Thoughts on Health Care Reform

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I was recently asked by our friend, Gary DuBois, to join a conversation of Americans, expatriates and citizens of other countries about the state of the health care system in the United States and prospects for meaningful reform. Gary asked me to participate based on my work in the health care arena over the course of several careers.

Although I write on many subjects as a result of research, health care is one subject I write about based on extensive personal professional experience. I have been involved with the world's and U.S. health care system at literally all levels, from the general practitioner's office to large scale vertically integrated healthcare systems (birth to death and everything in between), diagnostic imaging, pharmaceutical, device manufacturers, insurance companies, public policy, etc.

The current and coming debate on health care reform will be filled with super-heated rhetoric and emotionally compelling marketing messages designed to sway political and public opinion. If it follows the historical pattern of public policy debate in the U.S., there will be very little discussion of facts. I believe the debate will produce a better outcome for the citizens of America if the citizens are educated on some facts concerning health care and those citizens subsequently demand their elected representatives operate within a framework of factual information.

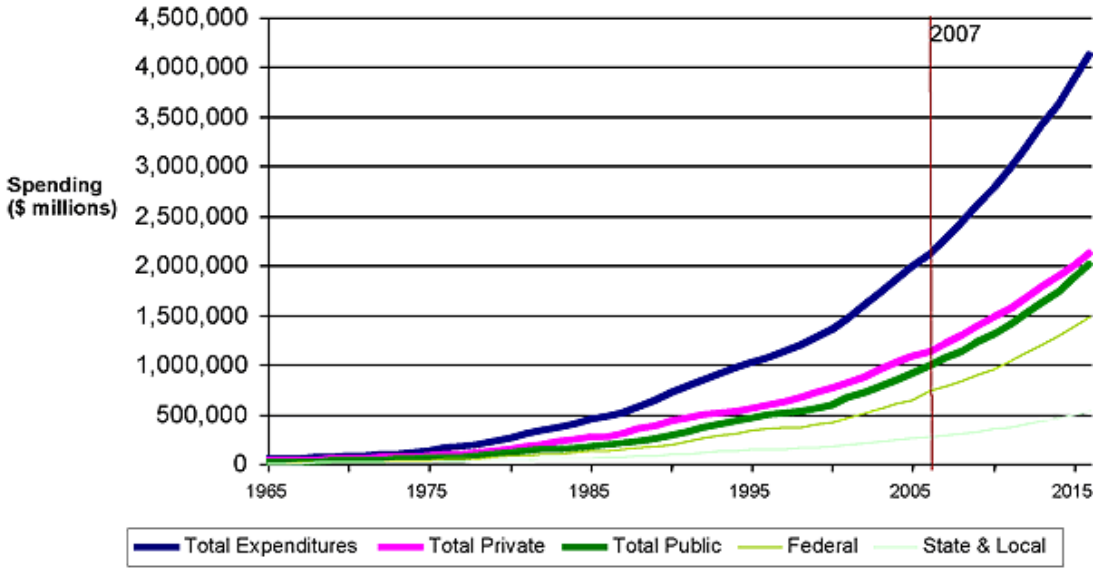
The following is a brief summary of some of the relevant facts, data and issues, along with some of my opinions, related to the health care system in the U.S.

There are two basic pools of people and correlated perspectives on health care in the U.S. The sample groups are bifurcated between those who have access to health care at low to moderate cost (those insured on affordable plans that provide reasonable access to care), and those who are not in that group, such as the self-employed and the uninsured. It is essentially impossible for those who have access to affordable health care to understand the nature and scope of the challenge in a direct and personal way, unless someone they know well or a close family member is in the group without access to affordable healthcare.

The core of the challenge is the uninsured. Nearly 46 million Americans, or 18 percent of the population under the age of 65, were without health insurance in 2007, the latest government data available. The number of uninsured rose 2.2 million between 2005 and 2006 and has increased by almost 8 million people since 2000. The large majority of the uninsured (80 percent) are native or naturalized citizens. The increase in the number of uninsured in 2006 was focused among working age adults. The percentage of working adults (18 to 64) who had no health coverage climbed from 19.7 percent in 2005 to 20.2 percent in 2006. Nearly 1.3 million full-time workers lost their health insurance in 2006. Nearly 90 million people—about one-third of the population below the age of 65—spent a portion of either 2006 or 2007 without health coverage. Over 8 in 10 uninsured people come from working families—almost 70 percent from families with one or more full-time workers and 11 percent from families with part-time workers. The number of uninsured children in 2007 was 8.1 million, 10.7 percent of all children in the U.S.

