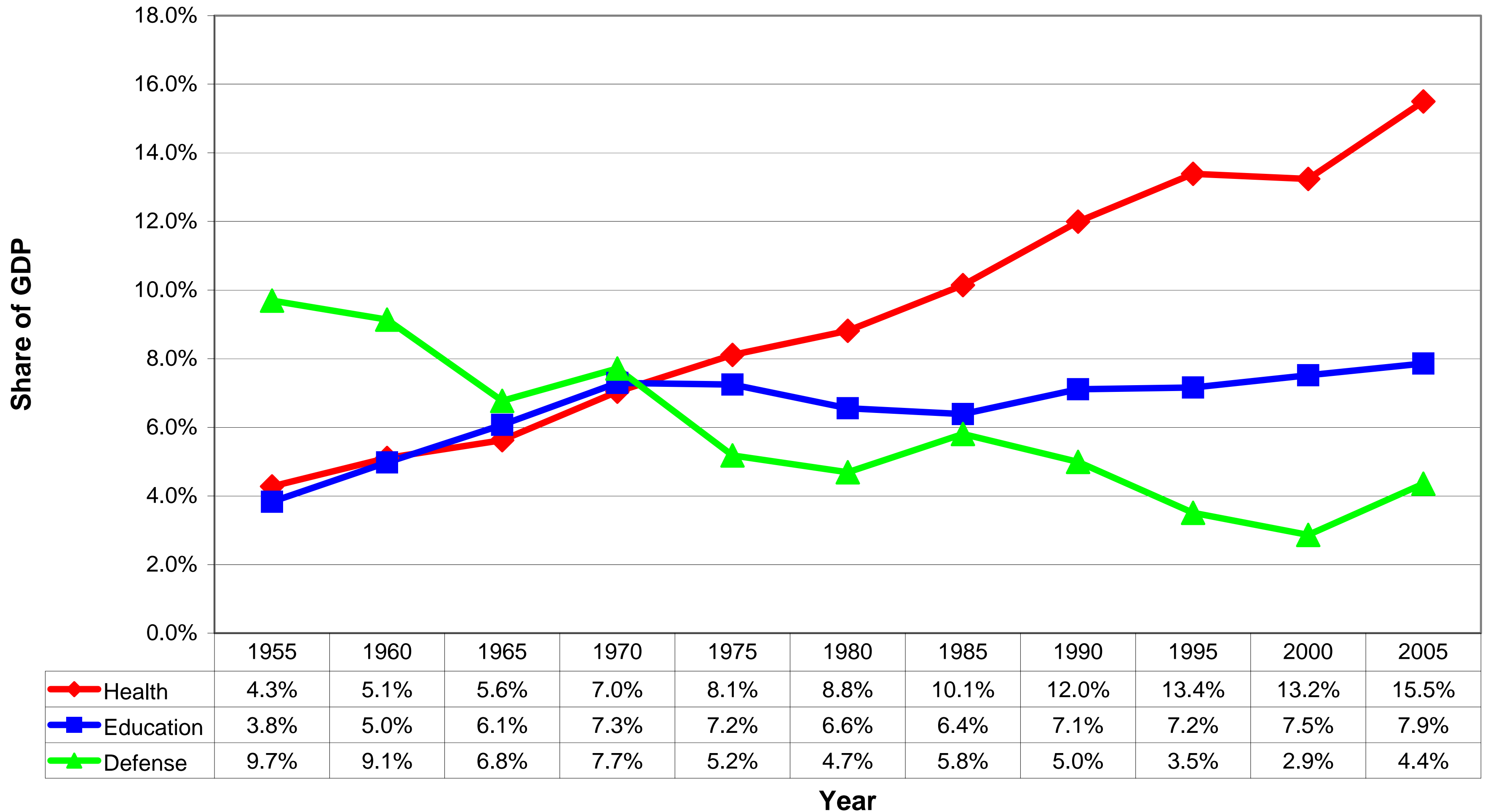
# Summary of Risks to Health Care's Sustainability

1. **External**
   - The economy—robust or struggling?
   - Payers—will they be able and willing to finance business as usual?
2. **Internal**
   - Will health costs continue to rise much faster than GDP?
   - Will insurance coverage stabilize or drop?
3. **Value** for money—will health care provide enough value, to enough Americans?

# 2. Spending increases, national

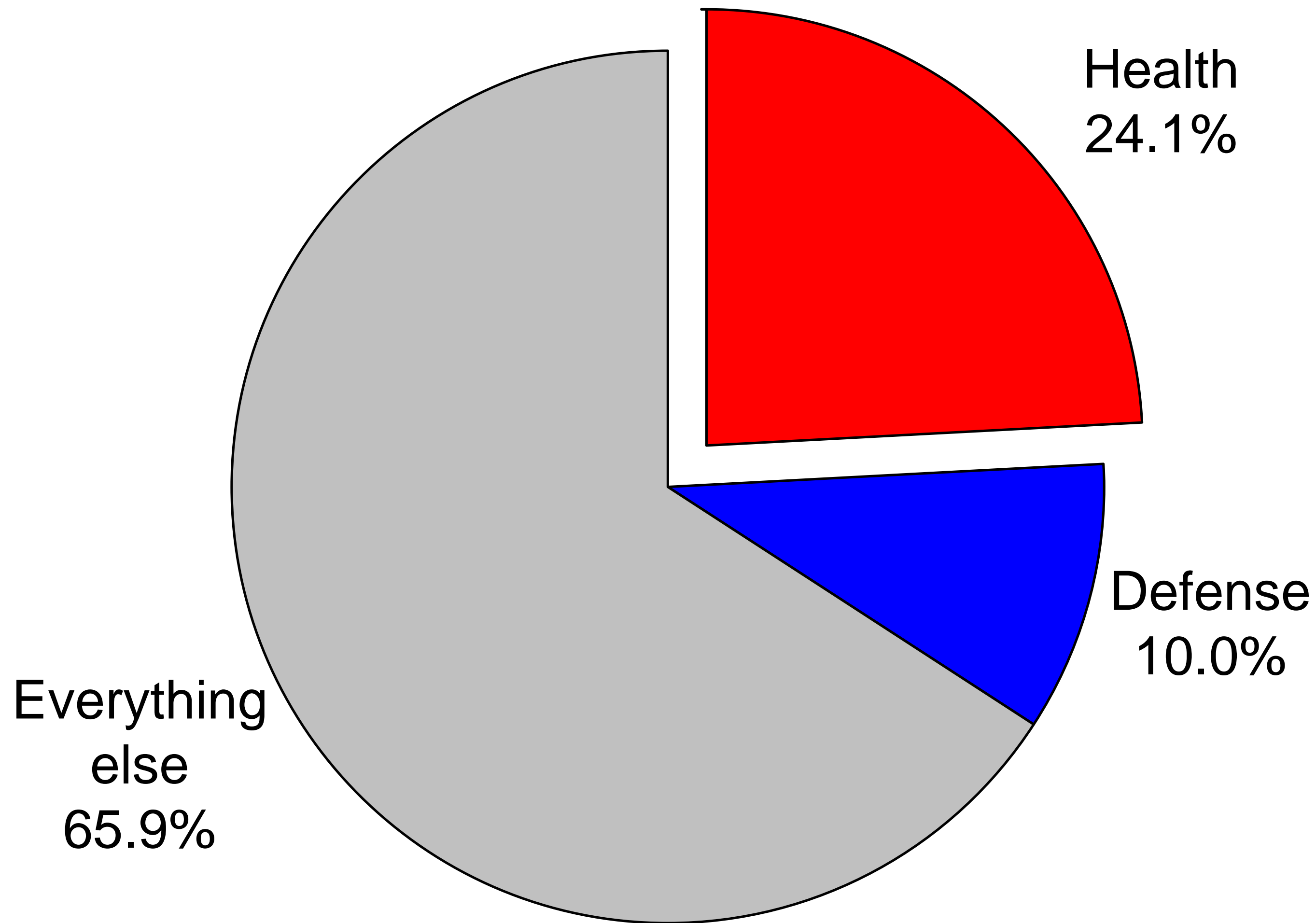
- Defense, health, education—no one knows this
- Rising share of economy
- Projected forward to 2014

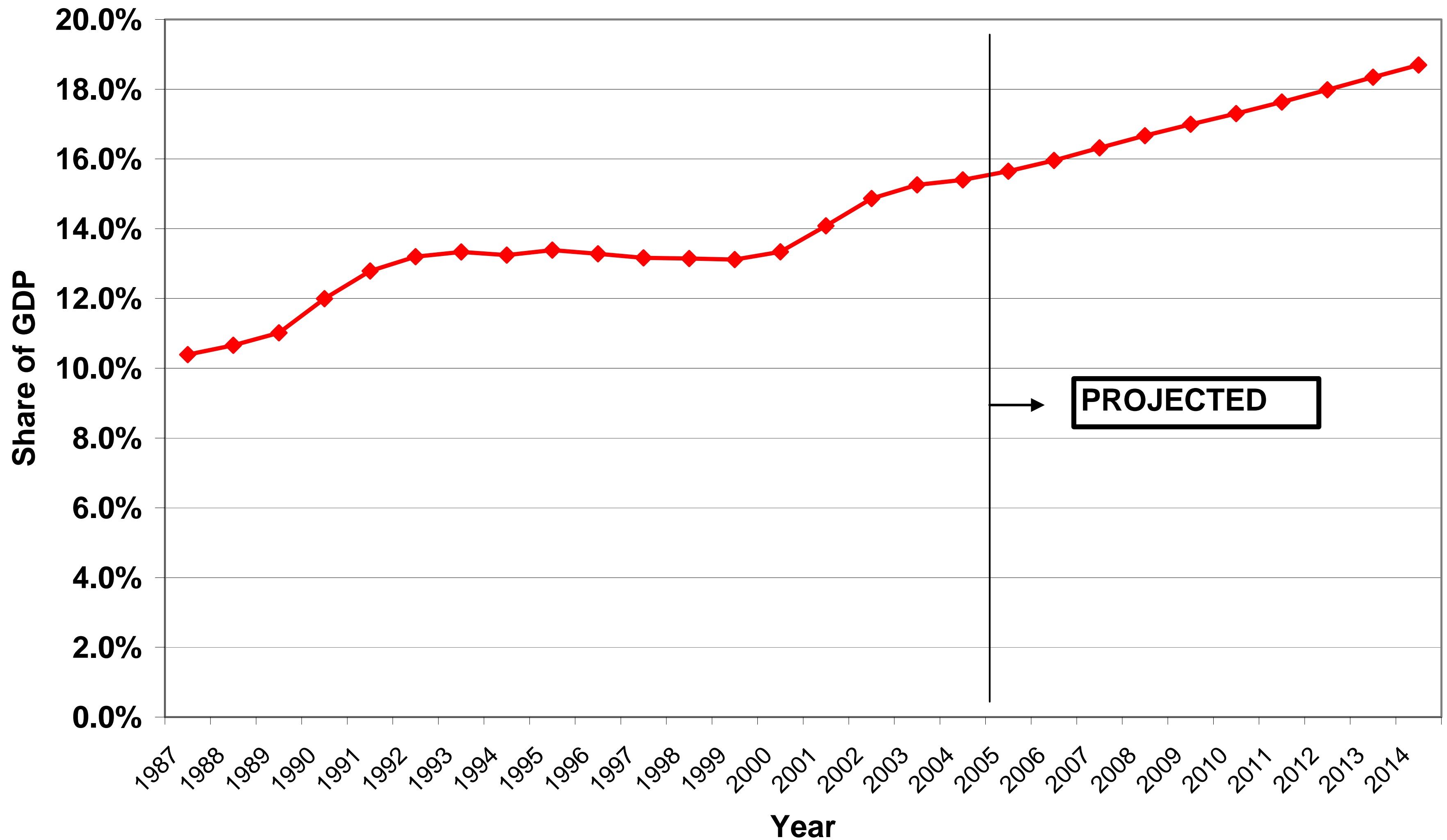
# HEALTH, EDUCATION, AND DEFENSE SHARES OF U.S. GDP, 1955 - 2005




| | 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% |

# SHARES OF GDP GROWTH, 2000 - 2005

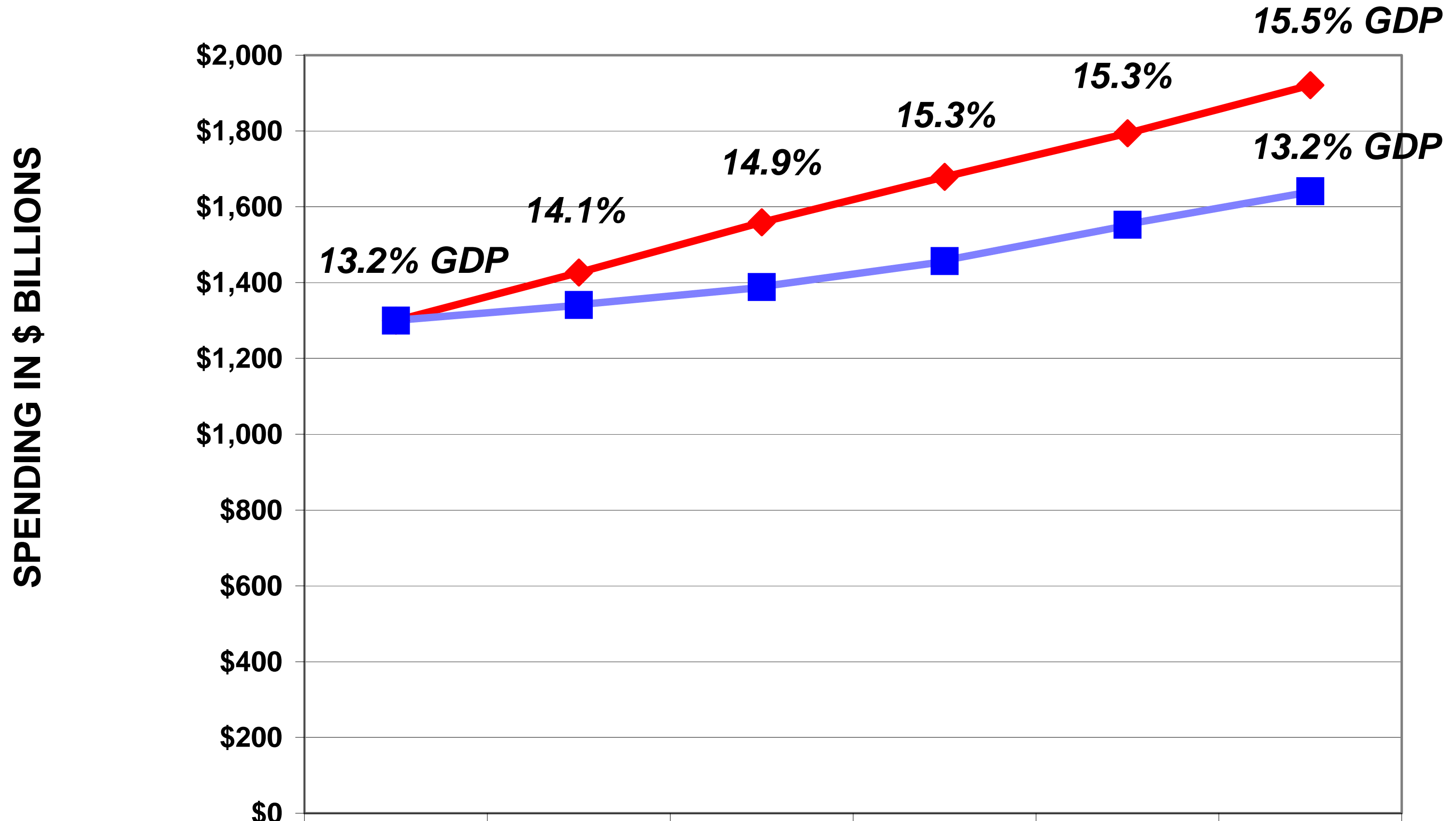



Health's Share of GDP, 1987 - 2014
Share of GDP
20.0%
18.0%
16.0%
14.0%
12.0%
10.0%
8.0%
6.0%
4.0%
2.0%
0.0%
PROJECTED
1987
1988
1989
1990
1991
1992
1993
1994
1995
1996
1997
1998
1999
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
Year

# HEALTH CARE’S APPARENT ADDICTION TO MORE MONEY FOR BUSINESS AS USUAL

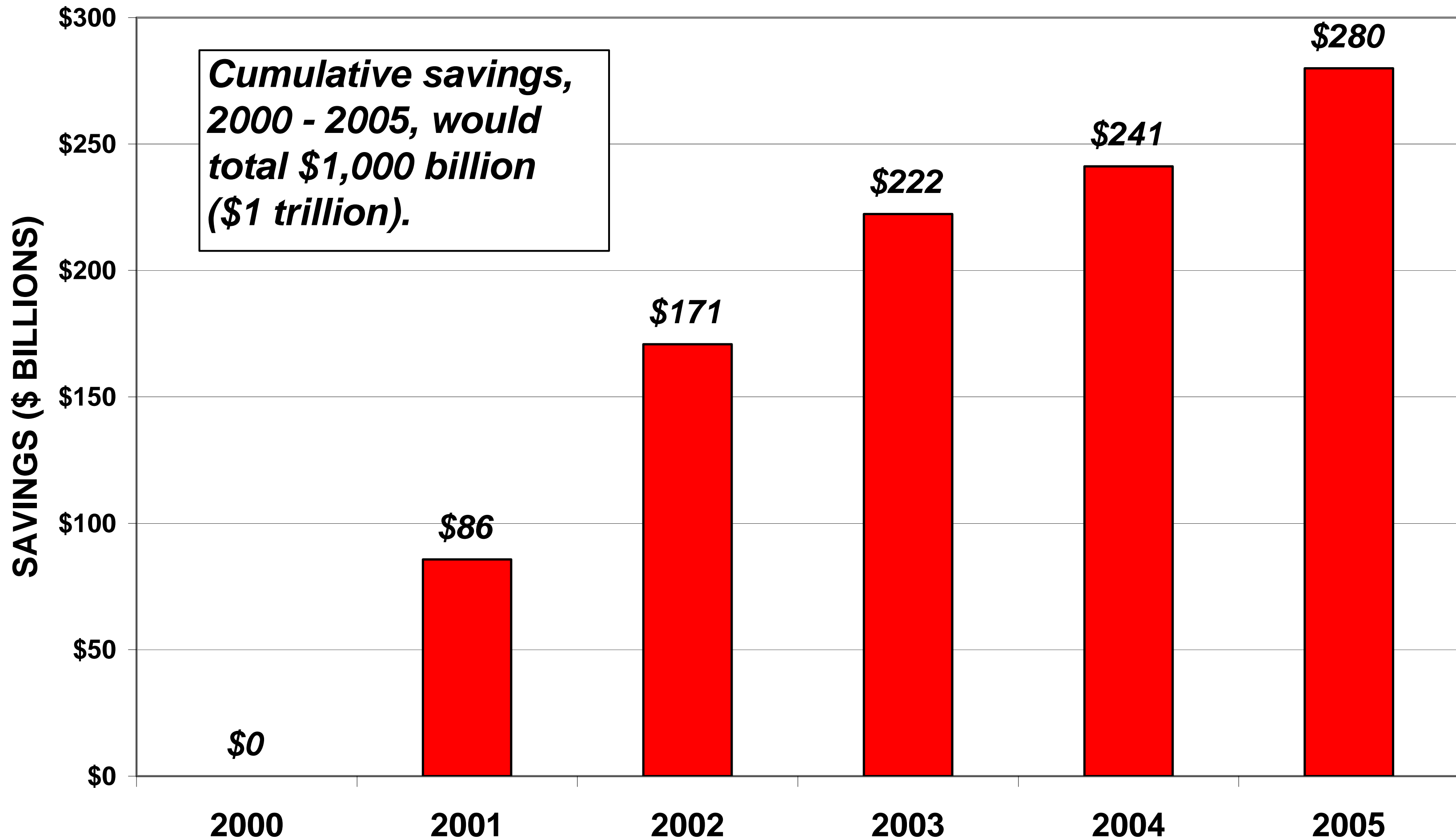
# U.S. HEALTH SPENDING, 2000 - 2005

## ACTUAL SPENDING versus SPENDING HELD TO 13.2% OF GDP



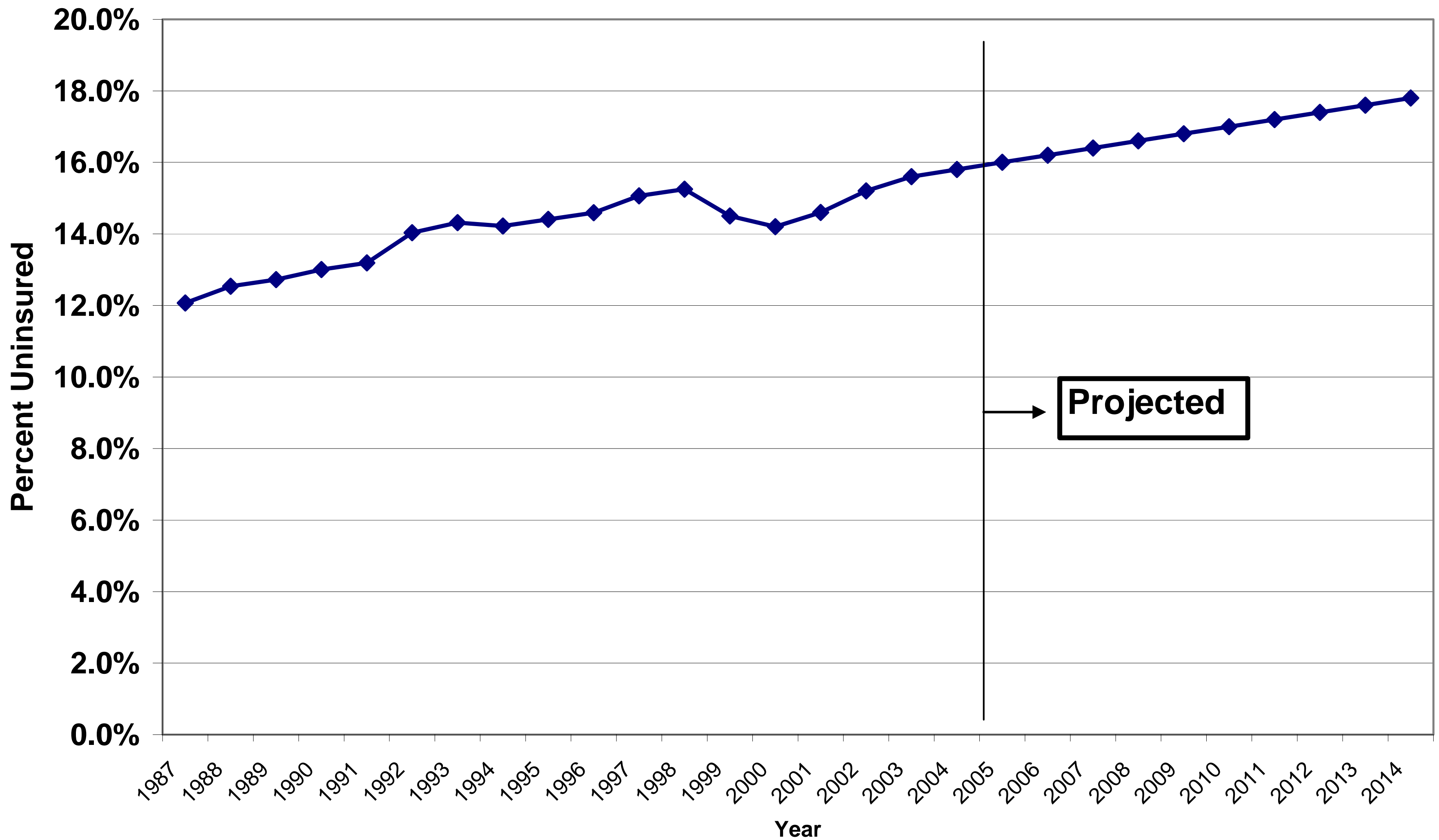

| | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 |
|---|---|---|---|---|---|---|
| ACTUAL SPENDING | $1,300 | $1,426 | $1,559 | $1,679 | $1,794 | $1,921 |
| SPENDING AT 13.2% GDP | $1,300 | $1,341 | $1,388 | $1,457 | $1,552 | $1,641 |

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



# 3. Coverage cuts, national

- People with no insurance
- People with inadequate insurance

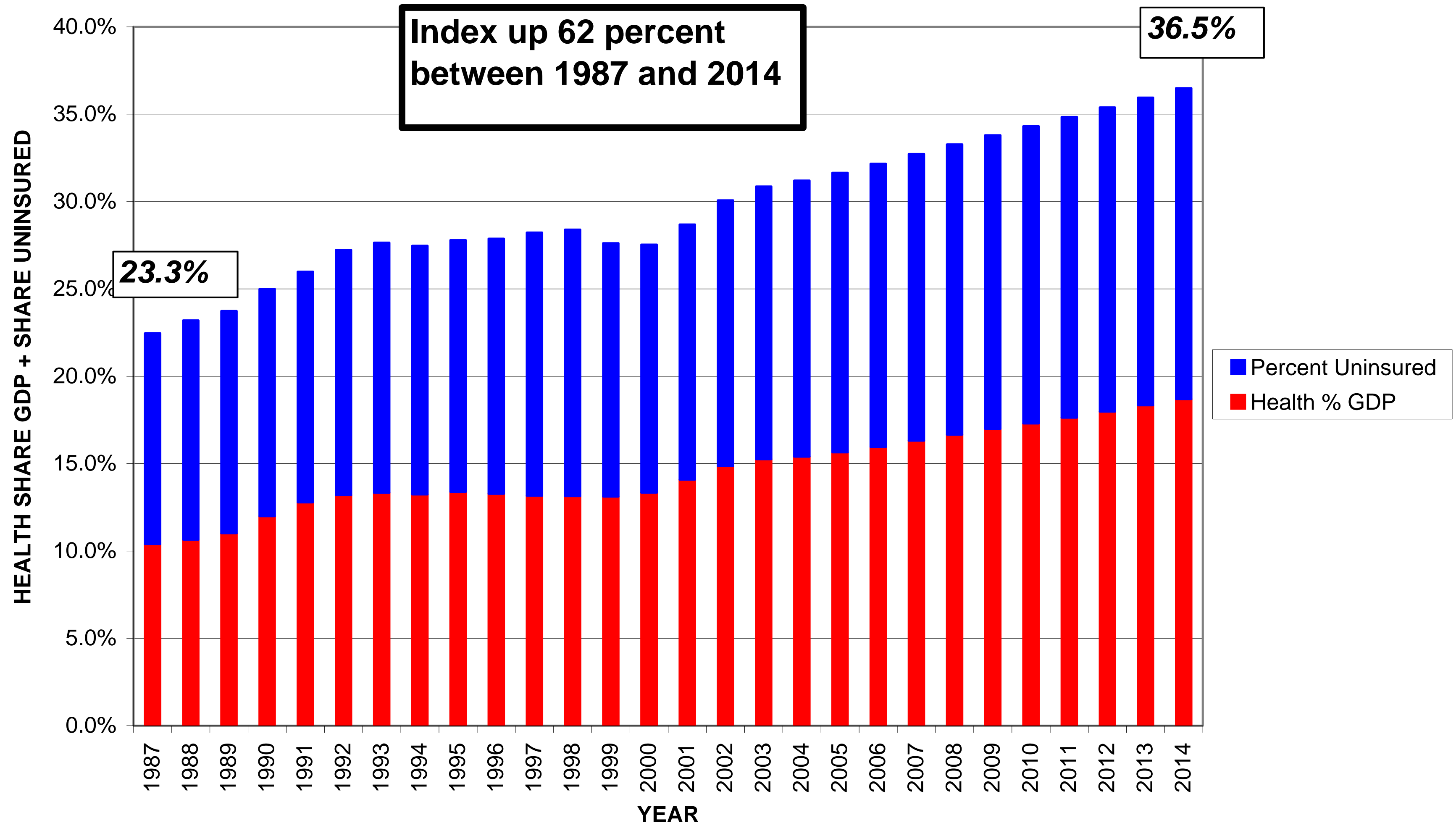


Percent Uninsured, 1987 - 2014
20.0%
18.0%
16.0%
14.0%
12.0%
10.0%
8.0%
6.0%
4.0%
2.0%
0.0%
Percent Uninsured
Projected
1987
1988
1989
1990
1991
1992
1993
1994
1995
1996
1997
1998
1999
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
Year

