

2019 Healthcare That Works for All

This paper is one of a series describing what a decade of successful change in healthcare could look like in 2019. Each paper focuses on one aspect of healthcare. To see the other papers for a comprehensive view of systems change, go to [http://www.altfutures.com/2019 Healthcare That Works For All](http://www.altfutures.com/2019_Healthcare_That_Works_For_All).

Health Economics in 2019

A Health Economics System That Works

Creating the economic institutions for a healthy society requires:

1. Creating the highest value return on healthcare dollars
2. Reducing exponential growth of healthcare expenditures as a percent of GDP
3. Preventing projected Medicare and Medicaid cost overruns
4. Linking incentives to patient health outcomes
5. Reducing both physician and patient demand for unnecessary or wasteful treatments
6. Increasing prevention to convert costs currently associated with chronic disease management and morbidity to costs associated with maintaining continued health
7. Fostering democratic dialogue around the values that shape America's healthcare spending priorities

How effective is our current healthcare economy?

Overtreatment, mistreatment, excessive administrative costs, untenable consumer expectations, and higher than average profit margins and doctor's salaries generate exploding healthcare costs that are not sustainable. These spiraling health costs threaten solvency on the individual, organizational and, with increased entitlement obligations through Medicare and Medicaid, the national level. It remains clear that America's fiscal future depends on implementing measures to reduce these costs and produce more health for every dollar spent because good health underpins economic performance.

Americans pay more per capita for healthcare than any other nation on Earth and, by every objective measure available, this spending is not well correlated with better health outcomes. Indeed, a representative study by the Johns Hopkins University Bloomberg School of Public Health has suggested that in 2000, the last year for which comparative data was available, the country spent forty-four percent more per capita than Switzerland, the nation with the next highest per person healthcare costs.¹

¹ Anderson, G. *et al* (2003) "It's The Prices, Stupid: Why The United States Is So Different From Other Countries." *Health Affairs*. May/Jun2003, Vol. 22 Issue 3, p89-105

Yet, for this price Americans received, on average, fewer physician visits and fewer days in hospital than their Swiss counterparts. Americans also have lower life expectancies than their Swiss counterparts. Additionally, administrative costs in the US as a percentage of expenditures have been estimated to be twice those in Canada.² In short, American healthcare is not behaving like a rational market.

Waste is also a persistent problem in America's healthcare economy. Scott Serota, President of the Blue Cross and Blue Shield Association, has highlighted statistics suggesting that "as much as thirty percent of the care given in America today is ineffective, redundant or inappropriate."³ This perception of widespread overtreatment and unnecessary procedures is reinforced by studies indicating that Medicare expenditures in some regions of the US are more than twice those in others but without better health outcomes to show for it.

This conclusion is supported even when the data is statistically controlled for possible mitigating factors (including age, sex, race, and burden of illness), suggesting that total health expenditures might be cut by nearly a third if care was reduced to the level administered in the most effective regions of the country.⁴ The finding extends to end-of-life healthcare, where it is estimated that Medicare could save 10 billion dollars annually if all US hospitals cared for dying patients with severe chronic illness using the standards of the nation's most efficient facilities.⁵

Forecast for a successful healthcare economy in 2019

In 2009, the newly inaugurated presidential administration was elected with an explicit mandate to rationalize the American healthcare system. A body of representatives from patient advocates, insurers, hospital systems, physicians, government, employers, pharmaceuticals and medical device companies was convened to facilitate anticipatory democracy through stakeholder input into the process of healthcare reform.

Recognizing that the United States allocated a far greater percentage of its GDP than other industrialized nations, the new administration declared in 2009 that it would cap growth of this percentage over the long term at no more than eighteen percent of GDP.

To moderate and balance stakeholder expectations government leaders emphasized that the existing healthcare economy was both undesirable and unsustainable at the national level. Interest groups were invited to be active participants in a collective process of reducing unnecessary procedures and administration, expanding basic access, moderating consumer expectations of limitless treatment, moderating industry profit-taking expectations and linking payments more closely to tangible health outcomes.