Financially, the scope of the challenge is large enough that many people cannot grasp the large numbers involved. For instance, in 2008 health care spending in the United States reached $2.4 trillion, and is projected to reach $3.1 trillion in 2012 and $4.3 trillion by 2016.

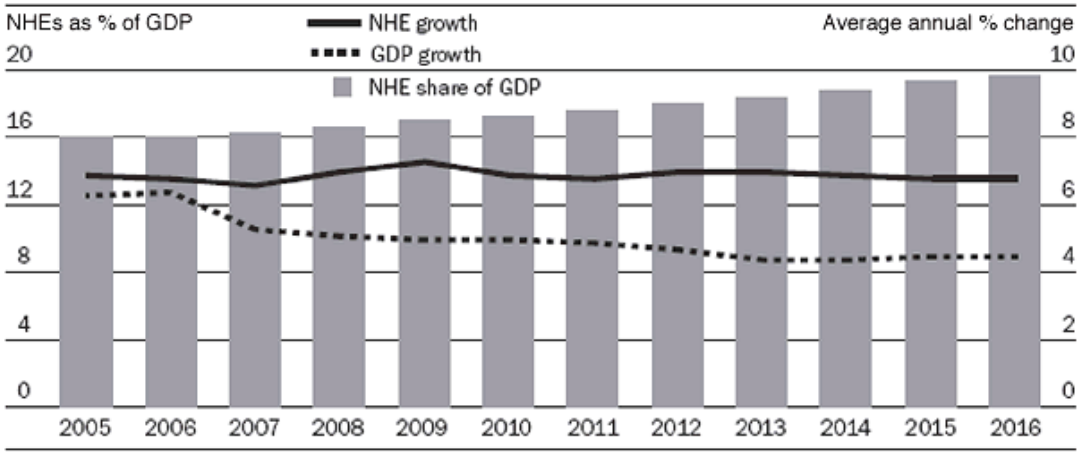
National Health Expenditures—Actual and Projected, 1965—2017



On the other hand, some facts about health care spending are little known, but easy to grasp, such as health care spending is 4.3 times the amount spent on national defense and every 30 seconds in the United States someone files for bankruptcy due to health care costs or in the aftermath of a serious health problem.

The U.S. health care system does not compare well with our global competition. In 2008, the United States will spend 17 percent of its gross domestic product (GDP) on health care. It is projected that the percentage will reach 20 percent by 2017. Although nearly 46 million Americans are uninsured, the United States spends more on health care than other industrialized nations, and those countries provide health insurance to all their citizens. Health care spending accounted for 10.9 percent of the GDP in Switzerland, 10.7 percent in Germany, 9.7 percent in Canada and 9.5 percent in France. Americans in 2006 spent $1,928 per capita on health care, at least two-and-a-half times more per person than any other advanced country.

