

**Beyond Band-Aids:
Curing the Sick American
Health Care System**

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Considering All Aspects, How Well Do You Think the American Health Care System Functions?

- Very Well
- Moderately Well
- Fairly Well
- Not Well at All

**Considering All Aspects,
How Happy Are You Personally
with the Health Care Services
You Receive?**

- Very Happy
- Moderately Happy
- Fairly Happy
- Not Happy at All



The U.S. Health Care System

- The financing system is
 - Inefficient
 - Inequitable, and
 - Fiscally unsustainable.

- The delivery system is
 - Fragmented
 - Not designed to care for chronic diseases
 - Haphazard and poor quality
 - High use of unproven and marginal therapies.

Health Care Reform

- True health care reform must fix both the financial and delivery systems.
- Unfortunately, most public discussions focus exclusively on the financing system and getting to (or close to) universal coverage. They ignore delivery system reform.

7 Goals of Reform

- Guaranteed coverage for all Americans
- Controlling costs
- Integrated, high quality delivery system
- Choice
- Fair financial responsibility
- Malpractice reform
- Helping the economy

Guaranteed Coverage

- 47 million uninsured in America.
- 75% of the uninsured are in households where there is one full-time working adult.
- 9 million uninsured children.

Controlling Costs

- In 2006, the U.S. spent \$2,100,000,000,000 --\$2.1 trillion –on health care.
- \$1 out of every \$6 spent in the U.S.

Controlling Costs

How Big is a Trillion?

- 1 million seconds Last week
- 1 billion seconds Richard Nixon's resignation
- 1 trillion seconds 30,000 BCE

Controlling Costs

The need for more than 850 insurance companies to see and contract with millions of employers, underwriting each one, adds greatly to administrative costs. Typically, administrative costs are on the order of 11% of premium, and this does not include the costs to employers to purchase and manage health care spending.

Increasing Efficiency

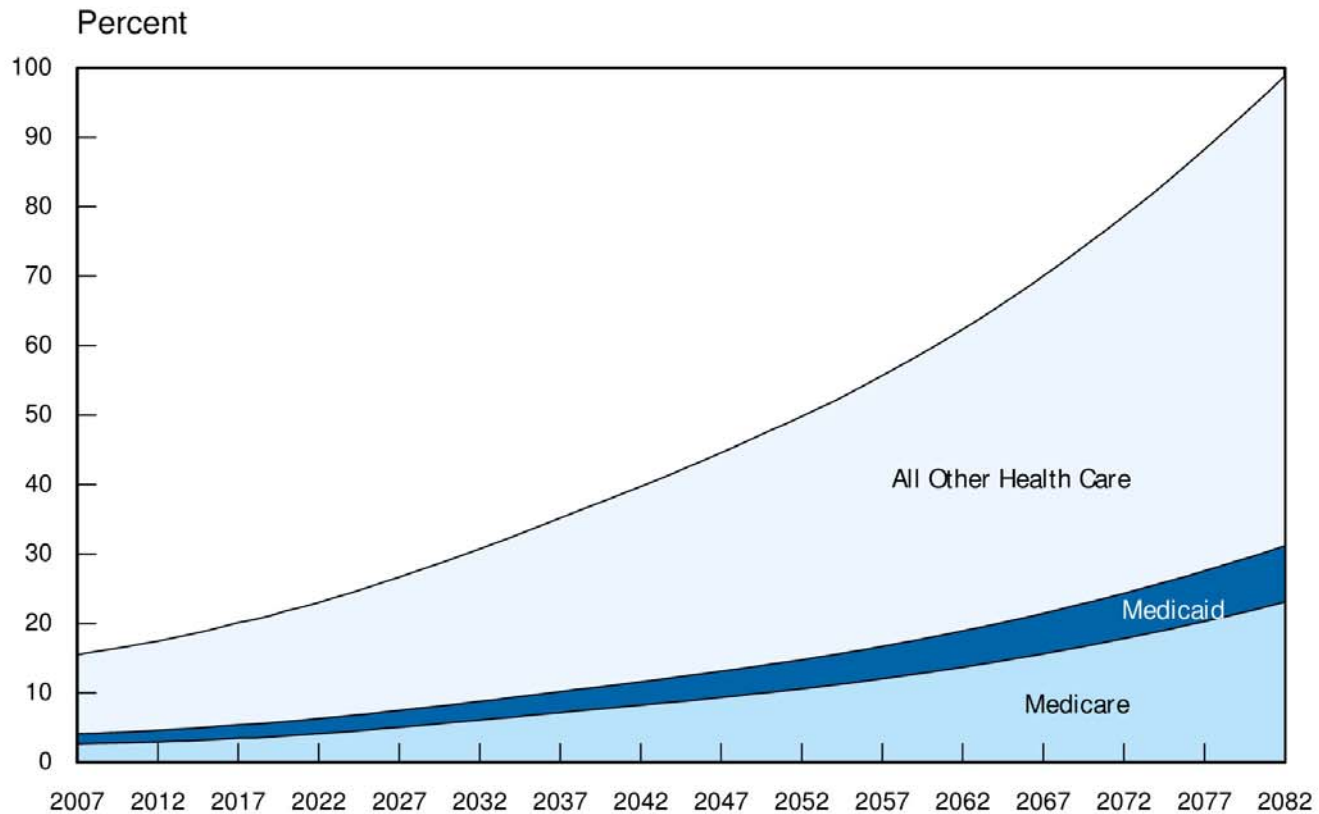
To understand how this could be different, consider that Kaiser Permanente signs only one annual contract for the coverage of more than 400,000 employees and dependents with CalPERs [and the] administrative costs are on the order of 0.5% of premium.