# Financial Coverage

- 45 million (1 in 7) are uninsured
- Some 30 million are financially under-insured
- Lack of insurance by sector
  - Pharmaceutical 75 million
  - Dental 100 million
  - Long-term care 200 million+
- Out-of-pocket co-payments, co-insurance, and deductibles are rising, as are employee shares of premiums

# Cost + coverage = Health Crisis Index


HEALTH'S SHARE OF GDP +
SHARE OF PEOPLE UNINSURED, 1987 - 2014
Index up 62 percent between 1987 and 2014
23.3%
36.5%
40.0%
35.0%
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
HEALTH SHARE GDP + SHARE UNINSURED
1987
1988
1989
1990
1991
1992
1993
1994
1995
1996
1997
1998
1999
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
YEAR
Percent Uninsured
Health % GDP

# 4. Economic doubts

- Optimism
- Pessimism
- Data

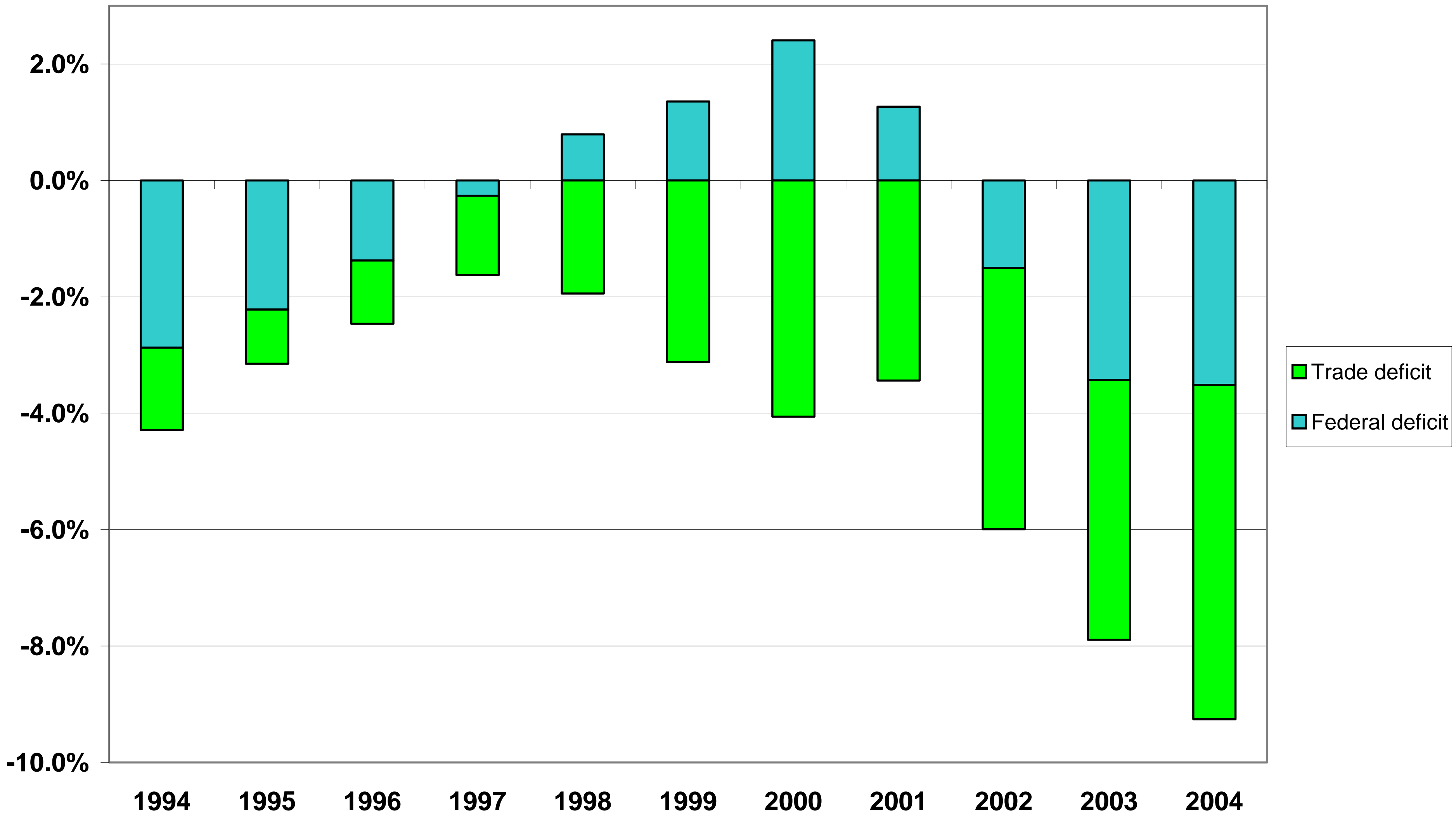
# **External** Economic Influences

- **Reasons for optimism**
  - Entrepreneurial innovation of U.S. economy
  - Resilience and drive of market have been proven repeatedly
  - Even if U.S. living standards decline relative to other nations, they'll still be very high as measured in real income per American

# External Economic Influences

- **Reasons for pessimism**
  - Living beyond our means
    - federal deficit approaching 4 percent of GDP
    - trade deficit approaching 6 percent of GDP
  - Low domestic savings → borrow from others, who might not lend in future
  - Tools to fight recessions—low big deficits and low interest rates—are being used aggressively during ostensibly good times

# U.S. Federal Budget + Trade Deficits, 1994 - 2004



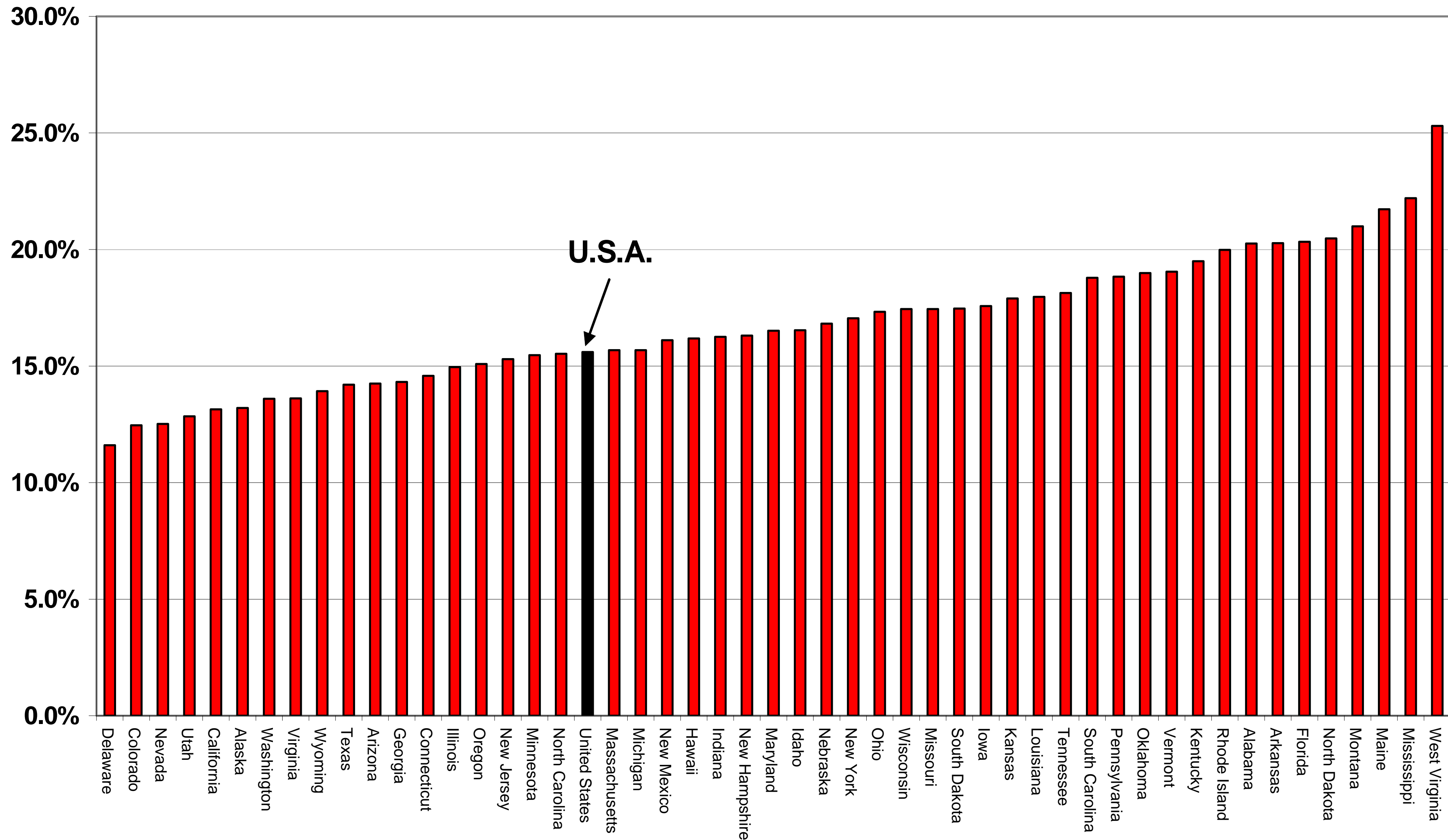
# 5. Pressure points

- By state—spending and coverage differences
- Capacity to generate revenue—inter-payer differences
- By sector—which areas of health care are most vulnerable?

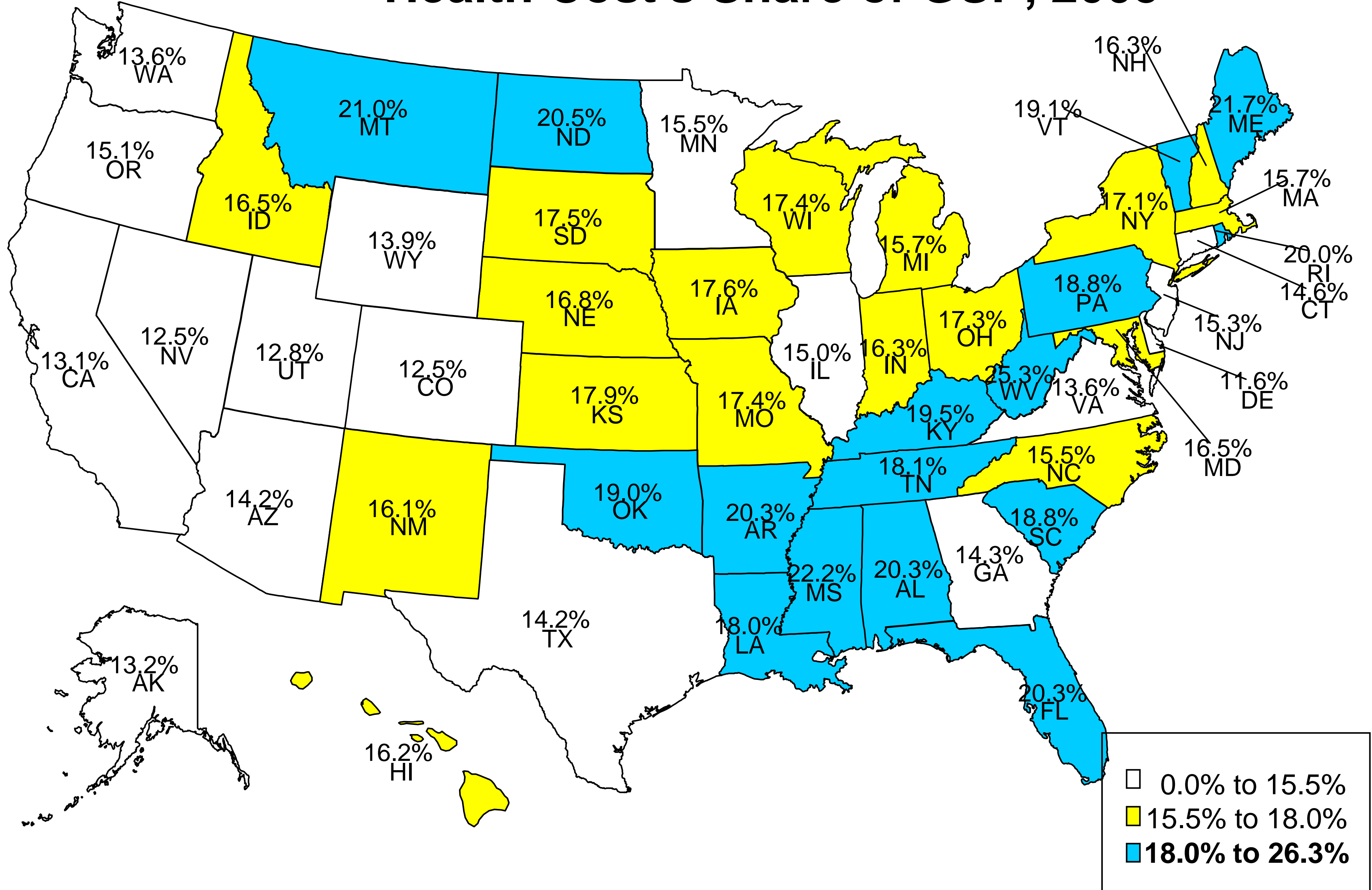
- Anticipating pressure, threats, and preparing to respond—jobs of caregivers, payers, governments