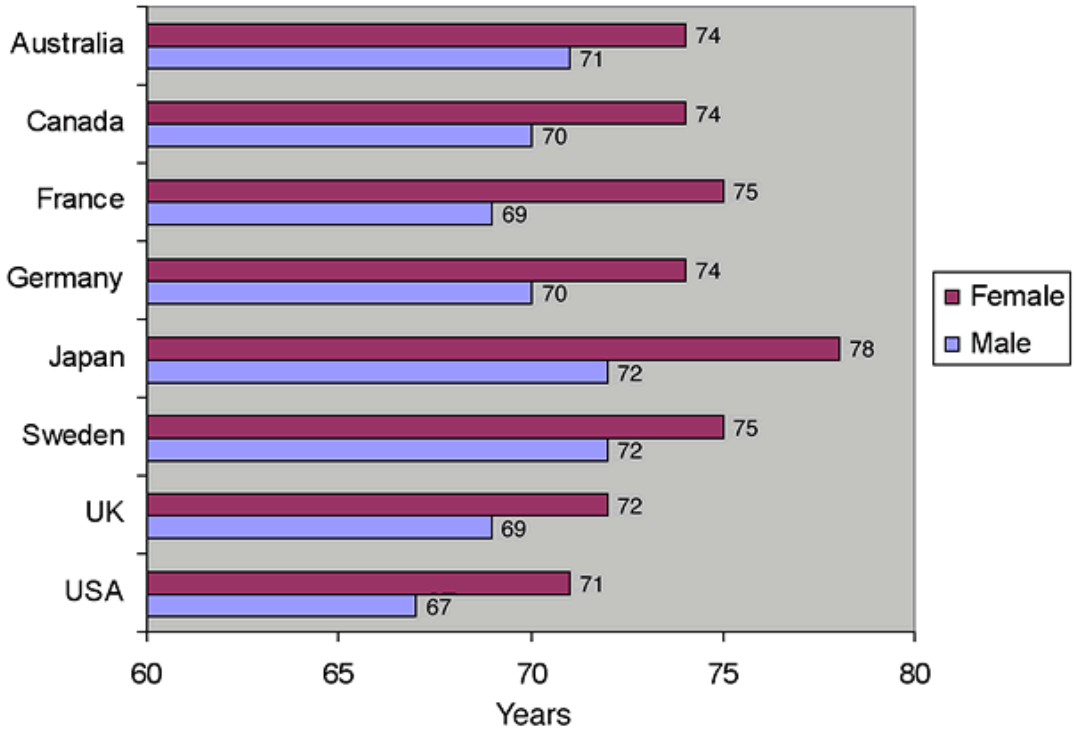
National Health Expenditures (NHEs) as a Share of GDP and Average Annual Growth in NHE Versus Growth in GDP, 2005–2017



NOTES: The left axis (NHE share of GDP) relates to the gray bars. The right axis (% change in GDP and NHEs) relates to the two line graphs.

If you add in what we get for what we pay for, a value metric for our health care dollars spent, the picture is even grimmer. Combining costs with statistics on life expectancy, death rates, cholesterol readings, blood pressures, etc., and comparing them with our global competition yields results that are not encouraging. On a 100 point health care value index, the United States is 23 points behind five leading economic competitors: Canada, Japan, Germany, the United Kingdom and France. Those five nations provide health care coverage for all their citizens, and though their systems differ, in each country the government plays a much larger role than in the U.S. The cost-benefit disparity is even wider — 46 points — when the U.S. is compared with emerging competitors: China, Brazil and India.

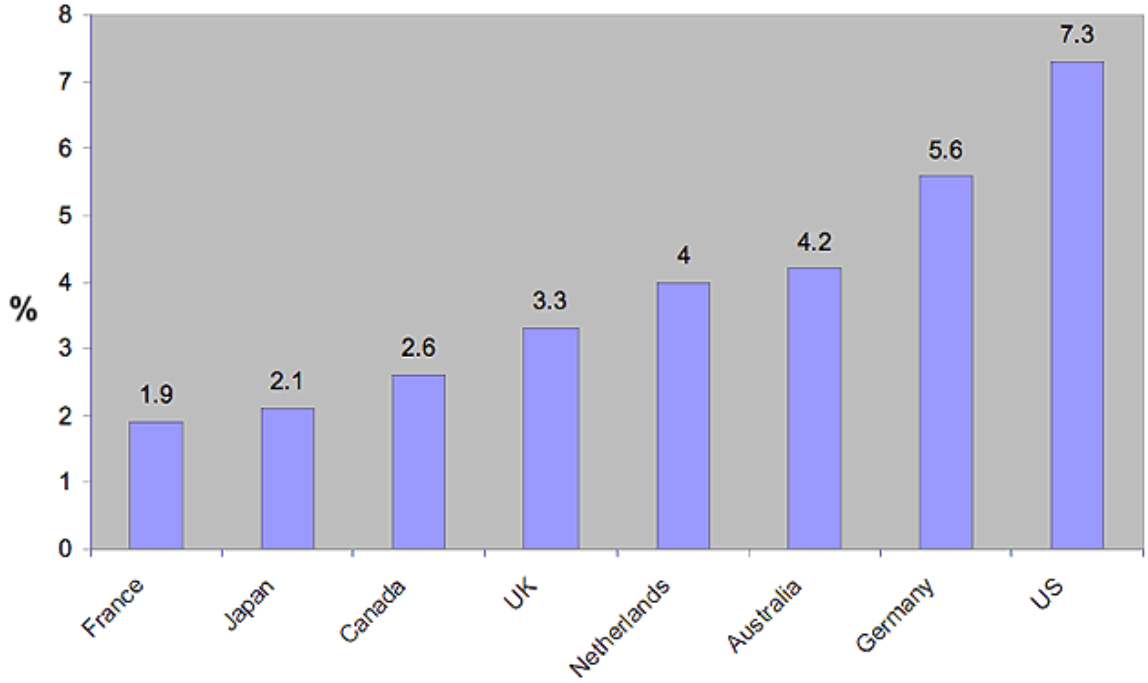
Healthy Life Expectancy at Birth



Where does all the extra money the U.S. spends versus every other developed nation go? One place it goes is in paying for the cost to provide health care to the uninsured. In the United States, hospitals and their emergency rooms are required by law to provide care in life threatening situations, regardless of the patients' ability to pay. The United States spends nearly $100 billion per year to provide uninsured residents with health services, often for preventable diseases or diseases that physicians could treat more efficiently with earlier diagnosis. Hospitals provide about $34 billion worth of uncompensated care a year. Another $37 billion is paid by private and public payers for health services for the uninsured and $26 billion is paid out-of-pocket by those who lack coverage. The uninsured are 30 to 50 percent more likely to be hospitalized for an avoidable condition, with the average cost of an avoidable hospital stayed is estimated to be about $3,300.

Another place it goes is multiple, duplicative layers of administration. According to a recent report, the United States has $480 billion in excess spending each year in comparison to Western European nations that have universal health insurance coverage. The costs are mainly associated with excess administrative costs and poorer quality of care. The United States spends **six times more per capita** on the administration of the health care system than its peer Western European nations.

% of National Health Expenditures Spent on Health Administration and Insurance, by Country



How does the excess spending on health care in the U.S. affect everyday people? A survey of Iowa consumers found that in order to cope with rising health insurance costs, 86 percent said they had cut back on how much they could save, and 44 percent said that they have cut back on food and heating expenses. Retiring elderly couples will need $250,000 in savings just to pay for the most basic medical coverage. A new survey shows that more than 25 percent said that housing problems resulted from medical debt, including the inability to make rent or mortgage payments and the development of bad credit ratings. About 1.5 million families lose their homes to foreclosure every year due to unaffordable medical costs.

How does the excess spending on health care affect business? GM spends more on health care per vehicle than it does on steel. Health insurance expenses are the fastest growing cost component for employers. Since 1999, employment-based health insurance premiums have increased 120 percent, compared to cumulative inflation of 44 percent and cumulative wage growth of 29 percent during the same period. Premiums for employer-based health insurance rose by 5.0 percent in 2008. In 2007, small employers saw their premiums, on average, increase 5.5 percent. Firms with less than 24 workers experienced an increase of 6.8 percent.

How does the excess spending on health care affect the future prospects of America? The unfunded liability for Medicare, the commitments the U.S. has made to pay for health care of its elderly, is $85.6 trillion. That is more than six times as large as the unfunded liability of Social Security. It is more than six times the annual output of the entire U.S. economy. If each American split the tab for all unfunded liabilities, including social security, the per-person payment to the federal treasury would come to $330,000. This comes to $1.3 million per family of four—over 25 times the average household's income. If we paid for it through increased taxes, we would need a permanent 68 percent increase in federal income tax revenue—from individual and corporate taxpayers. If we covered it through reduced spending, we would need to cut discretionary spending by 97 percent, including defense and national security, education, the environment, the courts, and many other areas,

These facts alone should be enough to convince anyone that the U.S. faces a significant challenge, a society-survival level challenge, with its out of control health care spending. But the numbers alone do not tell the whole story; they merely provide a vehicle to reach consensus that something must be done. The “what is to be done” step is the most challenging part, especially within the self-serving, poisonous, viciously partisan political environment the people of the U.S. are saddled with.

The successful, high-value health care systems in the industrial world are universal coverage. That means that everyone in the society is entitled to full and universal admission to the health care system. Quality levels across these systems vary dramatically, as in the question, “Universal admission to what?” There is, nonetheless, compelling evidence that this model provides the only proven path to health care system success. Universal coverage, however, is not without its challenges.

For instance, in the 1990s I participated in a nearly year long task force while consulting with GE Medical Systems. The time frame was during the Clinton administration health care reform proposal, debate, etc. I was a member of the team of PhDs, researchers, analysts and consultants working on the project. In our team’s various computer models, any universal coverage health care system that allowed multiple entry points to multiple tiers of care quickly disintegrated. In other words, you must have universal coverage with one entry point or you very quickly end up with very, very expensive care for a very, very small percentage of very, very wealthy patients while everyone else receives a much lower level of care.

An additional political, semantic and perception challenge of universal coverage is that any health care system that provides universal coverage includes rationing. The reason for this is no nation’s economy can afford a health care system that provides universal coverage for universal capability and unlimited throughput capacity. Any mention of rationing in the U.S. sets off alarm bells across the political spectrum. A little known fact is that the U.S. already has an effectively rationed health care system. The rationing is done by denying procedures, primarily by insurers. The U.S. does not have a health care system with universal capability and unlimited throughput capacity. This fact is not often recognized by the public, especially by those with access to affordable health care.

The citizens of the U.S. are not within a light year of being culturally ready for the reality of a health care system in which 95 year old Aunt Millie is ineligible for a hip or knee replacement. The public is also not ready to face a health care system that is procured and managed explicitly to reach the goal of throughput capacity matching its utilization rate. Although those are the metrics that hospital system C.E.O.s are held to by their boards of directors, you are unlikely to see that fact touted in an annual report, press release or anywhere else. In contrast, the public’s concept and perception of health care in the U.S. is still rooted in fee for service—anybody can get any procedure any time they feel like it, right up to the very second they die, and that the U.S. health care system can afford to provide it. The public, by and large, has no idea of the underlying costs involved in making those procedures available, much less paying for them, especially those who are well insured and those with access to quality care.

A structural challenge of universal coverage is that facing Western Europe today: demographics. When humans become educated and successful—in the flip the switch and the lights come on, turn the tap and fresh, safe water comes out—form of successful, they stop reproducing. The birth rates of developed nations are well below the replacement rate of 2.1 births per female (BPF). In many European countries, where they range from 1.2 to 1.9 BPF, the birth rates have been below replacement level for many years. Japan has a shrinking population, as does Russia. The challenge lies in that as fewer babies are born, there are fewer and fewer young workers to pay for the health care (and retirement costs) of the aging segments of the population. The resulting choices are few and brutal: increase taxes to ruinous rates or drastically decrease or eliminate funding for the elderly.

The U.S. also has a low birth rate, but has largely dodged the demographic bullet to date due to its more than one million immigrants per year. These immigrants tend to have higher birth rates for the first one or two generations until they too become successful and stop reproducing. The only thing that keeps America from the demographic death spiral of the rest of the industrialized countries is its one unique, differentiating aspect compared to all other nations on earth: it is a nation of immigrants.