Controlling Costs

- Medicare and Medicaid have 10% fraud at least.
- For Medicaid and SCHIP it costs 2 months of premiums to determine eligibility for children



Spending on Health Care as a Percentage of Gross Domestic Product Under an Assumption That Excess Cost Growth Continues at Historical Averages



Controlling Costs

- By 2028, health care will consume 28% of GDP. This is as much as all federal, state and local governments currently spend.
- By 2050, Medicare and Medicaid will consume all federal taxes.

“Even in fantasy, no one has yet come up with a way to pay for Medicare.”

Integrated Delivery System

- Fragmentation
 - 1 billion office visits per year: 33% to solo practitioners and 33% to groups of 4 or fewer physicians.
 - Typical Medicare beneficiary sees 7 physicians—including 5 specialists—in a year.

Integrated Delivery System

- According to *To Err is Human*, IOM report on quality of care, as many as 100,000 Americans die per year from medical errors.
- RAND study showed that Medicare patients get about 55% of proven, effective therapies such as cholesterol drugs or pneumococcal vaccine.
- AHRQ reports 30% of Americans with hypertension have it adequately controlled.

Integrated Delivery System

- Provide a lot of unproven, costly therapies
- Radiation treatments for early prostate cancer:

• 3-D conformal radiation	\$11,000
• Brachytherapy	\$15,000
• IMRT	\$42,500
• Proton Beam	\$115,000

Inadequate—single institution— data.

No survival difference.

At best a 10% decline in side effects from 14% to 4%.

Integrated Delivery System

- Urologists gave about one-third of men with early stage, good prognosis prostate cancer androgen deprivation treatments even though there is absolutely no evidence it prolongs survival or improves symptoms.
- Academic urologists were only slightly less likely to give androgen deprivation compared to doctors in private practice.

Helping the Economy

- Average cost of employment based insurance is about \$12,000 for family coverage. This is over \$5 per hour for 2,000 hours.

Health care insurance=1 minimum wage
worker

Helping the Economy

Linking health insurance to employment creates serious labor problems:

- Almost all strikes are over health benefits.
- More overtime and less hiring
- Job-lock
- Outsourcing
- Discrimination against older workers

What Should be Done?