# Which states are likelier to experience greater threats to sustaining their health care?

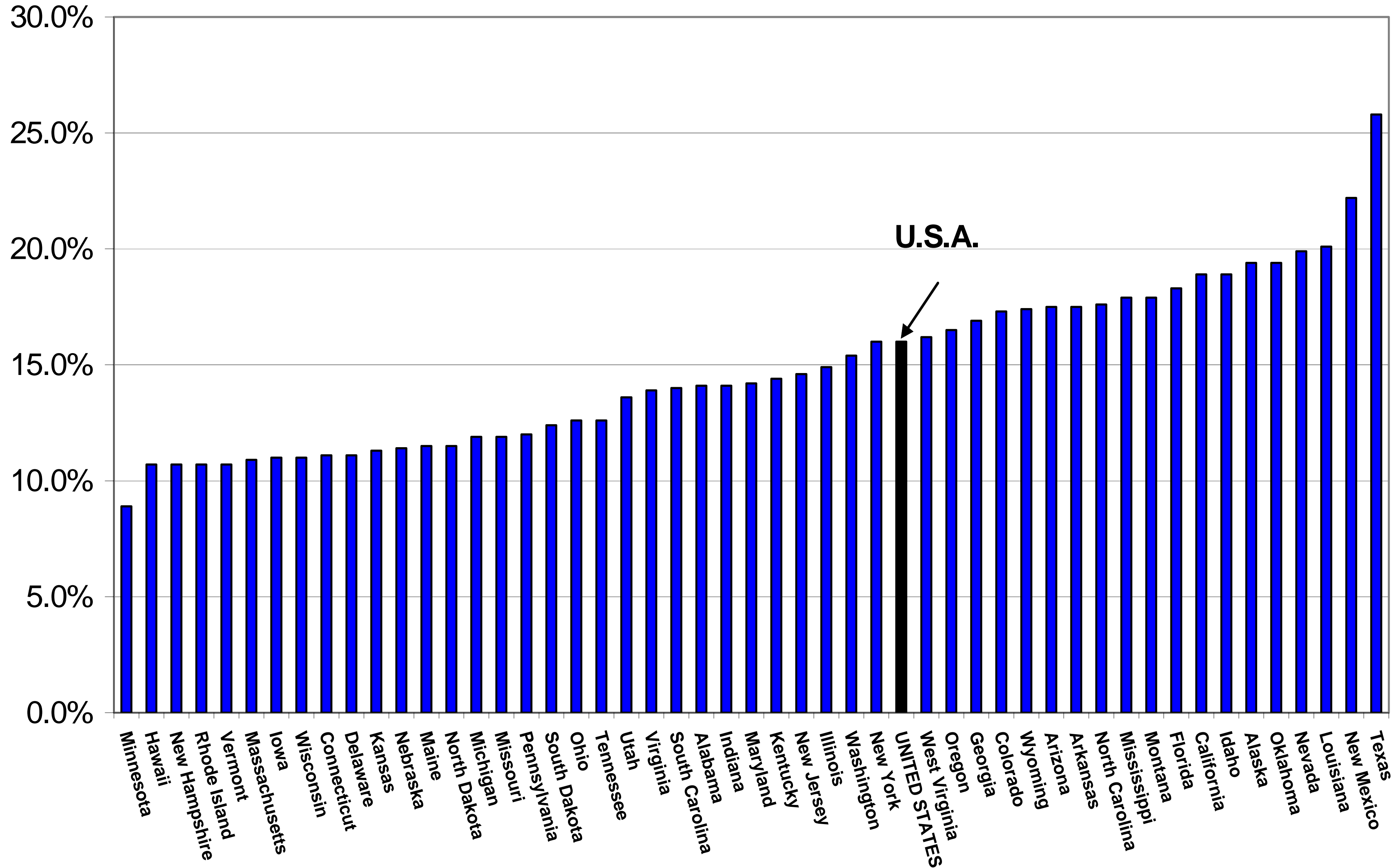
# Health Cost's Share of Each State's Economy, 2005



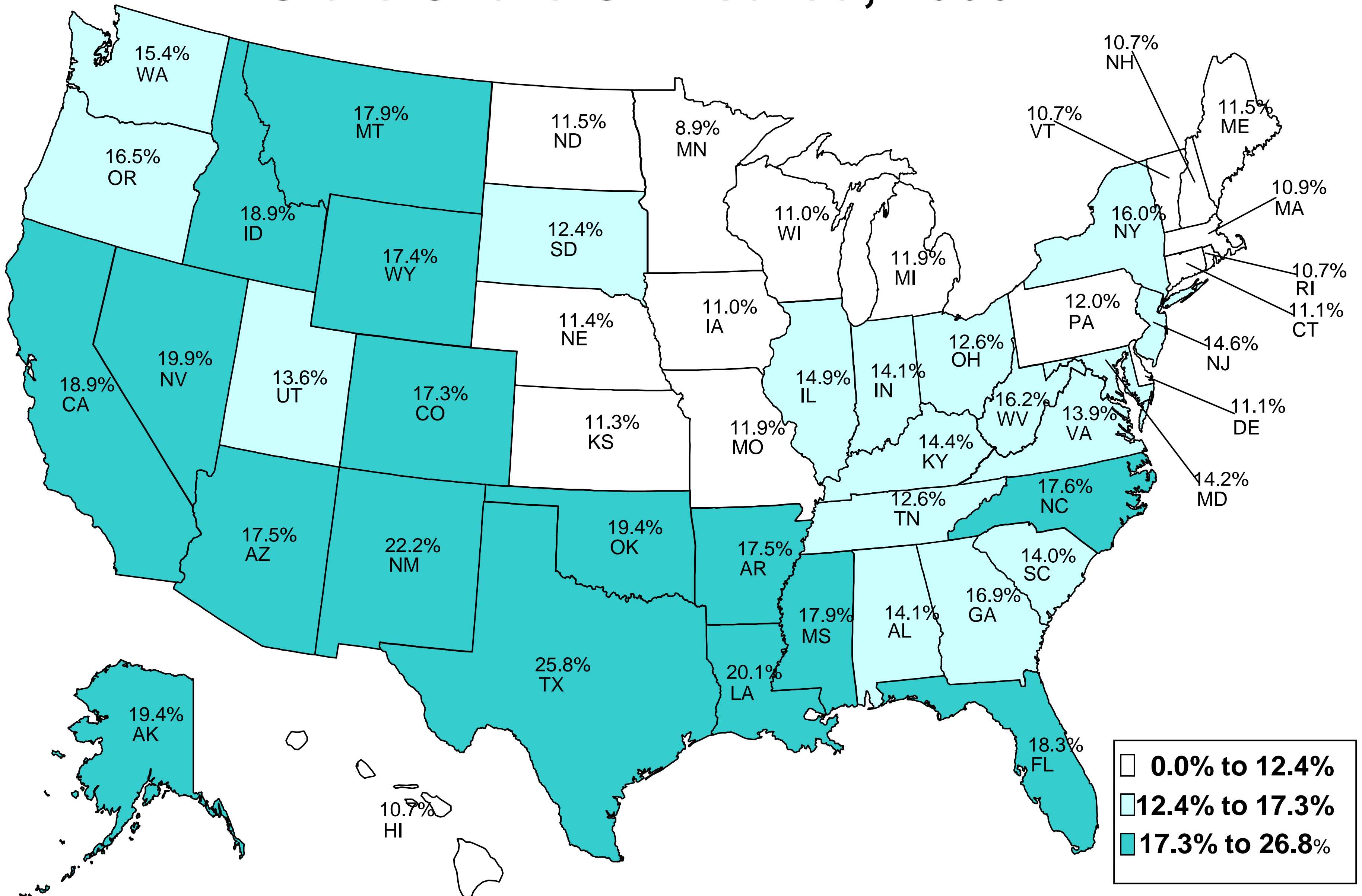
# Health Cost's Share of GSP, 2005



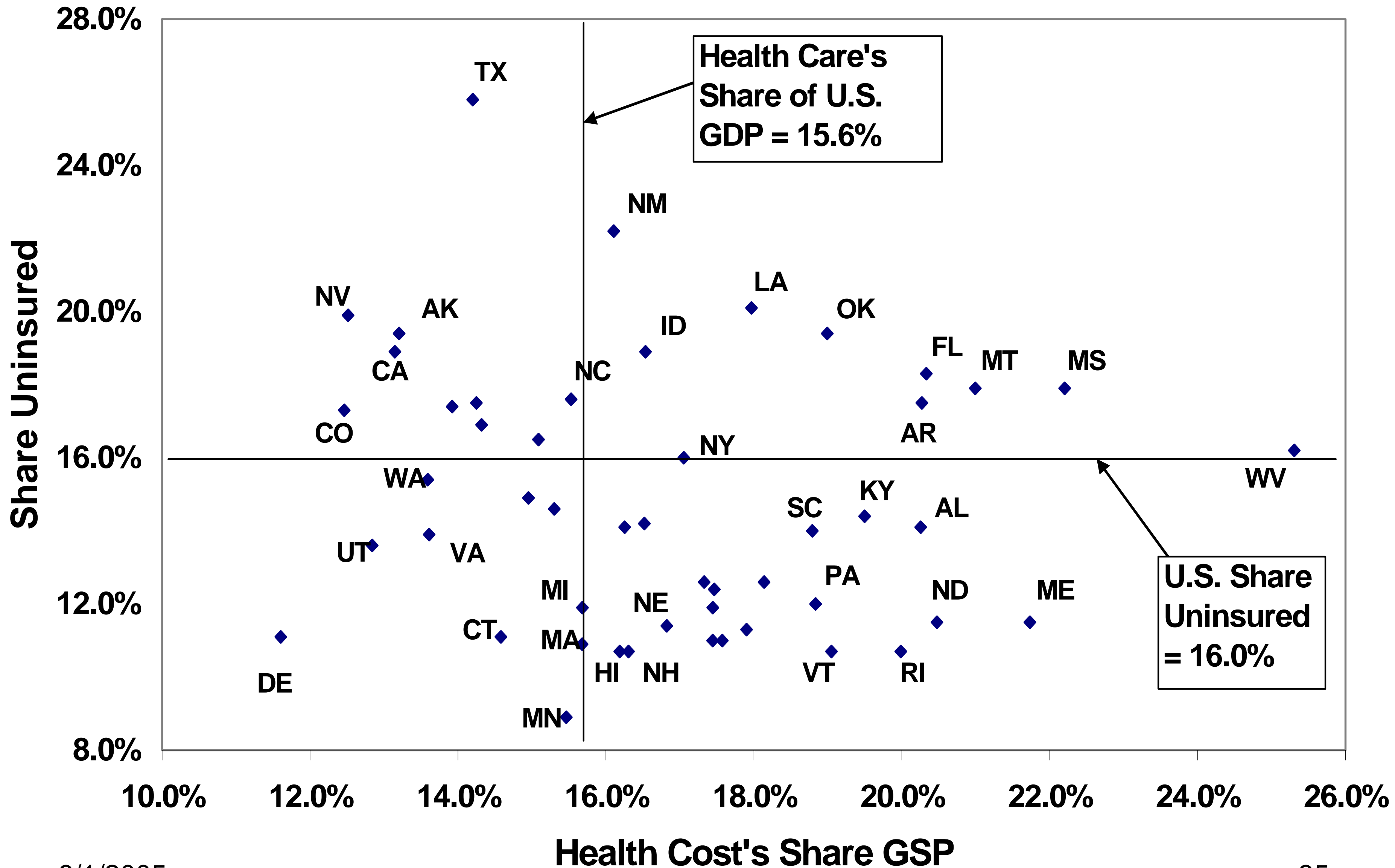
# Share of People Uninsured, 2005



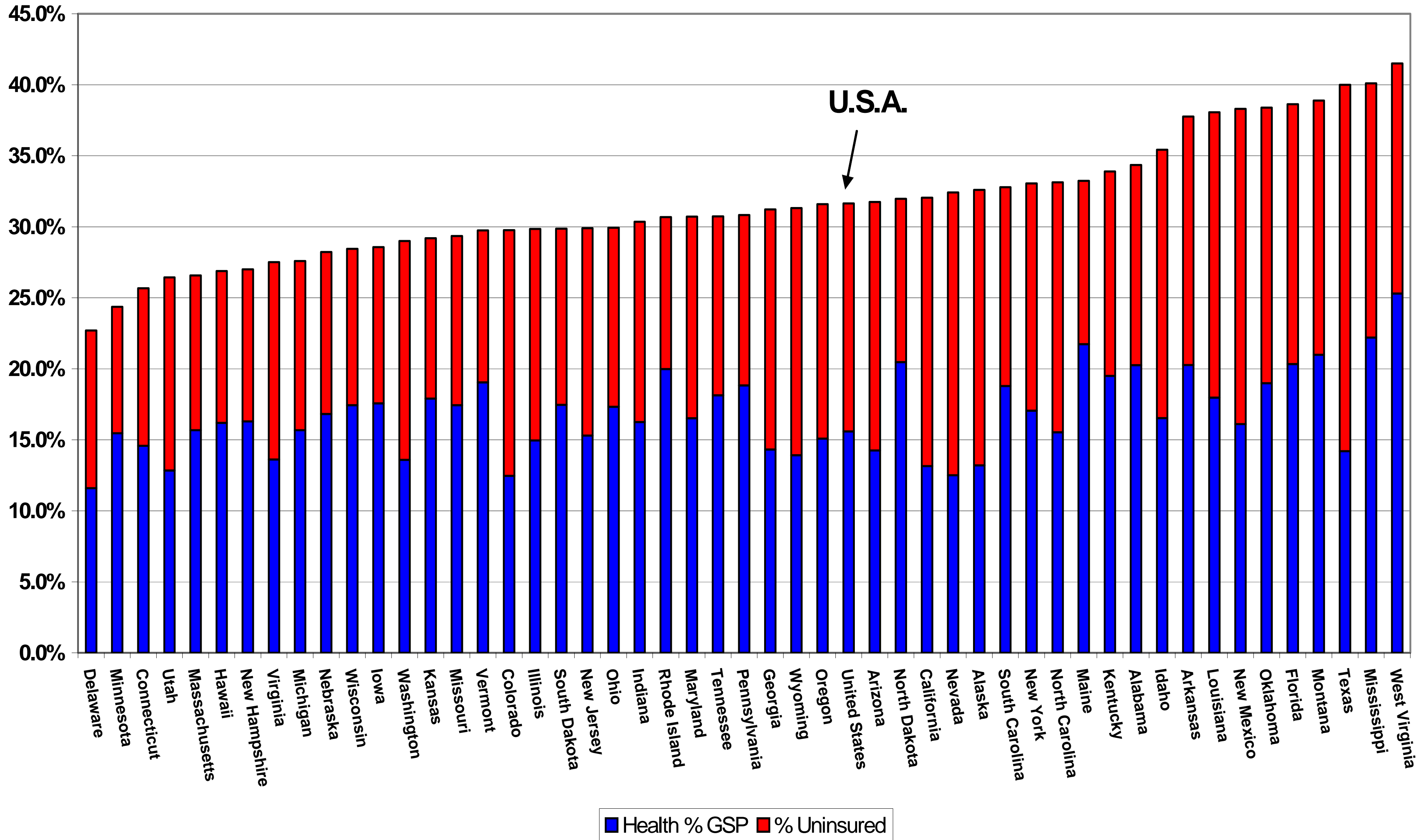
# State Share Uninsured, 2005



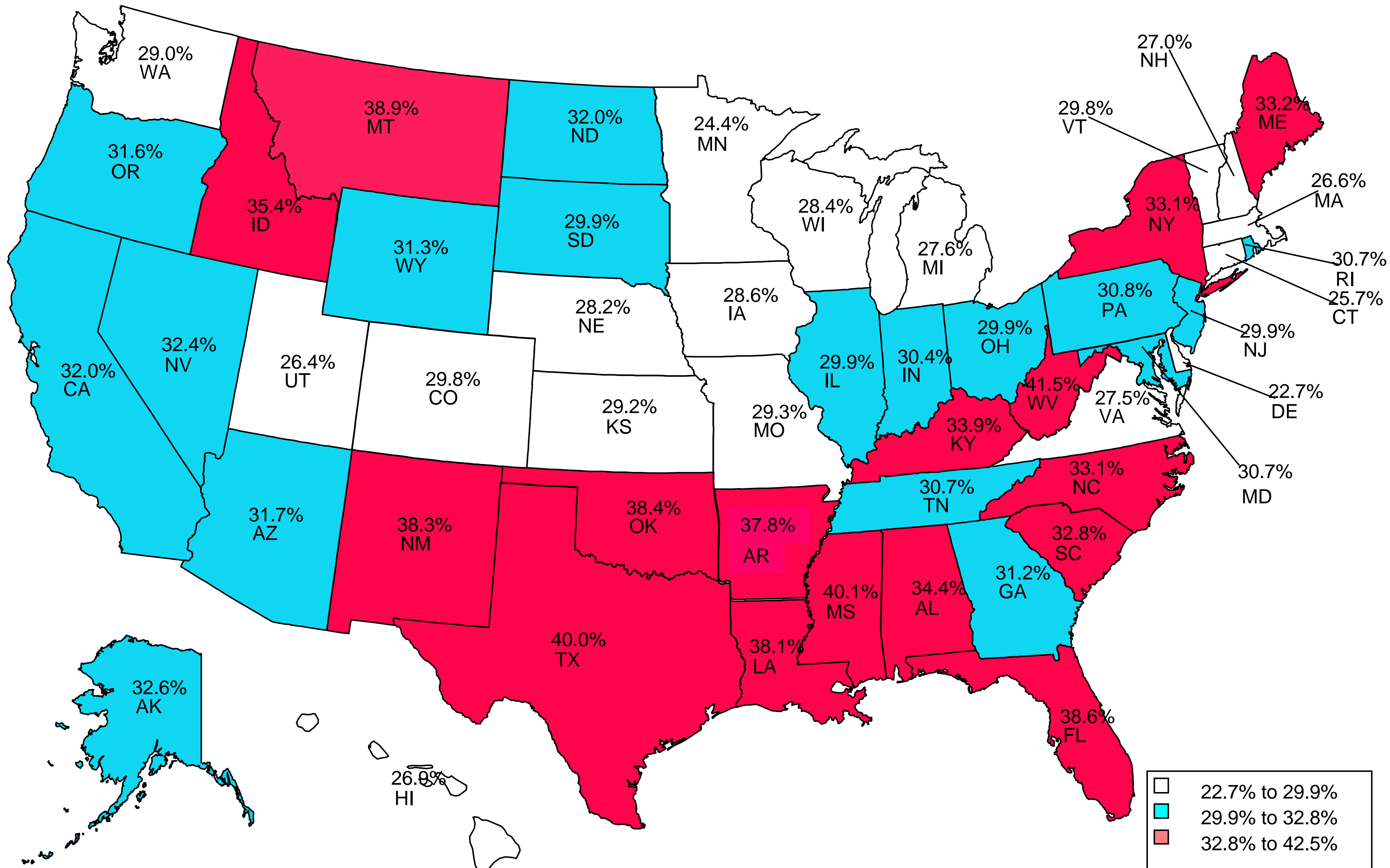
# Health Cost Share of GSP By Share Uninsured, 2005



# State Health Crisis Index, 2005, Ranked



# State Health Cost Share of GSP + Share Uninsured, 2005



# Which payers are likelier to experience threats to sustaining their payments for health care?

Where the money comes from—

# Sources of revenue to finance U.S. health care, 2005

| Source of revenue | $ billion | % of revenue |
|---|---:|---:|
| | | |
| Medicare | $332 | 17% |
| Federal Medicaid | 182 | 9% |
| State Medicaid | 135 | 7% |
| Private insurance | 691 | 36% |
| Out-of-pocket | 262 | 14% |
| Other public + private | 336 | 17% |
| | | |
| Total | $1,936 | 100.0% |

# Will some payers face greater pressures to slow growth in revenue?

- Whether the U.S. economy thrives or not, payers are experiencing varying levels of difficulty in generating increased revenues to finance health care. Consider
  - Federal worries about Medicare costs
  - Missouri's recent vote to eliminate its Medicaid program in 2008
  - Cities' and towns' difficulties in finding dollars for employees' health insurance
  - General Motors' $5 billion yearly obligation for workers' and retirees' health care

# If payers are forced to economize, will they hit patients or caregivers?

Patients

- Reduce eligibility, the number of people they cover?
- Raise employee/member/beneficiary share of premium?
- Raise out-of-pocket costs?
- Cease to cover certain services?

Caregivers—Reduce rates (DRG's, MD fees, nursing home or drug prices)?

# Transmission of cuts from patients to caregivers

| Hit to patient | Transmission to caregiver |
|---|---|
| Cut eligibility | Fewer paying customers, especially hurt caregivers with higher fixed costs |
| Raise patient premium share | Patients drop coverage, fewer paying customers |
| Raise OOPs | Some patients cease seeking care, others fail to pay OOP to caregiver |

# Cuts, transmission, responses

| Mode of cut | Transmission to caregivers | Caregivers' responses |
|---|---|---|
| | | |
| | | |
| | | |

# Which types of health care are likelier to face greater threats to sustaining care to patients and garnering adequate revenue?

Where the money goes—

# Personal Health Spending by Type of Care, 2005

| Category | $ billion | share of health $ |
|---|---|---|
| **Hospital care** | **$589** | **30%** |
| **Physician + related services** | **426** | **22%** |
| **Nursing home + home health** | **171** | **9%** |
| **Prescription drugs** | **224** | **12%** |
| **All other personal health care** | **254** | **13%** |
| | | |
| **Personal health care subtotal** | **$1,664** | **86%** |

# Which sectors will face greater stresses?

- This will depend partly on which sources of revenue are likelier to be squeezed. Broad Medicaid cuts, for example, are likeliest to crimp LTC spending.
- Sectors
  - Hospital
  - MD
  - LTC
  - Rx

- Sector-specific solutions—Rx, for example

# Massachusetts Pressure Points and Opportunities

- Highest personal health spending
- Highest MDs/population, with very high share specialists; maldistribution
- 4th-highest Medicaid share of health spending

# Health Care's Capacity to Respond to a 5% Drop in Real GDP

- A substantial (5%) drop in real GDP, whether gradual or sudden, would probably boost pressure to slow the rise in health spending, or even to cut spending.
- In response to this pressure, physicians and hospitals might react flexibly and successfully to protect themselves and their patients.  Or they might not.

# C. CAUSES OF PROBLEMS

# 1. Causes of economic problems

- Political stability in much of Asia + openness to investment = flight of capital, technology, jobs. Will they ever return? How?
- Dollar's power = other nations have long let us live beyond our means—can they safely cease doing so?
- U.S. 2005 apparently plays worldwide borrowing/ demand-boosting role of Germany in 1925
- Game Boys and Toyotas = bread and circuses?
- Hollowing out of U.S. economy, movement toward a virtual economy?
- We borrow to buy. Others pretend we'll be able to repay them. Do Chinese need strong dollar to keep exporting here? For how long? What if they pull the plug? Will a deep drop in dollar's value hike imports' prices, badly slicing real incomes here?
- How to break this financial addiction in ways that give the U.S. economy a soft landing?
- Consequences for U.S. employment, economic growth, real income, and income inequality?
- How to maintain indispensable U.S. political stability in face of growing income inequality and declining real incomes for many?
- Can real incomes grow in U.S. even if drop relative to industrializing world?

# 2. Causes of constricted revenue

- Arise from economic problems
- Health absorbing unaffordable shares of local + state government revenues, and revenues of many businesses with older workers
- Hospitals, doctors, drug makers, HMOs don't see or don't want to see the rising storm

# 3. Causes of high costs

# QUESTION: Which of these possible sources of recent/future increases in U.S. health costs do you think is the most salient?

**A** Aging population

**B** New technology boosts outcomes but *inevitably* costs more

**C** Legacy of open-ended health care spending + stark failure of almost all cost controls

- badly designed cost controls or weak political will to enforce them?

**D** Waste

**E** Efforts to boost coverage

# A. Share of U.S. population over 65

- 9.2% in 1960
- 12.4% in 2000
- 20.0% in 2030

- But most wealthy European nations now have elderly population shares that approach the level the U.S. will reach in 2030. And they now spend about one-half as much per person as we do.

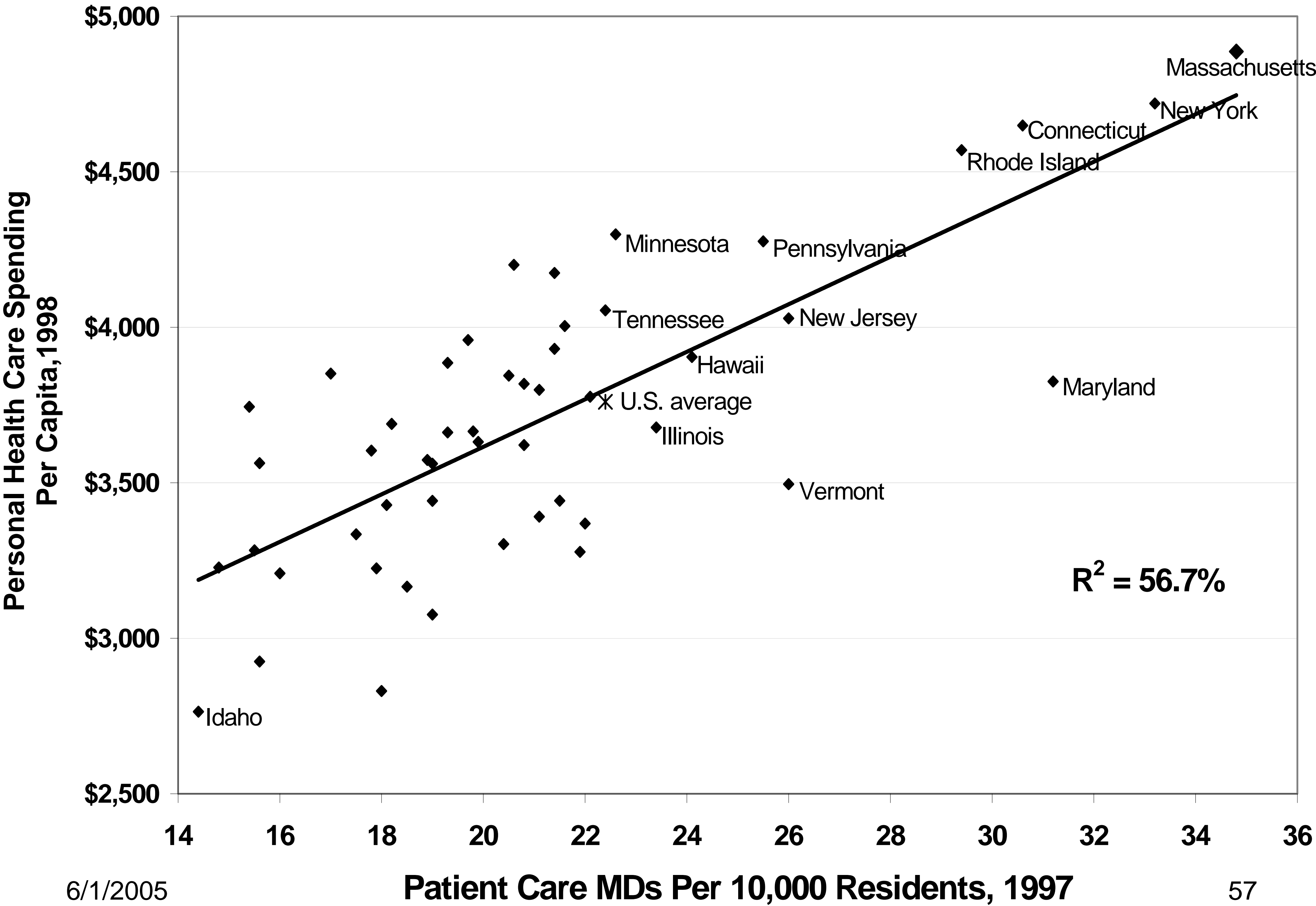
# B. New technology boosts outcomes but *inevitably* costs more

- YES: Implantable defibrillators, left-ventricular assist devices, better stents, better anesthetics, and better meds all cost more—and they're worth it.
- NO: If we rewarded cost-reducing technologies generously, they could cut cost in health care, as they do elsewhere in the economy.
  - How about a Nobel prize for something much cheaper (and just as good) as an existing technology?
  - How about a very big prize for an Alzheimer's drug that really works (and slashes nursing home costs)?

# C. Legacy of open-ended financing and failure of cost controls

- 1945-1972: most people thought that higher health spending was a very good idea. Hospitals and physicians got used to blank check financing.
- Post-1973, caregivers haven't cheerfully accepted either market or regulatory spending restraints.
  - Caregivers have successfully gamed most cost-cutting methods, though often with great effort.
  - Both physicians and hospitals have understandably gravitated toward more lucrative—and costly—patterns of specialized care—the most specialized in the world.
- Cost controls not politically popular—who gains?

# Physician Supply and Health Spending by State



# Trapped by romantic memories

- Doctors and hospitals are all trapped in the blank-check glories of pre-1973 health care finance
- Drug makers ("we know we're defying gravity") are all trapped in a world-without-a-business-plan of reliance on garnering one-half of their world-wide incomes from 5 percent of the world's people (U.S.A.)
- Those who want to protect coverage know that trade-offs are necessary, but most caregivers imagine—or publicly pretend—that more money for business as usual is a realistic option.

# Let’s connect the neurons

- In other wealthy nations, everyone knows that spending more on health means spending less on other things
- There, caregivers have essentially adapted clinical decisions to financial realities
- Americans often pretend these two things are not necessary.  This is delusional.

# D. Waste—1/2 of health spending?

1. **Clinical**: unnecessary care, incompetent care
   - Sometimes financially motivated
   - Sometimes caused by defensive medicine
   - Sometimes owing to ignorance of efficacy or cost
2. **Administrative**
   - Owing to complexity
   - And especially owing to payers' mistrust of caregivers
3. **Excess prices**
   - Rx, supplies, some incomes
4. **Fraud, theft**
   - Light punishment, perception that no-one's really hurt—we just need to boost revenue further

# E. Efforts to boost coverage

- Important in 1960s, as Medicare and Medicaid raise spending rapidly
- Seldom important subsequently
  - Medicaid growth, for example, has tended to partly offset drop in private insurance
- New Medicare Rx benefit (Part D) may raise spending, if enough people enroll

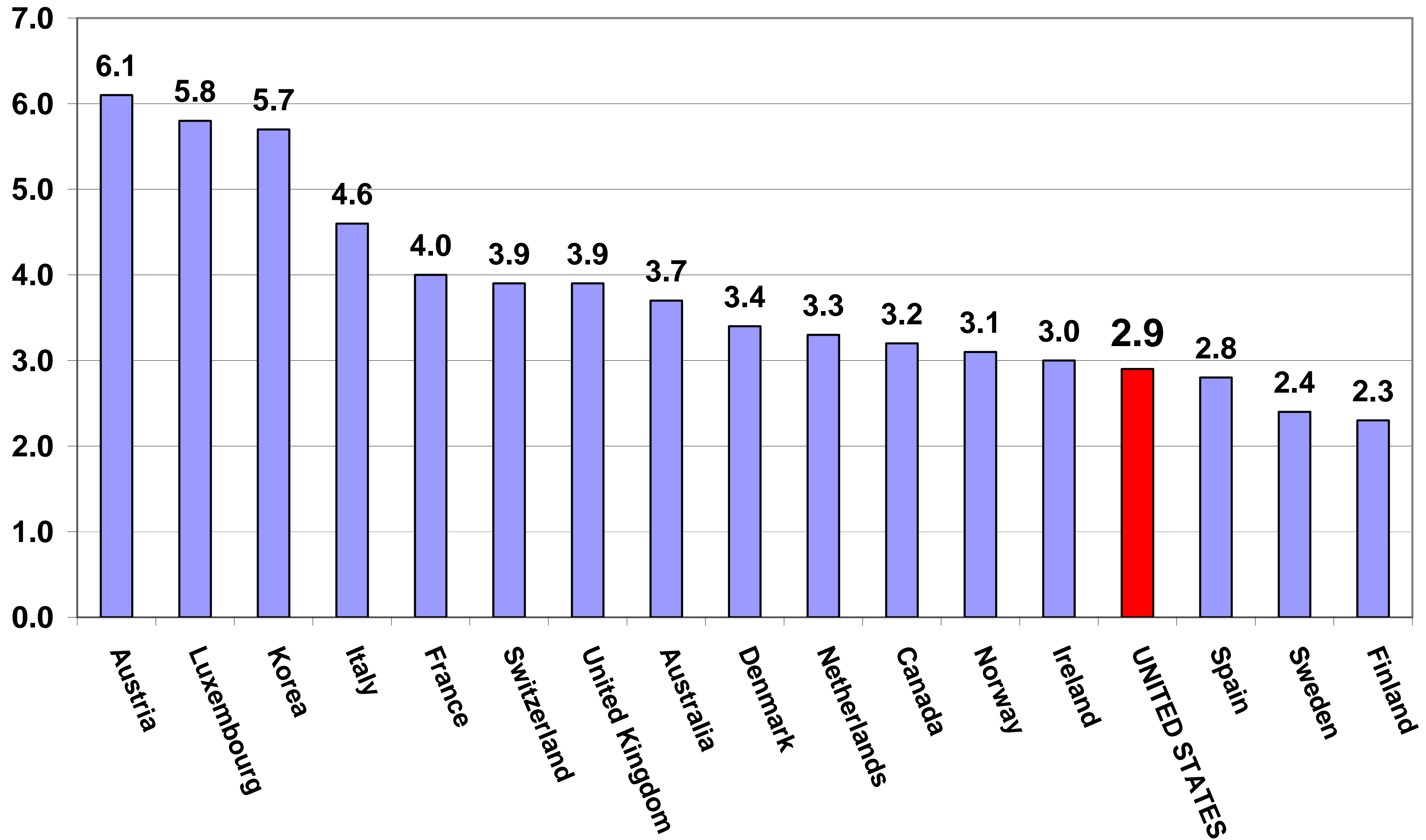
# 4. Causes of coverage problems

- Costs grew high before covering everyone
- Weak unions
- Regressive nature of insurance financing
- Racial, ethnic, geographic ties to lack of coverage
- Others

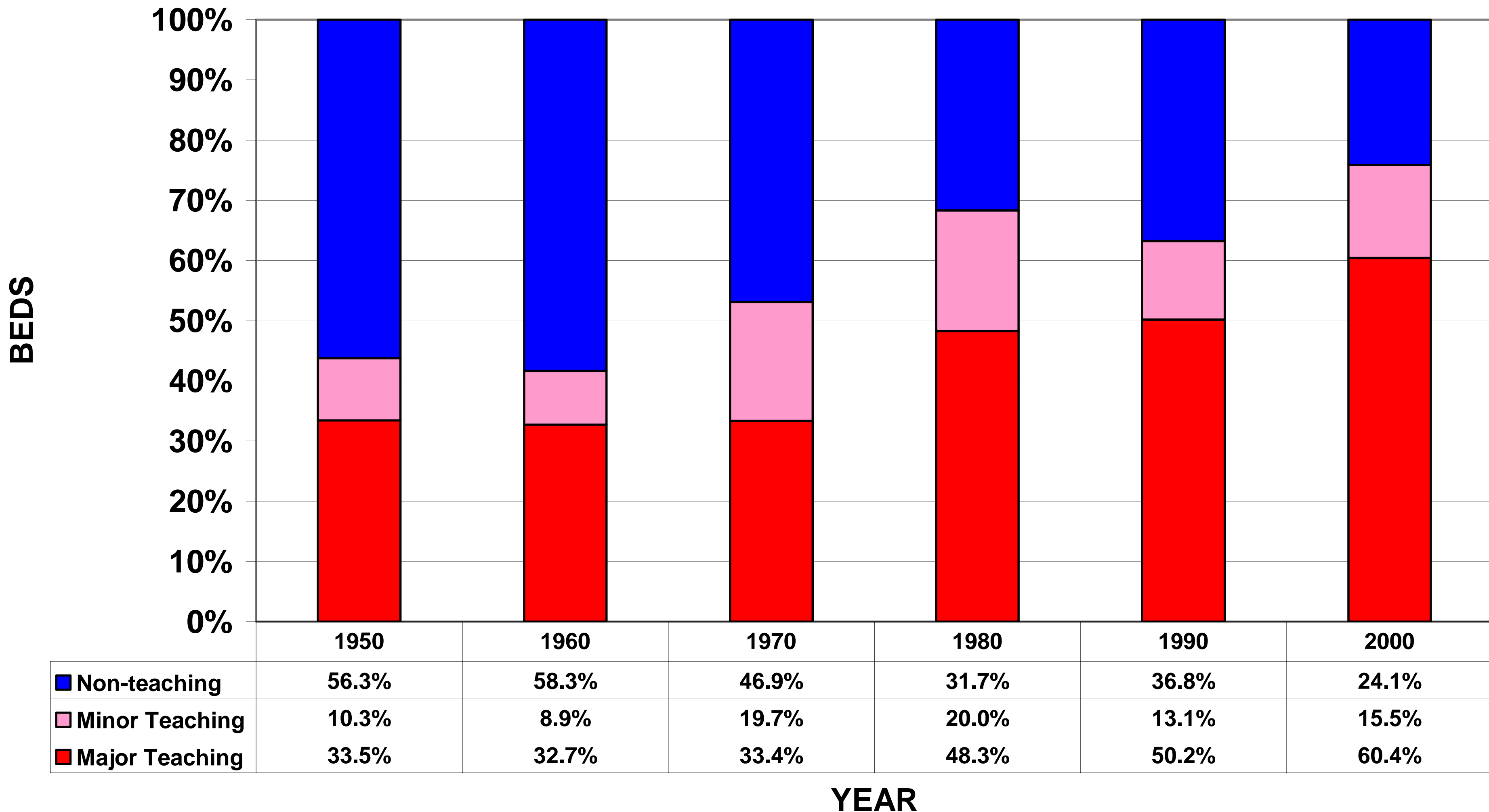
# 5. Causes of caregiver malconfiguration

- Specialization is remunerative to MDs, hospitals
- Teaching hospitals disproportionately survive—have MDs, more profitable payer mix, money in bank, political connections
- Teaching hospitals need specialized residents—especially in face of cut in hours
- Little public, planned pressure for balance
- Little public support to protect needed caregivers

# Acute Beds/1,000 Citizens, Wealthy Nations, 2000-2002

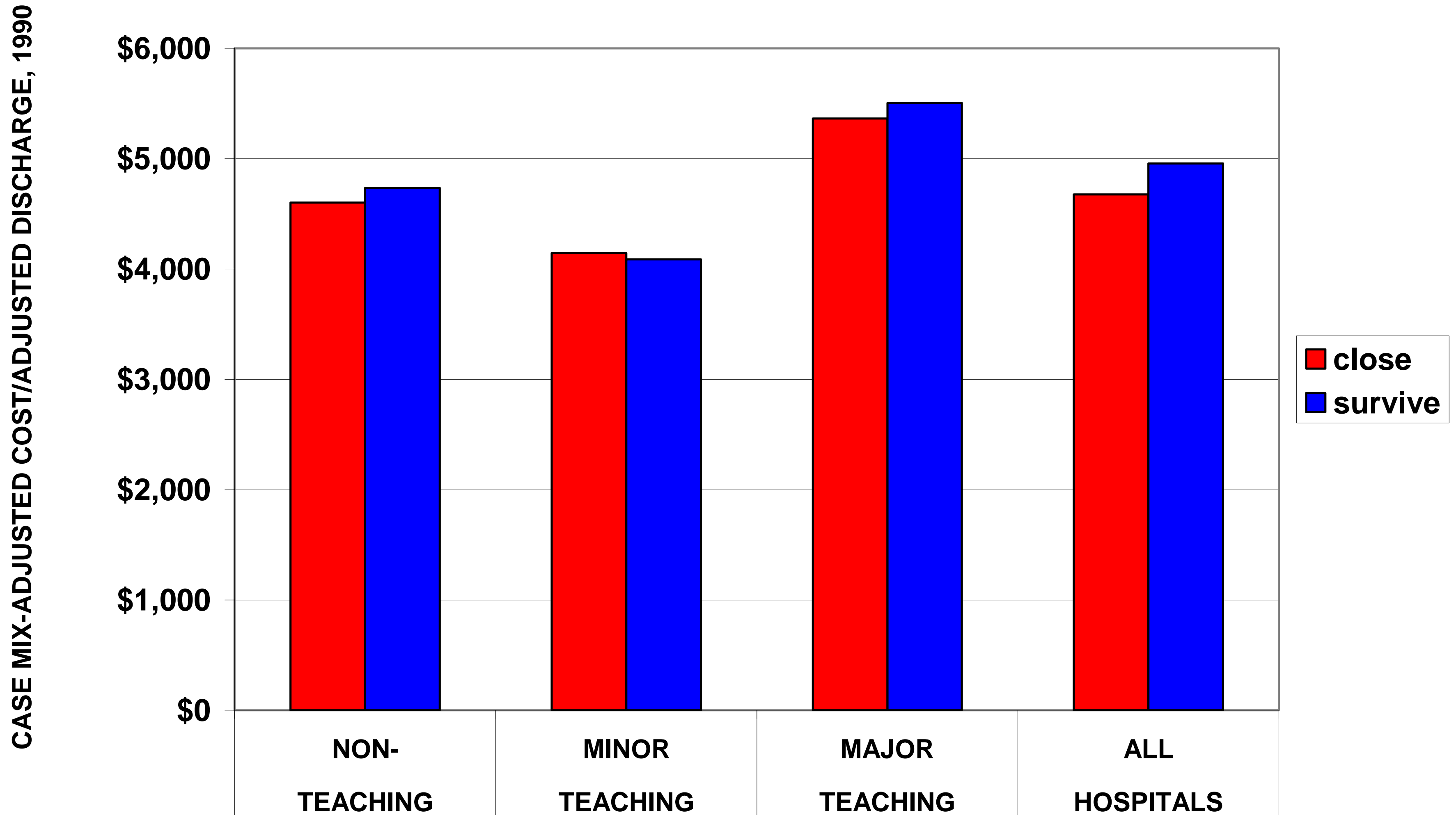


# SHARE OF BEDS BY TEACHING STATUS, 51 CITIES, 1950-2000

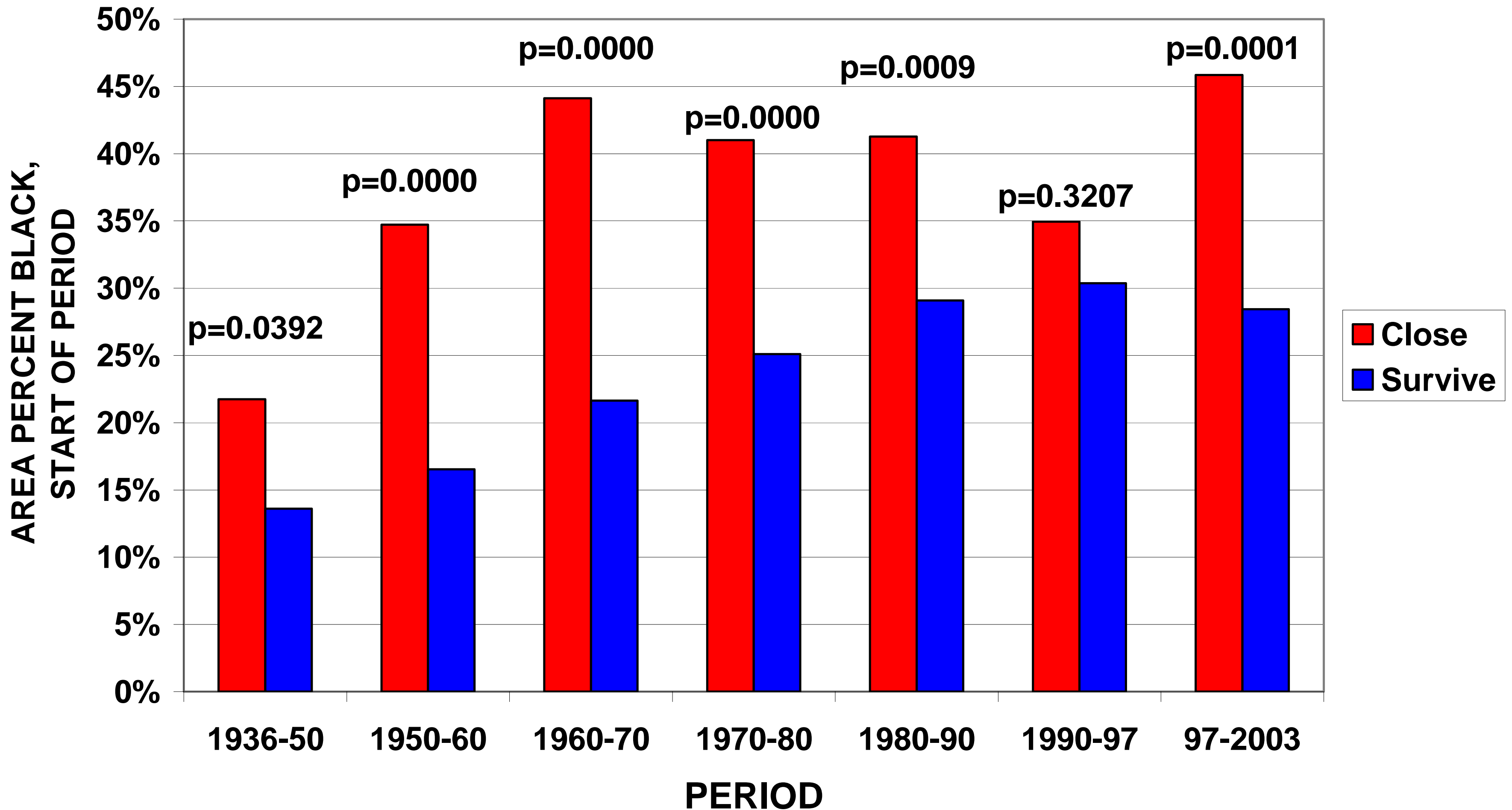



| | 1950 | 1960 | 1970 | 1980 | 1990 | 2000 |
|---|---|---|---|---|---|---|
| Non-teaching | 56.3% | 58.3% | 46.9% | 31.7% | 36.8% | 24.1% |
| Minor Teaching | 10.3% | 8.9% | 19.7% | 20.0% | 13.1% | 15.5% |
| Major Teaching | 33.5% | 32.7% | 33.4% | 48.3% | 50.2% | 60.4% |

# EFFICIENCY OF CLOSED AND SURVIVING HOSPITALS, BY TEACHING STATUS, 1990-2003



# AREA PERCENT BLACK, NON-PROFIT HOSPITALS CLOSING AND SURVIVING, 1936 - 2003

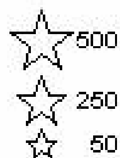


Detroit, Michigan

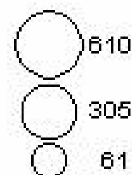
★ Hospitals Closing, 1936 - 2003

● Hospitals Open, 2003

pitals: Final Year Beds




lospitals: 2001 Beds



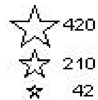

ent Black & Hispanic, 1990

## Washington, District of Columbia

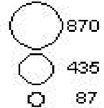
★ Hospitals Closing, 1936 - 2003

● Hospitals Open, 2003

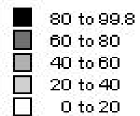
Closed Hospitals: Final Year Beds




Open Hospitals: 2001 Beds




Tract Percent Black & Hispanic, 1990

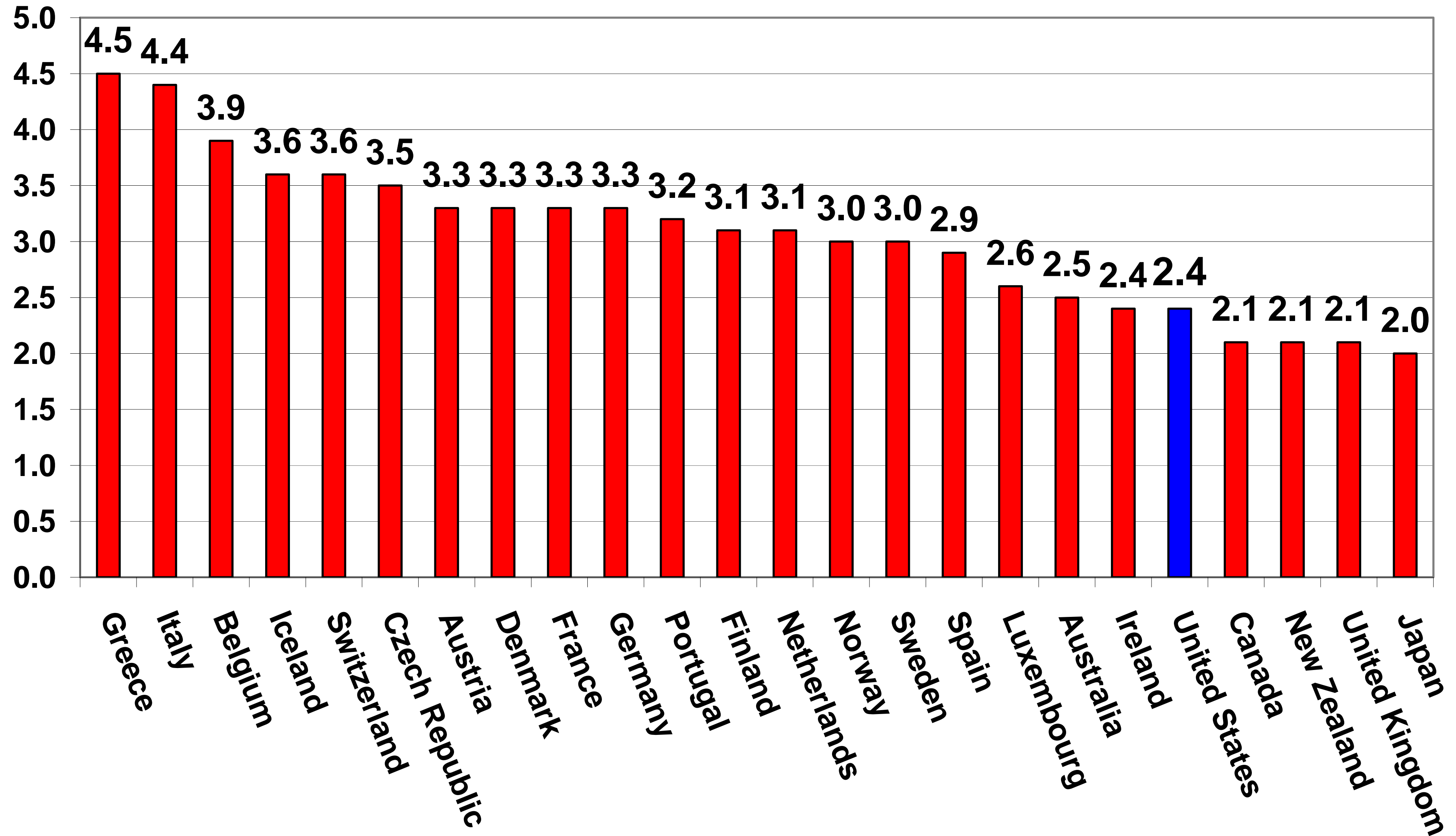



© 2003, Alan Sager

# WHAT PREDICTS MAJOR LEAGUE BASEBALL TEAM RELOCATIONS, 1950 – 1970?

- Race of residents living nearby
- Not attendance
- Not place in standings
- Not age of stadium

# Active Physicians per 1,000 People, 2002



# 6. Causes of failures to prepare

- Caregivers
  - Too busy demanding more money for business as usual, gaming revenue, marketing to attract more patients.
  - Not my job
  - It's scary to think about drops in real spending
  - Nothing I can do now will affect my chances of weathering the storm
- Payers
  - Too busy trying to save money
  - Not my job
- Government: Belief that larger market will keep economy strong, and that health care market's survival of fittest governs caregivers' future

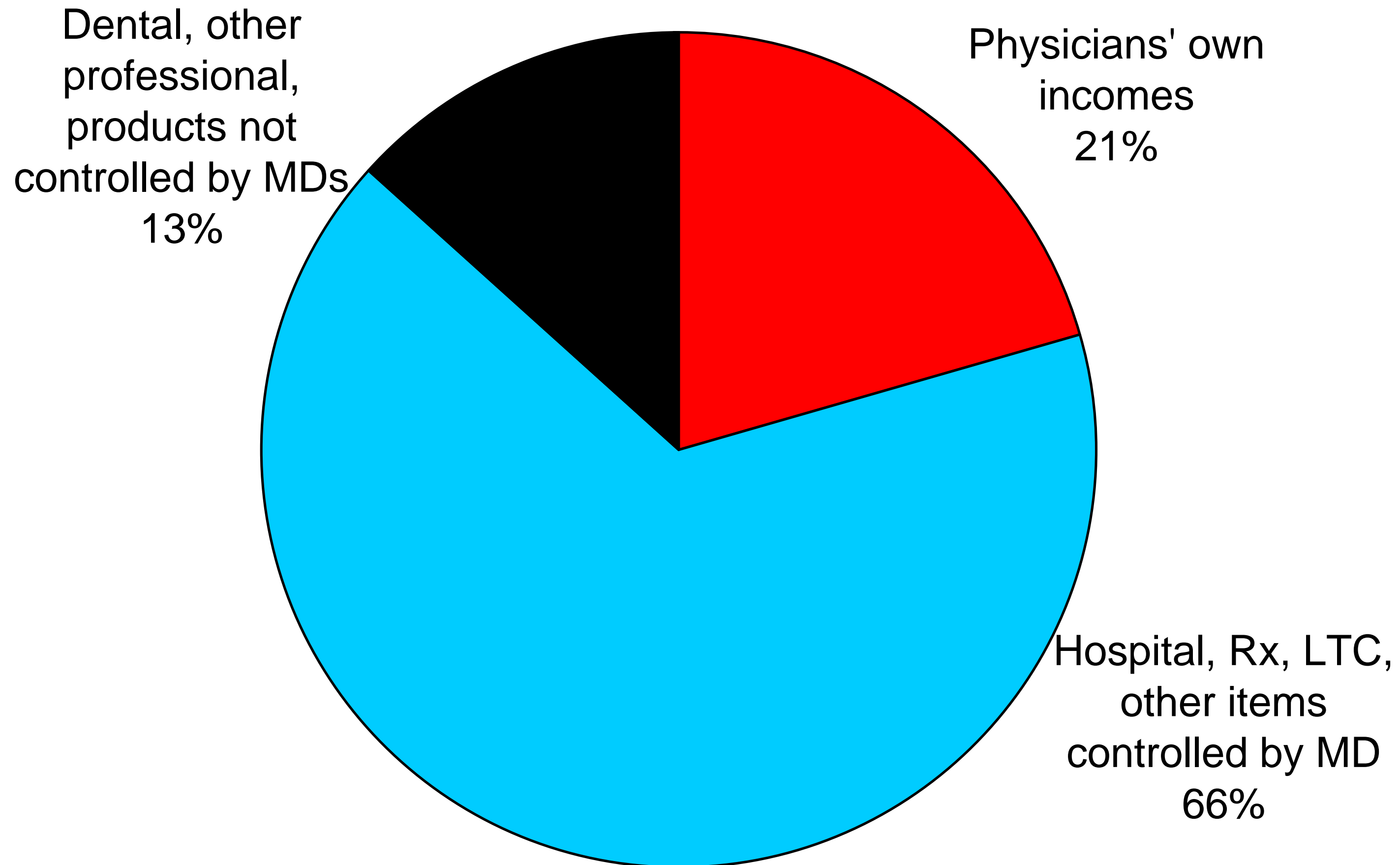
# D. SOLUTIONS THAT ADDRESS CAUSES

1. Costs
2. Coverage
3. Caregiver configuration

# 1. Containing Costs

- Physicians' strategic role in cutting waste
- A broad political deal translated into legislation, whose elements are tested in advance
  - If doctors agree to spend finite budgeted money responsibly and stretch the dollars to cover everyone,
  - we will end 90 percent of all financial paperwork and 100 percent of the threat of malpractice suits
- Sustained commitment to effective and affordable care for all—a change in physicians' values supported by group pressure
- Two watertight compartments
- Payment methods and caregiver supply are essential, but so are

# PHYSICIANS RECEIVE OR CONTROL 87% OF U.S. PERSONAL HEALTH SPENDING, 2003



- Payments to doctors must respect doctors' own needs and affordable patterns of care for all.
- Doctors' gross incomes may average about $500,000, but they retain only about $200,000. That's about 8 percent of total health spending. This 8 percent is what we have to get to doctors under circumstances that assure affordable high-quality care for all.
- Let's not get hung up on the 8 percent.

- Will single payer really contain cost? Why do we think doctors, hospitals, drug makers, nursing homes, dentists, and others will keep their costs under the ceiling of total national or regional revenue provided?
- Doctors' decisions commit the dollars. We have to ensure that these decisions are made with an eye toward affordable care for all

# Physicians' strategic role

- Cutting clinical waste is a retail business, one that must be supported by
  - better evidence on what works
  - data on actual marginal costs (not prices or average costs) of all common types of care
  - methods of paying doctors that are much more financially neutral but that require and reward marshaling finite dollars carefully
  - need to justify denial of care to patients and families in legitimate ways
  - MD commitment to care for all

# A big political deal

- Not voluntary, but translated into legislation
- If doctors agree to spend finite budgeted money responsibly and stretch the dollars to cover everyone,
  - we will end 90 percent of all financial paperwork and 100 percent of the threat of malpractice suits
- Test elements in advance

# A practical example

- U.S. has about 2.5 active patient care doctors per 1,000 people
- So 50 doctors (primary + most big specialties) could take on about 20,000 patients.
- 2005 personal health spending per person will be about $5,600, and 87 percent of this = $4900
- The 50 doctors would have almost $100 million to marshal to finance and deliver one year of care to 20,000 patients. (Some would be reserved for reinsurance.)

# Why 50 doctors per group?

- This seems large enough to afford solid clinical support (especially about efficacy and cost of care) and administrative support
- But it's small enough for doctors to know and monitor one another, and to knock heads to develop standards they're comfortable with
- And small enough for everyone to see the practical consequences of clinical decisions
- And, particularly, small enough to spot someone who's incompetent, wasteful, lazy, or otherwise not with the program

# Doctors use evidence and knock heads

- Each network of doctors gets evidence on how to diagnose and treat—what care works and who needs it.
- Each gets evidence on actual marginal cost of each service. It might even pay for hospitals and drugs by their marginal cost (with fixed costs absorbed outside the budgets of doctor networks).
- Each network makes care decisions in light of evidence on efficacy and cost of treatments.
- Each must care for all enrollees with money available.

# Risk adjustment

- Payments to each network would be adjusted for the age, illness, disability level, and other legitimate predictors of cost of care.

# Individual enrollment

- Patients would enroll individually, not as families, so a family member could choose a network that contained his/her primary care physician
- This way, we avoid a few huge networks in each metropolitan area
- Each network could refer to and pay physicians out of their network, but would have to include that under their budget

# Two watertight compartments

- One for money for doctors, which they must divide up among themselves in some fair proportion to competence, energy, and kindness
- The second is for the 67 percent of the personal health dollar that doctors control but don’t get—hospitals, meds, long-term care, and the rest.
- Doctors must spend all of the 67 percent, and can’t benefit personally from any conservative scrimping.

# Paying doctors

- Aim is to generate fair, agreed income targets
- Salary possible, with moderate bonuses for adhering to evidence-based clinical standards, greater efficiency, better outcomes, better patient satisfaction, greater energy
- Or fee-for-service, modulated for these things
- Challenges
  - measure these things accurately and cheaply
  - provide feedback in acceptable ways, probably from a group of peers or a diplomatic, respected, and vigorous medical director

# Monitoring

- Each network must be monitored to ensure fair patterns of service by age, income, race, ethnicity, religion, gender, and other potential axes of discrimination
- Patients with similar problems must be treated similarly

# Appeals

- Each network will have an appeals mechanism
- Because doctors can't be enriched by withholding care, their patients should trust them, reducing foundation for appeals
- As much as possible, it would be helpful to avoid Oregon-style published lists of what's covered or not, as these lists induce anguish, politicization of decisions, and put care under a constant spotlight. We want a solid foundation for trust, not trials (before judges).

# Less finance-related paperwork

- If physicians are paid in more trustworthy ways, they won't have to submit individual claims
- And they won't have to re-file rejected claims
- Movement from gaming the payment methods to working within inevitable constraints

# Less waste, fraud, and theft

- When dollars are visibly finite and pathology remains visibly remorseless, it becomes obvious to everyone that
  - waste kills
  - fraud kills
  - theft kills
- People therefore start confronting colleagues and, if necessary blow whistles

# Benefits to doctors who agree to do these things

- A solid organizational and financial foundation for efficient evidence-based care for all people
- An end to constant worry about financial meltdown of health care
- True, this may be a second-best, but one that's <u>possible</u>
- Tort-based malpractice system is abandoned in favor of no-fault compensation for lost wages (cost of medical care is covered through the universal care system)
- Because doctors are paid in trustworthy ways, 90 percent of finance-based paperwork is eliminated—they pay themselves.
- Doctors get to practice evidence-based and efficient medicine, making the hard choices

# (Detail: methods of containing cost)

| | Wholesale | Retail |
|---|---|---|
| **PUBLIC** | •Medicare prospective payments to hospitals by the diagnosis<br>•resource-based relative value payments to physicians<br>•certificate of need<br>•reward cost-cutting technologies<br>•boost primary care physicians and community hospitals<br>•prescription drug price controls<br>•Single payer cuts in admin. waste | •squeeze clinical waste through bedside rationing **within budgets**, coupled with end of malpractice system<br>•squeeze administrative waste by better payment methods—part of foundation for improving payer-caregiver trust<br>•develop/disseminate more evidence on what care works, and who needs it<br>•evidence to caregivers on actual cost of each type of care |
| **MARKET** | •hospitals compete by price, quality<br>•HMOs compete by price and networks' comprehensiveness<br>•prescription drug insurers compete by price, networks, and formularies | •raise patients' out-of-pocket payments<br>•further de-insure patients by promoting health savings accounts<br>•give patients better information about need for care and caregivers' price and quality |

# QUESTION: Which method of containing cost would be *most effective* + *helpful*?

| | Wholesale | Retail |
|---|---|---|
| PUBLIC | **A** Payers cut fees to caregivers, Regulate supplies of caregivers | **B** Empower MDs to spend carefully→ they cut clinical waste + paperwork |
| MARKET | **C** Hospitals, HMOs, and drug makers compete by price | **D** Make patients pay more→ they shop more carefully by price, quality |

QUESTION: Which method of containing cost is *most likely to be relied on in next decade*?

| | Wholesale | Retail |
|---|---|---|
| P U B L I C | **A** Payers cut fees to caregivers, Regulate supplies of caregivers | **B** Empower MDs to spend carefully → they cut clinical waste + paperwork |
| M A R K E T | **C** Hospitals, HMOs, and drug makers compete by price | **D** Make patients pay more → they shop more carefully by price, quality |

# 2. Coverage

- Bound tightly to cost control, else there's no vital pressure to contain cost, only abstractions like saving money for Medicare or your employer

# Methods of improving coverage

| | Small, Incremental | Big |
|---|---|---|
| Hike Cost | •Subsidize employer, employee purchase | •Medicaid expansions<br>•Employer mandate<br>•Individual mandate |
| Cut Cost | •High-deductible coverage/bare bones policies, supple-mented by Health savings accounts? | •Single payer?<br>•Financially neutral, physician-directed closed systems? |

# QUESTION: Which method of improving coverage would be *most helpful and effective?*

| | Small, Incremental | Big |
|---|---|---|
| Hike Cost | **A** Subsidize insurance purchase | **B** Expand Medicaid, employer or individual mandates |
| Cut Cost | **C** Bare bones insurance + Health savings accounts | **D** Single payer, or financially neutral MD-directed systems |

# QUESTION: Which method of improving coverage is *most likely to be relied on in the next decade?*

| | Small, Incremental | Big |
|---|---|---|
| Hike Cost | **A** Subsidize insurance purchase | **B** Expand Medicaid, employer or individual mandates |
| Cut Cost | **C** Bare bones coverage + health savings accounts | **D** Single payer, or financially neutral MD-directed systems |

# 3. Caregiver Configuration

a. Stabilizing needed hospitals
b. The right doctors in the right places
c. Affordable medications for all
d. Long-term care—never enough money to finance all that might be needed
e. Dentist shortage considerable—need to re-orient away from profitable sidelines and toward basic care for all

# The right hospitals in the right places—payment and planning

# CASE FOR INTERVENTION - 1

1. We lack a free market could to weed out the inefficient hospitals.
2. Even if we had a free market, it could only ratify purchasing power and doctor location—both maldistributed today.
3. Racial link with closings is unacceptable.
4. Massive bed shortages loom.
   - Average hospital census nationally now about 450,000—will rise to 770,000 by 2025.

# CASE FOR INTERVENTION - 2

5. Cost of replacing closed hospitals will soon be ~ $1 million/bed, $1 B/ 000 beds
6. Hospital today is usually worth more than promises tomorrow, especially when its survival depends on organizing needed care.
7. Jobs matter.
8. Burden of proof must shift--no other hospitals should be allowed to close without proof that they are not needed to protect the health of the public.

# ACTION STEPS

1. Identify needed hospitals likely to close
   - Which hospitals (and ERs) are needed to protect the health of the public, today and tomorrow.
     - ✓ What types of hospitals and where should they be located?
     - ✓ Which hospitals are required to attract and retain needed doctors to each locality?
   - Identify hospitals that are likely to close in time to intervene
     - ✓ Track financial ratios annually
     - ✓ Use long-term predictive model

# ACTION STEPS - 2

2. Raise public awareness of the risk to a needed hospital
   – Trustees and CEOs deny problems until it's too late
   – They often act as if they thought, "If we can't save this hospital, we would be embarrassed if someone else did it."
   – They often believe that hospitals that can't compete in the market deserve to close.
   – They claim that going public would only undermine the hospital prematurely.

# ACTION STEPS - 3

3. For temporary protection
   - Enact state hospital receivership law, allowing officials or citizens to petition a court to take control of a hospital and stabilize its finances.
   - Or urge governor to declare that closing Hospital X constitutes a "public health emergency," allowing state to seize control of needed hospital and stabilize it.
   - Underpin either legal step with short-term financial relief through state trust fund financed by 0.25 percent of each hospital's revenue, → about $1.25 billion yearly in U.S.
     - (and about $100 million in New York State)

# ACTION STEPS - 4

4. To durably protect each needed hospital, establish all-payer rate setting to guarantee enough money to sustain efficient, high-quality operation

- In a free market, each payer would pay the same price.
- Without a free market, only a public structure can protect each needed hospital

# b. Physician specialization and location

- Public financing of all medical education will make it much easier for students to enter primary care
  - $40,000 * 16,000/year * 4 years =
  - $2.56 billion = 0.13 percent of 2005's total health spending of $1,936.5 billion
- Income convergence (not equality) will help greatly.  It's essential.

# c. Affordable medications for all

- Medical networks can’t win this
- Need Rx peace treaty
- Payers persuade drug makers to cut prices in exchange for assured higher volume
- Total revenue unchanged, but now all needed prescriptions are filled
- To return profits to prior level, need only pay tiny marginal cost of producing added volume of pills

# Massachusetts has adequate leverage

Total 2004 Rx spending

- Massachusetts $3.7 billion
- Sweden $3.9 billion
- Australia ca. $9 billion
- New York State $19.5 billion
- Canada $21.8 billion

# d. Long-term care

- Talk of Medicare LTC benefit has ceased in wake of higher drug costs and MMA mess
- Fear of moral hazard—if you pay for the non-institutional care people want, they're likely to use it
- LTC is like a stone bridge whose halves hold up one another
- Need mobilize serious rise in voluntary aid and use that to secure containable increase in public financing—legislators won't have reason to worry that they have to fill a bottomless, receding pit—as families withdraw efforts in favor of new publicly paid help

# How to mobilize volunteers

- Bank volunteered time
- Create parallel economy of good deeds
- Move good deeds across time and space
- Use banked time to buy time insurance, so need only save expected value of average lifetime of help
- Motivation meaningless—who knows why we do things? Mix altruism and self-interest
- Work through established social networks of neighborhood, fraternal organization, work/union, religious congregations
- Back volunteered time with guarantee of paid help if no further volunteers emerge—like backing paper silver certificates
- Need manage like any economy—to guard against inflation, for example

# E. Moving forward

1. Economic contingencies and political panic
2. Getting ready

# Health Care's Capacity to Respond to a 5% Drop in Real GDP

- A substantial (5%) drop in real GDP, whether gradual or sudden, would probably boost pressure to slow the rise in health spending, or even to cut spending.
- In response to this pressure, physicians and hospitals might react flexibly and successfully to protect themselves and their patients. Or they might not.