Any proposed change in the health care system meets stiff and violent resistance from the vested interests whose profits, power and influence could be lost. One of the most powerful health care vested interests in the U.S., and the one that counts the vast majority of elected representatives as members, is the legal profession. In 2004, U.S. tort (liability lawsuits) costs reached a record $260 billion, or approximately $886 per person. U.S. tort cost growth since 1950 far exceeds U.S. population growth; even after adjusting for inflation, tort costs per capita have risen by a factor of more than nine between 1950 and 2004. U.S. tort costs exceed other countries' by a sizeable margin, when measured as a ratio to economic output (measured by GDP). The U.S. had a 2.2% ratio of tort costs to GDP, compared with Germany's 1.1%, Japan's 0.8% and the U.K.'s 0.7%. Medical malpractice tort costs totaled $28.7 billion in 2004, up from $26.5 billion in 2003. Since 1975, medical malpractice costs have increased at an annual rate of 11.7% versus 9% for all other tort costs. Research shows up to 30% of all procedures, tests and treatments performed in the U.S. health care system are unnecessary, and most of those unnecessary procedures, tests and treatments are performed due to liability concerns. Consequently, health care spending in the U.S. contains an estimated price premium of 10-30%, depending on the segment, due to liability costs. In colloquial terms, tort reform that eliminated ambulance chasing lawyers would immediately save everyone in the country 10-30% in medical costs. Almost all of the elected representatives in the U.S. are lawyers, so don't expect this change to happen in our lifetimes.

It is estimated that a universal medical I.D. number (a unique medical I.D. number for each citizen) would save more than 10,000 lives per year through avoided drug interaction, system-wide access to medical history, etc., to say nothing of the associated reduced cost of care. The people of the U.S. are terrified of a universal medical I.D. for privacy reasons. What they are not often aware of is that most, if not all, aspects of their health care are already known, cross referenced, and available to anyone who wants to pay for it.

Fully computerized health care records for every American would save many multiples of lives that a universal medical I.D. # would, but would cost many more billions and take many years longer to implement than any politician is talking about. The television version of this is while "We will computerize health care records, meanwhile creating jobs, and eventually saving billions in costs." is a great politician's sound bite quote, it is nowhere near realizable in the short- or mid-term.

A sound bite you will hear a lot in this debate is "We will eliminate fraud, waste and abuse and thereby save billions." There is fraud, waste and abuse, but not nearly as much as the politicians would like to easily find; and of what is there, much of it is centered in the professions, roles and business models of the politicians' major contributors, so don't expect any big changes in this area in your lifetime either.

More than 25% of the money spent by Medicare is in the last year of the patient's life. Medicare expenditures for those in the last year of life are almost six times that of spending for other beneficiaries. "Do whatever it takes." is so easy to say, but is now too expensive for the U.S. to afford. The people of the U.S. are going to need to learn a whole new script of what to say at the bedside in the last chapter of life. As a society, we can no longer afford "Do whatever it takes."

The U.S. health care system has generated the majority of the world's medical innovations, breakthroughs, and inventions (including pharmaceuticals) for more than 50 years. We, the health care consumers of the U.S., have been paying for all of that through inflated insurance premiums, sky high hospital bills and outrageous pharmaceutical costs while the world's other health care

systems have come along for the ride for free or at dramatically reduced prices. We can no longer afford to subsidize the world's health care systems. (This is one cost I have never seen factored into any analysis of the costs of other countries' health care systems. Many countries health care systems would show a dramatically different cost basis if they had to pay their own share of the world's medical innovation cost.)

The debate on the future of the U.S. health care system is often used as a proxy for ideologues and zealots who strongly support or oppose various forms of social economic structure. For some, a single payer system such as that used in many universal coverage systems is akin to building a duplicate Kremlin, brick by brick, around the Washington monument. The associated histrionics of the various proponents of forms of government and social economic structure provide little to no valuable input on the discussion around health care system design and implementation. This is not about capitalism vs. socialism. This is about rebuilding a health care system that the U.S. can actually afford and that provides parity outcomes with other industrialized countries. This isn't a civics debate; it's a human life and death debate. Stated colloquially, you can be "By God good enough for my grandfather so it's good enough for me!" bankrupt and dead, or you can be utilizing a system that we can actually afford and that delivers reasonable outcomes for reasonable costs and be alive. Your call.

In the political debate surrounding the health care system the phrase "We will build an American solution." is code for "My vote is for sale." In the course of my careers I've watched this happen up close and personal. The vested interests of the current health care system will stop at nothing to preserve their prestige, power and profits. Since the American political system sanctifies influence peddling, that means the vested interests of the status quo of health care will buy lots of votes. If you are on the outside of the system, there is no one buying votes for you, your children or your grandchildren. If you don't have access to affordable health care, there is NO ONE out there buying votes for you. Who do you think will win that contest?

While the very thought of nationwide health care reform can be overwhelming, it is important to remember that this attempt at reform of health care is not the first in America. The U.S. undertook health care system reform in the 1970s with a move from fee for service to managed care. While the transition did slow the rate of growth in costs as a percentage of GDP, the cost of the health care system of the U.S. has since grown to such a size that the economy can literally no longer sustain it. The cost of health care is one of the primary factors bankrupting the nation, especially as it relates to unfunded health care liabilities for the rapidly aging population.

While there are nearly an infinite number of potential outcomes to the health care system debate, in practical terms the political environment of the U.S. limits the range of options. For instance, a single payer system, which arguably is the most efficient, is not even on the table as an option due to its "third rail" political volatility. And of the options that are viable candidates, none provide a panacea solution and all imply varying impacts on existing structures and levels of service.

The RAND Company, an influential private and public policy research organization, created an analysis of the range of politically viable options that are likely to be the leading candidates on a stand-alone or hybrid basis (http://www.randcompare.org/analysis/) as part of their overall public policy research on the health care system reform effort (http://www.randcompare.org/). Due to its position as a leading input to the formation of public policy in America, the options that RAND has identified are likely to be close to what the U.S. implements as a new health care system. Consequently, it is important to be informed about what your elected officials are being briefed on by the RAND researchers. Fortunately, the bulk of their research and conclusions in this area are available on the http://www.randcompare.org/ website. If you want to know what your elected representative will propose as a new health care system, and be subsequently relentlessly lobbied on by the vested interests, it pays to read the RAND COMPARE information.

RAND Corporation COMPARE Policy Options Dashboard

Effect on Health Care: Positive Negative Uncertain No Effect No Evidence

Customize Columns	Spending	Consumer Financial Risk	Waste	Reliability	Patient Experience	Health	Coverage	Capacity	Operational Feasibility
Change Insurance Coverage									
Individual Mandate	No Effect	No Effect	Uncertain	No Effect	Improve	Improve	Increase	No Effect	Difficult
Employer Mandate	No Effect	No Effect	No Effect	No Effect	Uncertain	Improve	Increase	No Effect	Moderate
Purchasing Pools	No Evidence	Uncertain	Uncertain	Uncertain	Improve	No Evidence	Uncertain	No Evidence	Difficult
Refundable Tax Credit	No Effect	No Effect	Uncertain	No Effect	Uncertain	Improve	Increase	No Effect	Easy
Medicaid/SCHIP Eligibility	No Effect	Decrease	Uncertain	No Effect	Uncertain	Improve	Increase	No Effect	Easy
Open Enrollment in FEHBP	No Effect	Uncertain	No Evidence	No Effect	Uncertain	Improve	Increase	Uncertain	Uncertain
Change Benefit Design									
High Deductible Health Plans	Decrease	Uncertain	Uncertain	Uncertain	Uncertain	Uncertain	Uncertain	No Effect	Easy
Change Payment Rules									
Hospital P4P	Uncertain	N/A	No Evidence	Increase	Uncertain	Uncertain	N/A	N/A	Difficult
Physician P4P	Uncertain	N/A	No Evidence	Uncertain	Uncertain	Uncertain	N/A	N/A	Difficult
Bundled Payment	Decrease	Decrease	Decrease	No Evidence	No Evidence	Uncertain	N/A	N/A	Difficult
Change Health Services Delivery									
Health IT	Uncertain	No Evidence	Uncertain	Uncertain	Uncertain	Uncertain	Uncertain	Uncertain	Difficult
Disease Management	Uncertain	No Evidence	No Evidence	Increase	Uncertain	Uncertain	N/A	No Evidence	Easy
Change Legal Environment									
Medical Malpractice	Uncertain	No Evidence	Decrease	No Evidence	No Evidence	Uncertain	No Evidence	Uncertain	Easy
	Spending	Consumer Financial Risk	Waste	Reliability	Patient Experience	Health	Coverage	Capacity	Operational Feasibility

As you can see in the graphic, there is an ocean of uncertainty and lack of evidence in the problem space bounded by the politically viable health care system proposals for the U.S. There are no clear winners and no options that are not without risk or potential downsides. One or more of these options will more than likely compose the bulk of the new U.S. health care system. Which do you think is best for the country, your community, and your family?

When considering what option is best for America, it is critically important to compare best practices with other industrialized countries. See what works. See what works well. Note that the current U.S. system works well primarily in enriching lawyers and some insurance companies. It is pretty poor in health care outcomes, which is what this is supposed to be all about. Set all of your political partisanship aside for a moment and ask yourself the honest question, “Is America’s health care system as good in providing quality outcomes for an affordable price as other industrialized countries?” The honest answer to that question is an unequivocal *no*. In my opinion, we can do better than we are currently doing in providing high quality outcome health care for an affordable price.

Unfortunately, the best option may not be the one selected. The choice may be driven by fear, fueled by emotionally charged advertising. In the health care system debate you will see, hear and witness countless examples of heart rending personal tales of tragedy funded by proponents of various desired outcomes. The most powerful will cite or assert anecdotal evidence of a real person’s real experience. Anecdotal evidence is just that, anecdotal. I can cite two personal examples of traumatic instance health care in other countries that was world class in outcome and cost less than $50. I can cite one in the U.S. that cost more than $8,000. Should those personal anecdotes shape the outcome of the debate on a national health care system? In a national scale debate, the only evidence that really matters when considering how to design a national health care system are national level forms of evidence: statistics, data and facts. They are not nearly as interesting as yet another story of personal trauma, but they are the forms of evidence that are relevant to the scale of the challenge. How does the current U.S. system stack up fact vs. fact? Stated colloquially, plain and simple, unless you are very wealthy or very well insured, it sucks.

The option of “Keep the health care system we have now.” is not a viable choice for the U.S. The country, its economy and its citizens can simply not afford the system we have been burdened with. The status quo works great for those with affordable access to quality care. The status quo is a disaster for those with no affordable access to quality care and for every American who is paying for the current, broken system.

From the purely pragmatic, economic and financial perspective, the U.S. has a completely dysfunctional, bizarrely inefficient health care system. It is riddled with systemic flaws and duplicative layers of inefficiencies, redundancy and profiteering. If it provided superior health care outcomes relative to other systems in comparable countries, it could possibly be defended, but it does not. Stated colloquially, if you were presented with a clean white board, you would be hard pressed to design a national health care system as, lacking a better word, *stupid* as the system the U.S. currently employs.

The most important things to remember in the coming debate are:

a) The U.S. health care system is a train wreck. It is broken. It does not work anymore.
b) The U.S. can no longer afford the system it has in place.
c) There are many examples of systems that work reasonably well to very well in other industrialized countries of the world.

The upside to the current health care debate is it offers an opportunity for the U.S. population as a whole to wake up the reality that the 60-year-long post WWII frat party kegger is now over. It’s hangover and clean up the mess time. As an economy, we no longer spin off enough cash to afford many of the luxuries that we have been able to afford for the past decades. The current health care system is one of them.

There was a time when we could afford a 10-30% liability surcharge on every health care dollar. There was a time when we generated so much excess wealth that we could afford multiple layers of bureaucracy, infrastructure and overhead for each health care transaction. There was a time when we could afford an illogical, dysfunctional health care system. That time is over.

Whatever health care system we end up with, the one single option that is not available is anything resembling what we have now. We simply can’t afford it anymore. If what comes out of this debate looks anything like what we have now, all we have done is deferred the inevitable. Is that what we want to do, kick yet another can down the road for our children to clean up? Isn’t it time we stood up and took responsibility, made the hard choices and started to reshape the country to match our current resource reality, and most importantly, our current financial realities?

In my opinion, this is an achievable goal. It will be incredibly disruptive, challenging and difficult. But as we’ve recently learned as a nation, difficult is not impossible.

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A PDF version of this document is available at www.hackneys.com/docs/healthcarereform.pdf

This document may be freely distributed in its entirety for the purposes of discussion and debate regarding the health care system in the United States.

For questions, contact the author, Douglas Hackney at dhackney@egltd.com.

To add your comments to the debate, see Mr. Hackney's blog at www.autopsis.com

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