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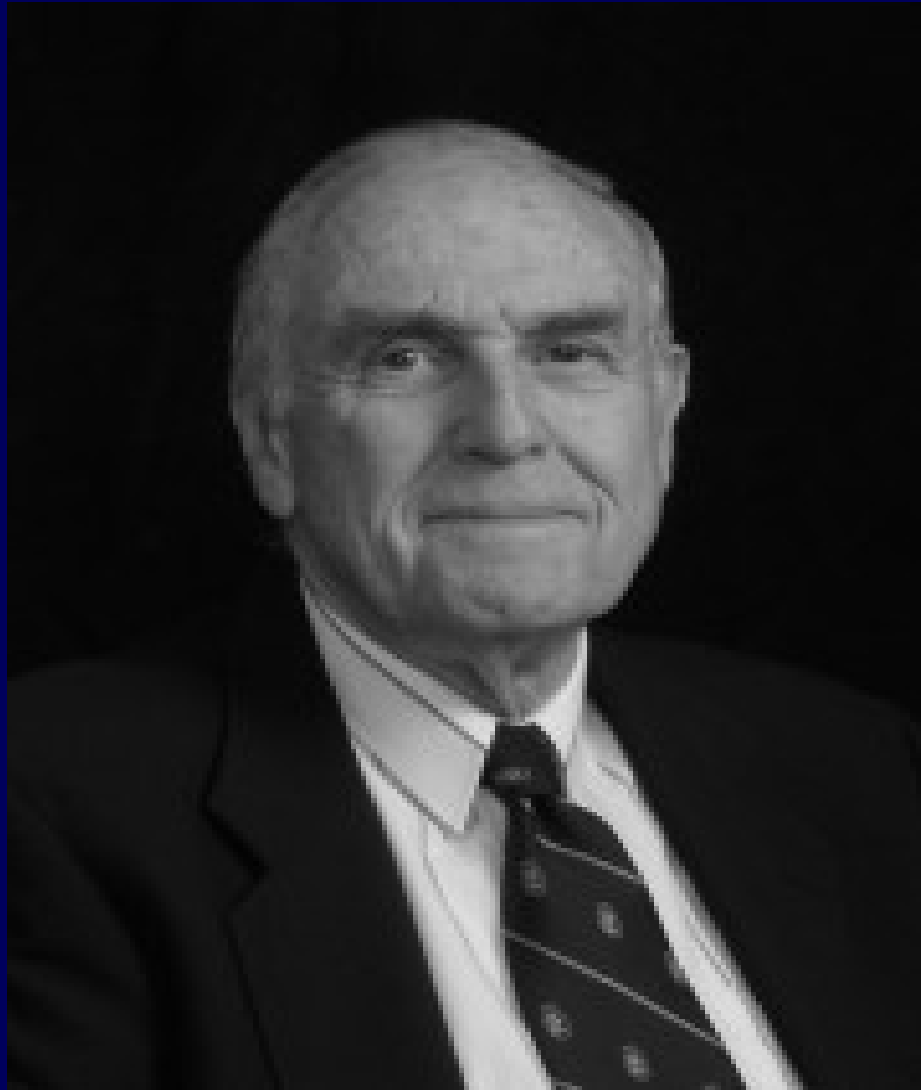


White House photo by Eric Draper



DISCLAIMER

These views merely represent
The Truth.



Victor R. Fuchs, PhD

4 Types of Reform Proposals

- Guaranteed Healthcare Access Plan
- Incrementalism
- Individual and/or Employer Mandates—
The Massachusetts Health Plan
- Single Payer

Guaranteed Healthcare Access

1. Every American receives a certificate to obtain a standard benefits package through an insurance company or health plan. Not a cash certificate, but an insurance certificate. Standard benefits package is modeled on FEHBP that Congressman and Senators get. Better than what 85% of the insured receive and better than Medicare benefits.

Health plans are paid a risk-adjusted premium —paid more for sicker patients.

Guaranteed Healthcare Access

2. Americans have free choice of any qualified plan. 5-8 plans in most areas. Americans who do not enroll are randomly assigned to a health plan by their Regional Health Board
3. Certificates are funded by a *dedicated* value added tax—VAT. VAT starts at 10%.
4. Freedom to purchase more services than standard benefit with after-tax dollars.

Guaranteed Healthcare Access

5. Private sector organizes and delivers care.
6. Elimination of tax exemption for employment-based insurance.
7. Phasing out of Medicare, Medicaid, SCHIP and other government programs. No person is removed from their program, but there will be no new enrollees.

Guaranteed Healthcare Access

8. Administration and oversight by National Health Board and 12 Regional Health Boards modeled on the Federal Reserve System. Sets standard benefits package, oversees insurance exchanges, regulates health plans, and reports to Congress.
9. An Institute for Technology and Outcomes Assessment to evaluate new interventions and collect and disseminate patient outcomes in health plans.

Guaranteed Healthcare Access

10. Centers for Dispute Resolution and Patient Safety to adjudicate claims of patient injury and to promote proven patient safety measures.

Advantages of Guaranteed Healthcare Access

- Guaranteed coverage for all—All—100% -- Americans are covered regardless of income, age, or health status.
- Controlling costs—Reduced insurance underwriting, sales and marketing costs, no costs from income-linked subsidies, and no business costs associated with buying and managing health insurance.

Advantages of Guaranteed Healthcare Access

- Integrated, high quality delivery system—Health plans provide infrastructure, information, and incentives for integrated care. They have to report outcomes—providing incentives for computerization and infrastructure changes. They get a fixed premium for each person for standard benefits—providing incentive to cover only interventions that pass technology assessment. Individual consumers—not employers or government—choose health plans and have incentive to choose high quality.

Advantages of Guaranteed Healthcare Access

- Freedom of choice—Americans can choose their physicians and health plans and whether to buy additional services.
- Fair financial responsibility— Everyone pays VAT. The more you consume the more you pay. Average American family pays \$4500 and gets about \$12,000 benefit.

Advantages of Guaranteed Healthcare Access

- Malpractice reform—Centers for Dispute Resolution solve malpractice reform with quick payment to people who are harmed. Also has organization authority and responsibility for introducing system wide proven safety measures.

Advantages of Guaranteed Healthcare Access

- Helping the economy—Business no longer pays for health care, eliminating the incentive for out-sourcing and allowing the hiring of more workers.

Reduces labor-management conflict.

No job lock for workers—complete portability.

Reduction in many taxes—e.g. state sales tax and Medicare payroll tax.

Economic Feasibility

- Costs of the current system—without Medicare or nursing home coverage (2006 dollars):

Employment-based coverage \$723 billion

Medicaid and SCHIP \$269 billion

Other safety net costs \$ 10 billion

Total Non-Medicare \$1002 billion

- Economic feasibility means the voucher plan should cost about \$1002 billion in year 1.

Economic Feasibility

How much would it cost to purchase employment-based insurance at 2006 rates?

	Population	Annual Premiums	Total Annual Cost
Individuals	41.2 million	\$5174	\$213.2 billion
Families	65.2 million	\$11,216	\$731.3 billion
TOTAL	257.6 million		\$944.5 billion

Economic Feasibility

- But, the uninsured and Medicaid recipients are sicker and will use more health care services than Americans with employment-based coverage.
- How much more? \$50 billion.

Economic Feasibility

- The total cost of the Guaranteed Healthcare Access Plan would be

\$994 billion

Controlling Costs

- “Rheostat” based on the dedicated VAT—any increase in benefits requires willingness to increase taxes.
- Lower demand by requiring additional services to be paid for by after-tax dollars.
- Competition among health plans will lead to heavy emphasis on cost-effective care.
- Systematic technology and outcomes assessment will change delivery and research by drug and device companies.

Incremental Reform

- Expand SCHIP to all children
- Electronic medical records.
- Medical savings accounts with catastrophic insurance over \$5,000.

Incremental Reform

- Main appeal of incremental reform is not the quality or adequacy of the reform but the supposed political feasibility.
- Triumph of politics over policy.

Incremental Reform

- Incremental reform is business as usual.
- If you like the current system, you like incremental reform.
- Builds on a broken system.
- Fails to achieve any of the 7 goals. No universal coverage, no cost control, no improved delivery system.

Mandates

- “Fill in the cracks” reform.
- Relies on the current system and tries to make as few changes as possible to get as close to universal coverage as possible.

Mandates

- Mandate –Require individuals and/or employers to buy health insurance, even if only catastrophic coverage through high deductible health plans.
- Insurance exchange—Create an exchange to pool previously uninsured, self-insured, small businesses for lower rates.
- Subsidies—Provide subsidies to lower income people—usually up to 300% of poverty—or small companies to buy health insurance.

Mandates

- Additional Cost:

\$100 to \$150 billion more per year

Mandates

Coverage

97% covered. Many—those with incomes between 300-400% of poverty— excluded because not “affordable” even with subsidies.

Controlling Costs

Some efficiency in insurance exchange.

No sustained cost control over time because relies on existing system.

Mandates

Integrated
delivery system

None. Relies on existing delivery system.

Freedom of Choice

Better for uninsured, self-insured, and small businesses. Not better for others in employer-based insurance.

Fair financial
responsibility

Uses same tax system and tax breaks as currently adds regressive payroll taxes.

Helping economy

No help and may hurt if use payroll tax to fund subsidies.

Mandates

- Preliminary experience in Massachusetts confirms these worries.

Coverage:

- Uninsured before Mandate: 620,000
- “More than 200,000 previously uninsured residents have enrolled, but state officials estimate that at least that number, and perhaps twice as many, have not.”

Mandates

- Real problem will be cost control, making it unaffordable to employers and the state.
 - Rising costs will mean employers will pay the penalty rather than provide insurance.
 - State will have to provide more subsidies.
 - This will force either increasing taxes to pay for subsidies or exempting more people or companies from the mandate.

Mandates

“[Massachusetts’s] insurers plan to raise rates 10% to 12% next year [2008], twice this year’s national average... If we continue with double-digit inflation, I don’t think health care reform is sustainable.”

Jon Kingsdale

Executive Director

Commonwealth Health Insurance

Connector Authority

Single Payer

- “Medicare for All”
- Physicians’ Working Group for Single-Payer National Health Insurance—
otherwise known as Canadian-style single payer.

Single Payer

- Single national health plan –A single public plan covering all Americans for all medically necessary services.
- Reduced administrative costs—National health plan would operate with 3-4% administrative overhead as Medicare does now. Eliminates administrative costs of insurance companies.

Single Payer

- Negotiated fees and payments—Same reimbursement system as Medicare. Physicians paid by fee-for-service or salary at a hospital or managed care plan. Establish single national drug formulary with negotiated prices.

Single Payer

- Many people believe single payer is the ideal.
- If it has to be compromised for universal coverage to be enacted, it is a compromise.
- This is wrong.

Single Payer

Radical reform of the financing system while retaining the 19th century fragmented delivery system.

Single Payer

Coverage

100% Coverage

Cost Control

Improved efficiency by eliminating insurance administrative costs and need determinations. Still problems—see below.

Single Payer

Freedom of
Choice

100% freedom of choice of doctors
but limited choice of insurance
products.

Helping
Economy

Removes employers, but will
worsen problems if no effective cost
control.

Single Payer

- Key Problems
 - No integrated delivery system.
 - Has no cost control or failed cost control mechanisms.
 - Politicization of decision-making

Single Payer

- Reform of the delivery system requires 3 “I”s
 - **Infrastructure** for coordinated and integrated care. Mechanisms to bring physicians, nurses, pharmacists, hospitals, home health agencies onto one team.
 - **Information** shared electronic medical records, guidelines with reminders, and outcomes measures on performance.
 - **Incentives** so people work together and have interest in delivering quality not just quantity.

Single Payer

- Only an organization like an insurance company can integrate different providers and systematically measure clinical outcomes.
 - Single payer is against such organizations.
- Institutionalizes fee-for-service delivery system which does not provide infrastructure, information, or incentives for integrate delivery of care and makes quality initiatives impossible.

Single Payer

Cost control dilemma:

- 1) Cover everything, producing the cost problem with Medicare
- 2) Constrain supply and generate queuing, which is deeply resented and results in gaming by the well-off.
- 3) Lower fees and payments, leading to physician and hospital special pleading.

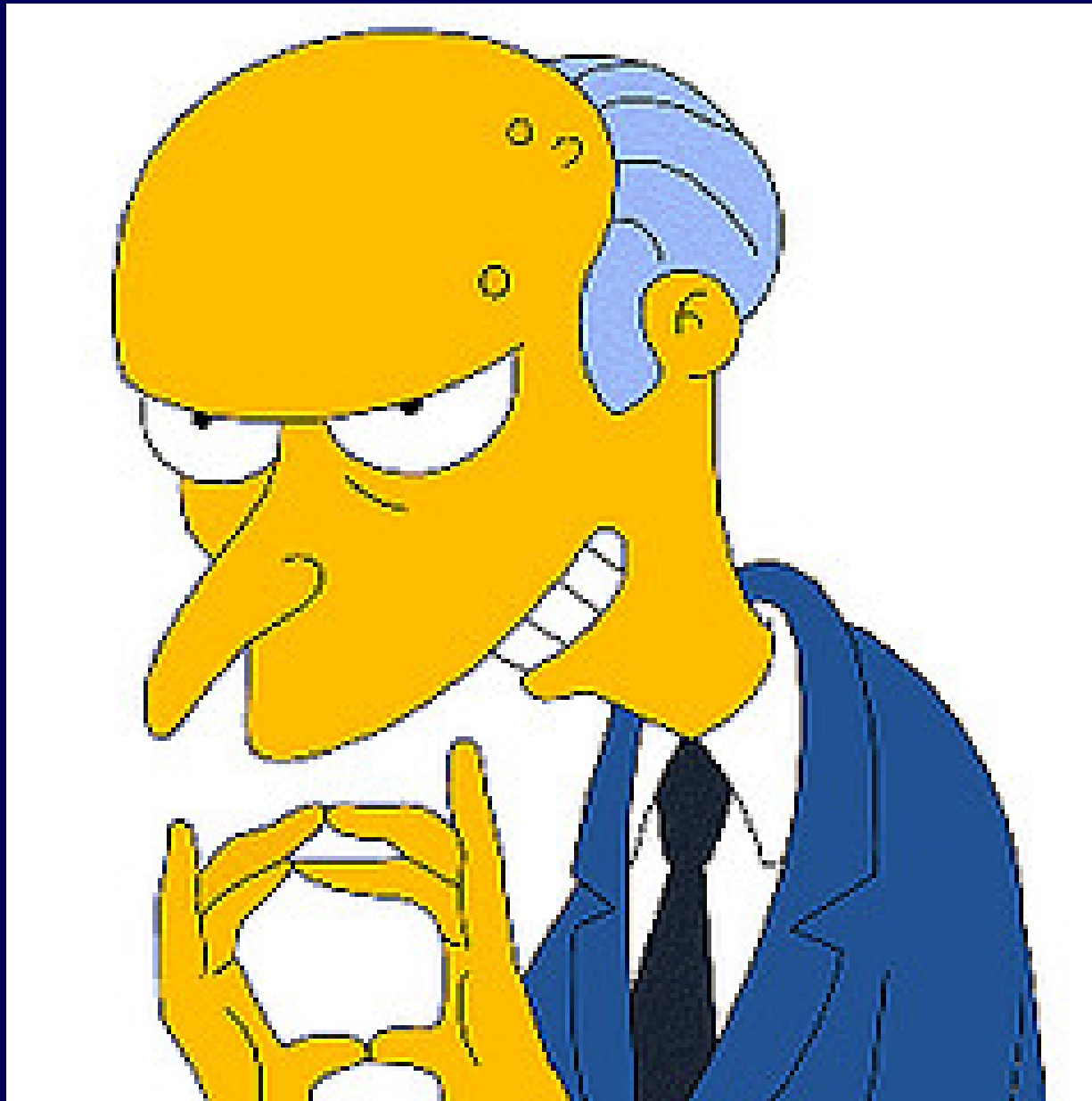
Single Payer

When single payer advocates imagine the administrator of the national health plan they imagine:



Single Payer

But what if the administrator were...





Single Payer

Medicare, which provides near-universal coverage to U.S. residents 65 years and older, is the prototypical single-payer model and routinely exhibits the problems of the model. Although permitted to arbitrarily set fees, Medicare has found it difficult to do so effectively. Across the board fee changes elicit broad based political reaction; narrowly focused changes draw sub rosa special-interest lobbying.... [P]atient advocacy groups, often supported by industry and specialty societies, encourage coverage for specific services....

Single Payer

Rather than market discipline, Medicare is subject to political manipulation and bureaucratic rigidity....

Single-payer advocates envisioning an equitable and efficient healthcare system idealistically disregard the example of Medicare and the ethos of the U.S political system.

Harold Luft

Institute for Health Policy, UCSF

New England Journal 2006

Ethical Feasibility

Several important ethical challenges:

- Using costs to determine what services will be provided.
- Tiering of health benefits—allowing the rich to buy more services.
- Holding individuals responsible for their health behaviors.

Ethics of Tiering

- Practicality—the rich can always, always buy out.

Ethics of Tiering

- Key ethical consideration is not whether rich can buy up, but whether the standard benefits for all are good enough.

Ethics of Tiering

- Justice is based on acceptance of scarcity.
- Society is not required to provide people with everything they might want. There is not enough resources.
- Society should provide those goods that are important for giving people the opportunity to pursue a reasonable life.

Ethics of Tiering

- Justice requires society guarantee individuals reasonable health care that keeps them living a normal life span and functioning so they can pursue opportunities.
- This is the standard benefits package.

Ethics of Tiering

- Autonomy is an essential element of justice. