Testimony on Single Payer Health Care

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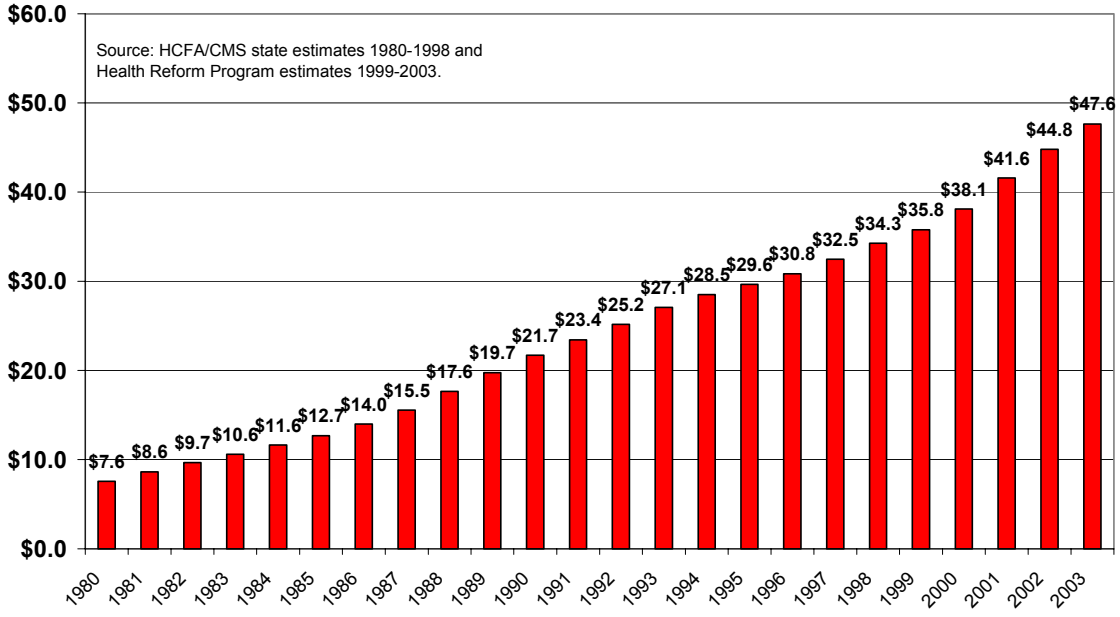
I. The Looming Problem: Massachusetts Medical Meltdown

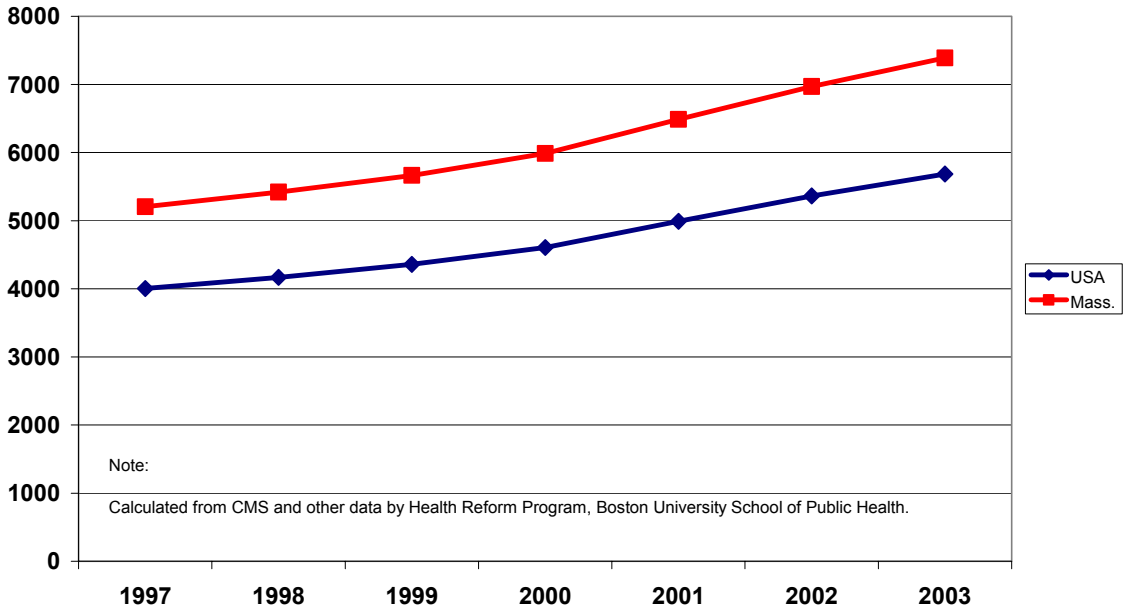
Cost is rising, coverage is falling, caregivers are suffering, and each party thinks mainly of its own needs.