² Woolhandler, *et al* (2003) "Costs of Health Administration in the U.S. and Canada." *NEJM* 349(8) Sept. 21, 2003

³ Serota, S. (2007) National Press Club Remarks. May 7, 2007.

⁴ Fisher, E. (2003) "Medical Care- Is More Always Better?" *NEJM*. 349 (17). October 23, 2003

⁵ Dartmouth Atlas Project (2008) Dartmouth Atlas of Health Care 2008.

As the broader healthcare reform process moved toward universal insurance coverage in 2011 and 2012, a parallel and bipartisan political conversation was engendered to publically emphasize that the anticipated growth of healthcare costs was unsustainable for both individual consumers and for the nation's immediate fiscal future. Evidence that American health outcomes are not a function of quantity of care was emphasized and the ongoing effort to eliminate overtreatment was deliberately made as transparent as possible. Expectations of near universal insurance coverage were moderated by a clear message that the system was designed to efficiently deliver highest-quality care in accordance with evidence based best practices and that payment for additional care that was not supported by evidence and cosmetic or unnecessary treatments would be the responsibility of individuals. Business tax deductions for employee insurance benefits were capped at a fixed percentage of the median national income for individuals.

Finally, as universal insurance legislation eliminated denials of coverage based on preexisting conditions and encouraged portability, there have been the beginnings of a broad based movement to emphasize the upstream prevention of chronic diseases. While this measure does not necessarily represent an overall healthcare cost savings because the price associated with increased longevity may offset gains, it does facilitate greater lifetime productivity and a higher health return for the health dollars that are invested.

As Medicare, Medicaid and universal insurance all become ever more vital national fiscal issues, healthcare cost increases as a whole are closely tracked and are annually benchmarked against other industrialized nations, intensifying both political awareness of higher health costs in the US and consumer agitation for a more adequate return on money invested.

Pragmatic steps to achieve this vision of a better future

- A. Foster anticipatory democracy beginning with parallel conversations on healthcare values and expectations at both industry and consumer levels to guide the allocation of finite resources.
- B. Discuss difficult issues like end-of-life care and situations and conditions in which publically-funded interventions may not be advisable are part of the social contract and ongoing dialogue in healthcare.
- C. Empower a politically insulated bipartisan body to guide the public conversation over economic priorities.
- D. Frame the initial debate by widely publicizing overtreatment statistics, the nation's very low ranking in comparative international cost/benefit evaluations, and projected tax increases and as a result of health entitlement program overruns.
- E. Establish an independent organization to begin comparative evaluation of common treatment options and to undertake publicizing results.

- F. Encourage a number of experimental pay for performance, reference pricing, administrative streamlining and treatment benchmarking initiatives.
- G. Address the issue of exponentially increasing healthcare costs in any health reform initiatives designed to expand access to care and/or insurance coverage.

What would happen if we fail to change?

If left unaddressed, increasing healthcare costs will ultimately trigger national fiscal insolvency even as these unprecedented expenses fail to be reflected in the nation's relatively modest health outcomes. Already, healthcare costs are the main cause of individual bankruptcies and the increased cost of health obligations are a leading cause of business failure. Indeed, the burden that American companies bear for employee health coverage puts them at a disadvantage in flexibility relative to organizations in regions where healthcare is a state mandate.

Ultimately, the projected continuation of these unchecked but exponentially increasing healthcare costs is the single greatest driver toward a national fiscal crisis. Already running substantial deficits, America's federal government is not equipped to absorb the additional cost overruns that would result from keeping Medicare and Medicaid benefit increases at a pace with health sector inflation. Ironically, current projections forecast that without intervention, 2019 is the year that the Medicare trust fund will be exhausted and the system will go bankrupt.⁶ Additional costs associated with the provision of universal health coverage are likely to further contribute to this untenable situation.

If trends in America's health economics continue unchanged, within a generation the country will find itself facing national bankruptcy as a result of paying far more than any other nation for care that ultimately produces only mediocre health outcomes.

⁶ The Board of Trustees, Federal Hospital Insurance and Federal Supplementary Insurance Trust Fund 2004 Annual Report.