A. High and rising costs—and premiums

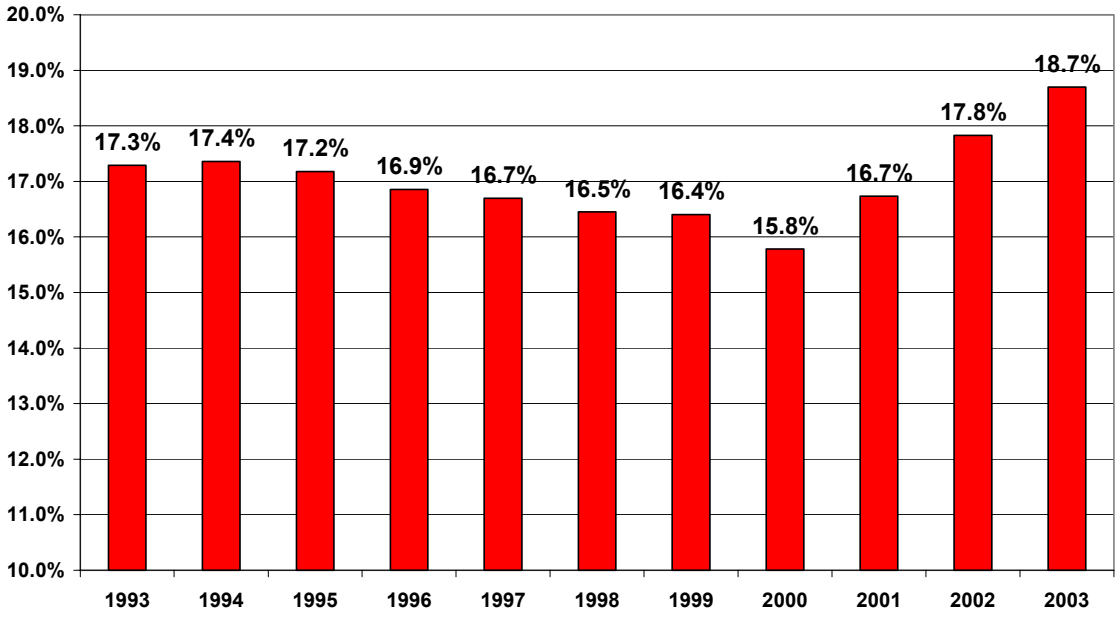
MASSACHUSETTS TOTAL HEALTH SPENDING,
$ BILLIONS, 1980-2003



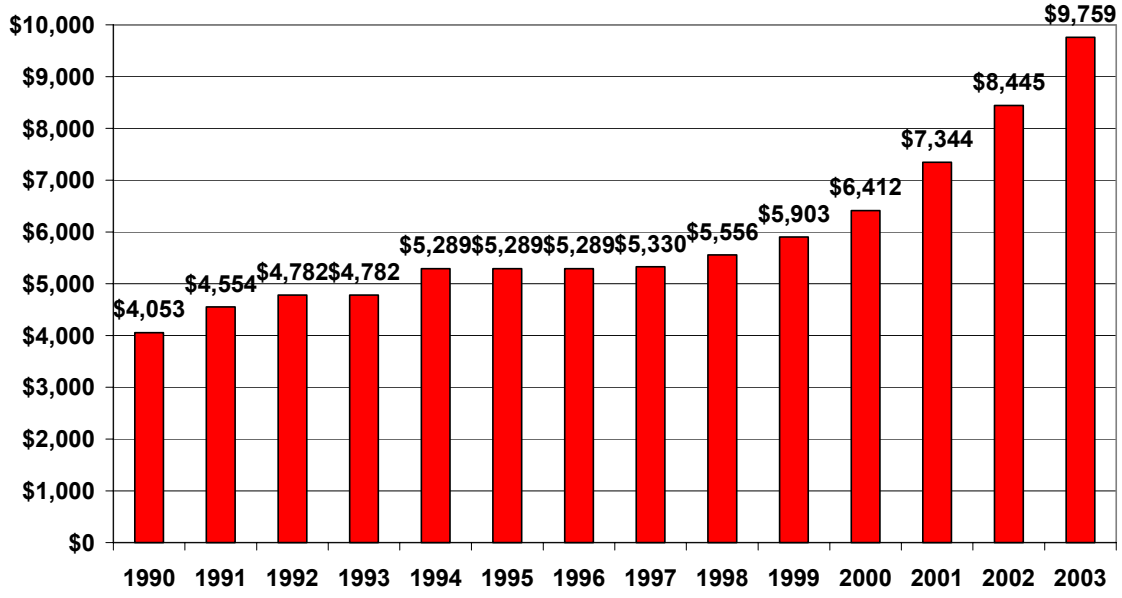
TOTAL HEALTH SPENDING PER PERSON, MASSACHUSETTS AND U.S.A., 1997 - 2003



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



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



Why are health costs so high—and rising—in Massachusetts?

Some groups (hospitals and others) deny our costs are high. Yet, if we spent at the U.S. national average, we would save some $11-12 billion this year alone.

Some of our higher costs are actually attributable to

- higher wages,
- research,
- service to patients from other states,
- a slightly older population,
- and the like.

But more of our higher costs are actually associated with

- serving more patients in costly teaching hospitals (highest rate in the nation)
- relying heavily on hospitals to provide outpatient (non-emergency) care, even though that tends to be much more costly
- the nation's highest physician/population ratio
- a tradition of relatively elaborate and expensive care
- higher nursing home spending

This is not just a hospital problem. Massachusetts health care costs per person are higher in virtually every sector of health care.

B. Rising numbers of uninsured and under-insured people

No matter which survey you choose to use, federal or state, we are in trouble.

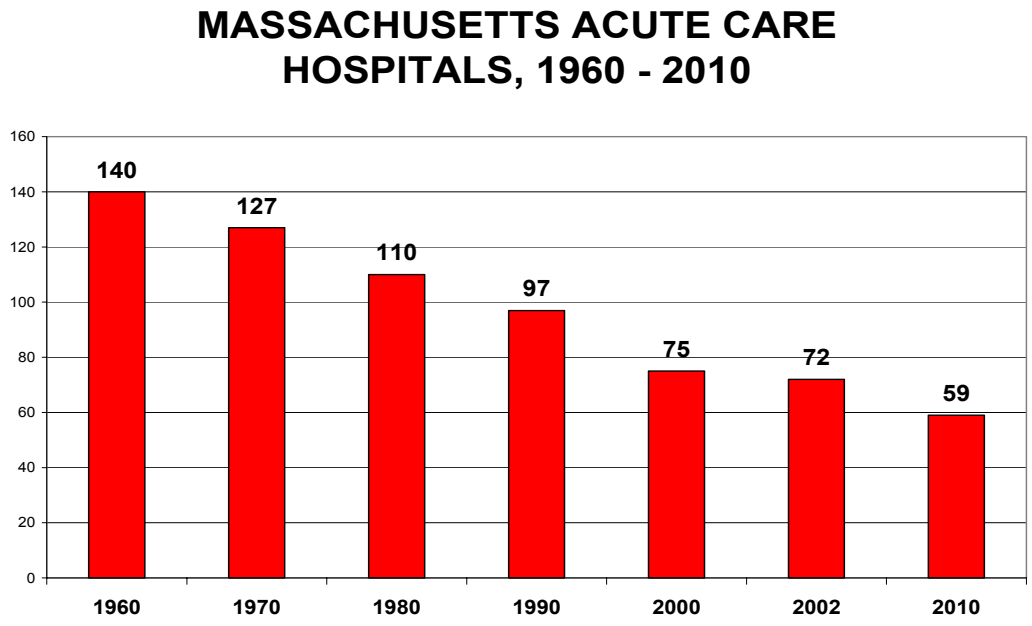
According to the Current Population Survey data released on 30 September 2003,

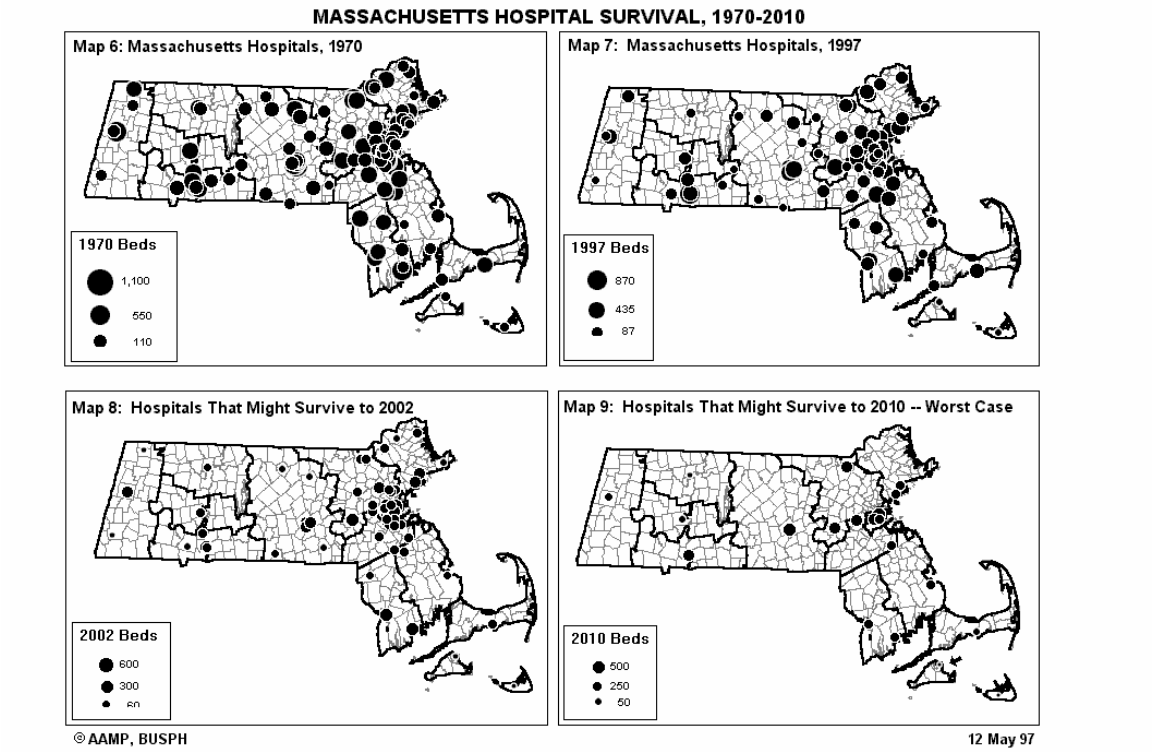
- 9.1 percent of Massachusetts residents lack health insurance (2001+2002 average)
- fifth best in nation
- but rising
- and 9.1 percent means almost 600,000 uninsured year-round, plus people uninsured for parts of years.

Underinsurance is an enormous problem. Nationally, one American in four has no insurance for prescription drugs. With the steady loss of retiree health insurance and Medicare HMO prescription drug insurance, the numbers lacking prescription drug coverage are growing steadily. Coverage for needed long-term care and mental health services is weak and becoming weaker for many people.

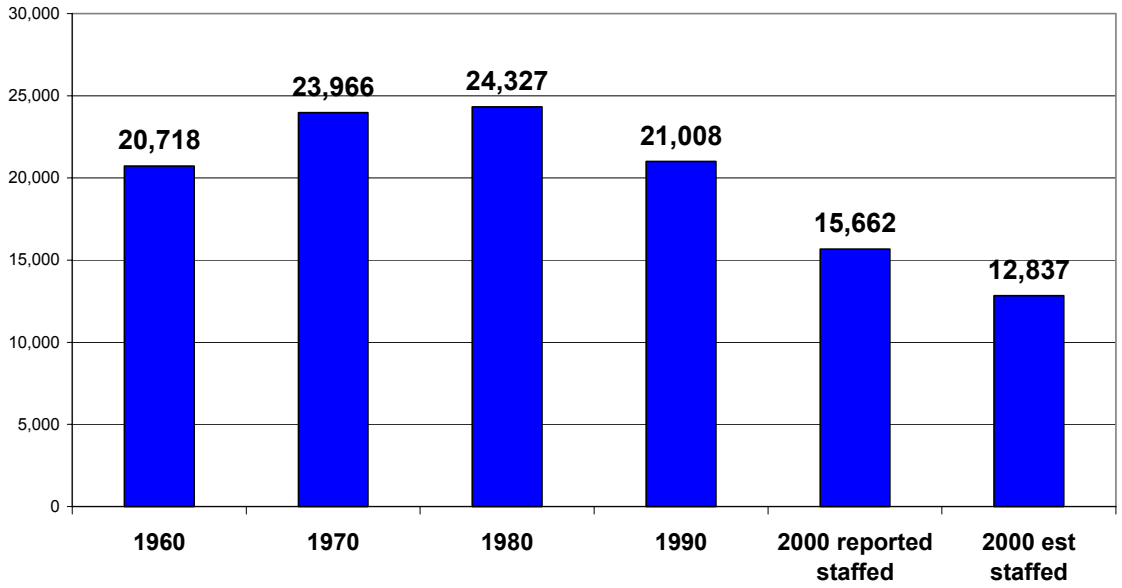
C. Caregiver crises

- hospital closings





MASSACHUSETTS ACUTE HOSPITAL BEDS, 1960 - 2000



Our analyses of Massachusetts and other data show that the more efficient hospitals are generally more likely to close, as are hospitals in lower-income cities and towns. The closing of smaller and mid-size community hospitals is forcing more and more patients to travel farther to seek care at costly teaching hospitals.

In the next decade, our state is likely to face shortages of thousands of hospital beds. Construction costs will soon approach $1 million per bed. This parallels the crisis that many cities and towns face in replacing closed public schools in the past 20 years.

- nursing home closings

We are also closing nursing home beds that will be needed before too many years have passed.

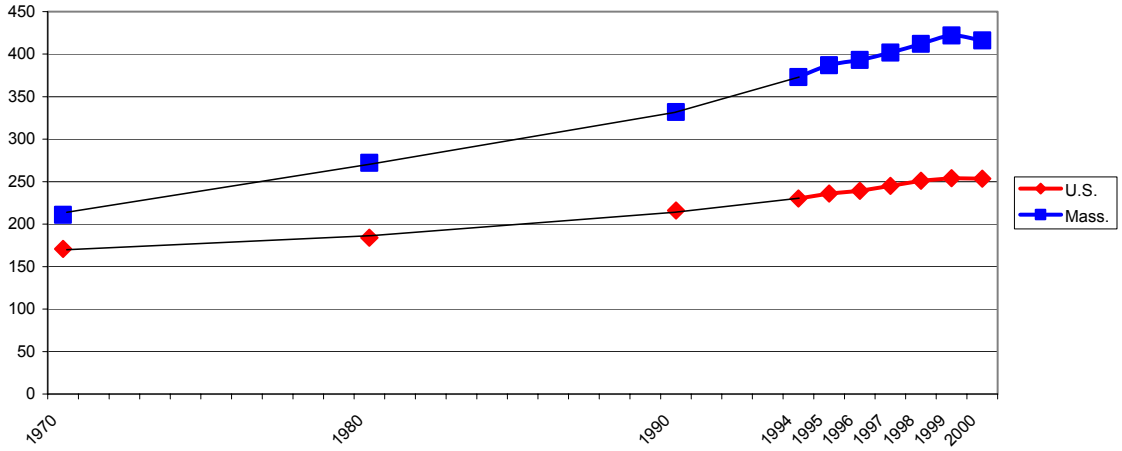
- nursing shortages

Massachusetts is second in the nation (behind only Alaska) in RNs per 1,000 residents, yet we seem to have a substantial shortage of nurses willing to work in acute care hospitals.

- doctor complaints

Massachusetts leads the nation in doctors per 1,000 people, even after excluding researchers, educators, and administrators. Yet (or perhaps because of this very substantial physician supply), Massachusetts physicians often make less than their counterparts in other states.

MASSACHUSETTS AND U.S. PHYSICIANS
PER 100,000 RESIDENTS, 1970 - 2000



D. Causes of the problems

1. Each party thinks mainly of its own needs

- Hospitals say they are losing money and demand higher payments. Doctors and nursing homes seek rate increases. Drug makers? Let's not talk about them.

- Employers decry higher premiums. But since wellness, prevention, managed care, price competition, and hospital closings have all failed to slow premium hikes, employers have essentially given up. Giving up includes increasing employee premium shares and raising patients' out-of-pocket costs.

- State governments have just about no money to spend and no desire to raise taxes.

- The federal government is not willing to find more money, except to appease pressing demands.

Each group seeks more money (or, for payers, less money) for business as usual.

Anyone who thinks this can last long is deluding themselves.

2. Higher spending is not necessary or desirable

Even if higher and higher health spending were possible, it is not desirable.

Spending more money on health care makes our state even less competitive.

Yes, health care is a vital part of the state's economy, and it employs lots of people. But it is increasingly difficult to find the money to pay all the people health care would like to employ. High premiums for health insurance are part of the high cost of doing business in Massachusetts. They tend to deter creation of new jobs in the Commonwealth.

Equally important, more money for health care means less money for everything else we all care about—education, environment, criminal justice, housing, infrastructure, transportation, and all the rest—even vacations.

And, because we already spend enough to cover everyone and to sustain all needed caregivers, higher spending should not be necessary.

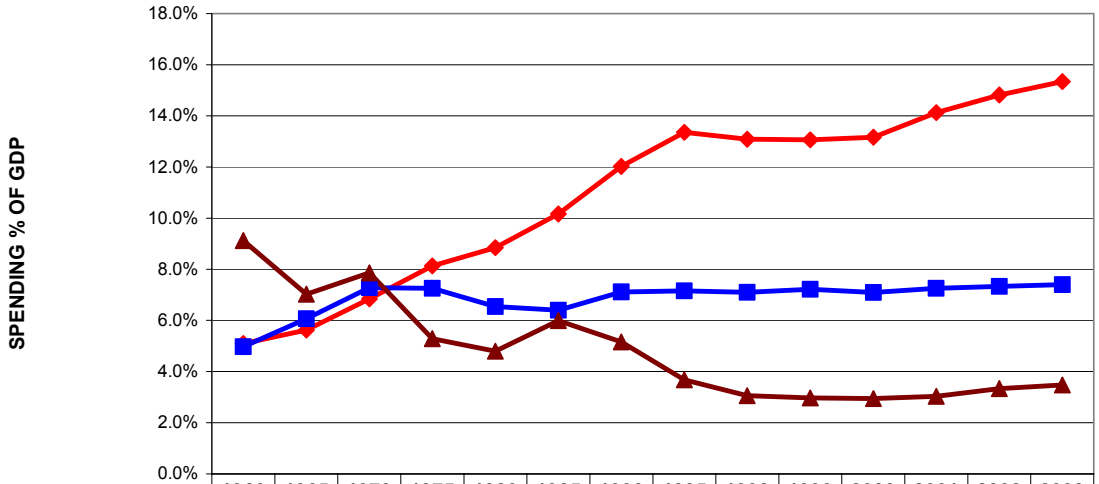
- Unfortunately, just about one-half this year's Massachusetts health spending of almost $48 billion will be wasted on administration, unnecessary care, incompetent care, unnecessarily high prices, theft, and the like.

- The challenge is to spend more carefully.

Even if you don't think that single payer is a good idea today, and even if you think that more money for business as usual will continue to patch together Massachusetts health care, ***legislators have a fiduciary obligation*** to think about the "what if." What if Massachusetts health care melts down? What would that look like? How badly would everyone who needs or gives care be hurt? How badly would the state's economy be hurt?

If you think that more money for business as usual is likely, or even possible, for much longer, please consider these national data:

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

3. But costs are out of control, owing to

- closing of efficient hospitals and movement of care to world's costliest hospitals
- failure of price competition
- failure of managed care

With the failure of the traditional cost control methods, many individuals are now blaming patients for high spending. After all, this argument runs, patient stubbornness destroyed managed care by demanding unrestricted access to specialists. The main purpose of these assertions is to shift attention from the failure of past cost controls and the absence of any promising substitutes. This rationalizes demanding that patients pay more, to make them think twice about whether they really need that prescription, MRI scan, test, or surgery that the doctor ordered.

This is nonsense. Patient mistrust of HMOs that gave doctors and hospitals financial incentives to withhold care—along with doctors' and hospitals' anger at income restrictions—were the main reasons HMOs had to increase prices. Also, the years when HMOs seemed to be saving money were the years they were squeezing out dollars from hospitals by not paying for the days that cost less than charges, and when they were cannibalizing their reserves to keep prices low and build market share.

The absence of effective cost controls in U.S. and Massachusetts health care today is one of the greatest reasons to fear the prospect of medical meltdown, and therefore one good reason to support single payer health care.

II. The Solutions: Pooling revenue, containing cost, covering everyone, paying all needed caregivers fairly, and encouraging/obliging doctors to spend money carefully

A. Pooling revenue

Unless all health care revenue is pooled in one place, administrative waste will be hard to eradicate and it will be hard to cover everyone or contain clinical waste.

Revenue can be pooled in one of two ways:

- combining all of today's public streams of money and replacing private health insurance and today's out-of-pocket spending with new tax money,

- or combining all of today's public streams and existing private health insurance premiums while replacing only the out-of-pocket spending with new tax money.

The second approach means a tax rise about one-fourth as great as when private insurance is also replaced by public financing. But this makes it necessary to require employers and employees who now pay for private insurance to maintain their effort, at least in today's nominal dollars. They benefit by a freeze in their obligations in today's dollars, which means that they avoid future price increases and that inflation gradually reduces their real burden of insurance substantially.

In the second approach, a new payroll or other tax could be levied on all employers, but employers' payments for health insurance would be a credit against this tax. It would then fall mainly on employers which have not in the past provided health insurance. But it would fall much less heavily on smaller and less profitable employers than would a typical Dukakis or Clinton employer mandate. That's because this approach is a percentage of payroll, not a $10,000 hit for each employee seeking family coverage.

In both approaches, because money is pooled, spending can, for the first time, be capped. Health care would have a budget, just like state government, families, and everything else in the real world.

As we and our colleagues showed several years ago, in a study for the Massachusetts Medical Society, single payer wins savings of $5.2 billion (in 1999 dollars), which more than pays for the $4.2 billion cost of covering all uninsured people and covering all prescription drug costs and much long-term care for all currently under-insured residents of the Commonwealth. A copy of the April 1999 testimony that presented these findings is attached to today's testimony.

B. Containing cost

Pooling revenue makes it much easier to contain cost.

Administrative waste is reduced by instituting one method of paying doctors, one for hospitals, and the like. Caregivers find it easier and cheaper to bill. Payers find it easier to pay. We have estimated very substantial administrative savings.

Consolidating the revenue also makes it much easier to squeeze out clinical waste and theft. If the dollars are known to be finite, doctors who seek money to finance needed care that is not being provided today owing to lack of funds will be motivated to identify wasted money in hopes that it can be reallocated. Theft is easier to fight because, when dollars are known to be finite, the connection between theft and harm to patients is clearer. Stealing money deprives patients of needed care. This motivates whistle-blowing and more careful monitoring of spending.

Pooling the money in one place also facilitates covering everyone within a budget. That is because doctors, who control some 75 percent of the health dollar, can be asked and obliged to spend money as carefully as possible. Doctors know where the clinical waste is to be found. They can squeeze it out. When this is done under an overall budget, the dollars saved by eliminating excessive or low-value care can be marshaled to slow spending increases and to help previously under-served patients.

Consolidated financing is essential to financing comprehensive health care for all residents of Massachusetts. Looking ahead, though, it is not enough—by itself—to ensure affordable medical security for years ahead.

That is because health care costs continue to increase as the population ages and as costly new medical advances are made—advances like expensive new drugs, surgical treatments, and transplants.

But what good are these medical advances if all residents can't afford them? Everyone who lives or works in Massachusetts deserves medical security. This first requires deciding what "medical security" really means. It then requires making sure that the state shapes health care—both delivery and financing—to reach this goal. If we don't deliberately plan to succeed, we are probably planning to fail.

C. Covering everyone

One of the vital elements of single payer is that everyone is covered immediately. Medical security, at last. This is good in itself. It also makes it easier to contain costs in

a responsible and effective manner. No longer can money be saved by rationing care by ability to pay, or by erecting financial barriers between patient and caregiver. Instead, money must be saved by careful spending.

Ultimately, no state or nation can ever spend enough to win immortality for its citizens. Immortality is not the goal. Rather, the goal should be medical security, which might be described along these lines:

- All residents of Massachusetts should be able to get the health care they need—high-quality health care that works—without having to worry about whether they can afford it.

D. Paying all needed caregivers fairly

Today, in the absence of genuine free market forces, some hospitals are under-paid while others are over-paid. Highly competent doctors are paid the same fees as their less skillful or compassionate colleagues. Drug makers are paid prices that are much greater than many of us can afford—and also much higher than are necessary to protect drug makers' profits or research.

E. Encouraging and obliging doctors to spend money carefully

Consolidated financing is essential to cutting administrative costs—which is essential to financing comprehensive health care for all. But consolidated financing is not enough by itself to ensure affordable medical security for years ahead, as the population ages and costly medical advances are made. For the future, affordable high-quality health care for all Massachusetts residents requires spending the state's vast but finite health dollars as carefully as possible. Doctors, hospitals, and other caregivers must be paid in financially neutral ways that encourage, liberate, and require them to spend money carefully. "Professionalism within a budget" can help balance the books, getting as much health care as possible to the people who need it.

This requires that doctors—who make the key decisions about how the great bulk of health care dollars are spent—are particularly empowered to spend money carefully. This should begin by recognizing that doctors traditionally get about one-fifth of the health care dollar. They should be assured this money, to be divided up among them in reasonable proportion to competence, kindness, effort, and other factors.

But doctors also should be encouraged, liberated, and required to allocate the great bulk of the remaining 80 percent of the money (excepting only dollars needed by dentists, public health agencies, researchers, and other independent actors) to provide the care that all Massachusetts residents need. Doctors would have to spend all of that money on their patients, and could not spend more. They could not personally benefit by economizing on care. This approach encourages patients and payers to trust doctors' decisions.

If a physician does not provide a certain service to a certain patient, the reason would not be to enrich a physician or a for-profit HMO. Rather, the only reason for denying a service would be to make that service available to another patient who needed it more.

This is nothing more than spending money carefully—getting as much health care as possible to the people who need it. This is nothing more than recognizing that all people need health care but that dollars are always going to be limited. Pathology is remorseless but resources are finite.

The problems that will lead to medical meltdown in Massachusetts are real. They are pressing. They will destabilize health care in this state—if they are allowed to worsen and if state government does not prepare to deal with them.

The worst time to figure out how to address a crisis is after it hits. If Massachusetts is beset by medical meltdown—with one or two million uninsured citizens, with dozens of hospitals closing or in bankruptcy, and with doctors driving cabs—it will be too late to plan careful and deliberate solutions. Legislating reforms in an atmosphere of panic, with starkly inadequate financing, and with no experience with what works and what does not, is likely to result in disaster.

It will be helpful to design and test real reforms now, before the storm hits. It will be vital to bring together all of the key actors and ask them to think about how to craft health care for the Commonwealth that covers everyone, that pays everyone fairly, and encourages efficient and effective care, and that is durably affordable. Only state government can do this job.

If the governor does not quickly embrace this responsibility, the legislature should consider establishing a permanent, emergency health care commission, resembling the Ward Commission, to devote continuous attention to shaping affordable and high-quality health care for all who live, work, and do business in Massachusetts.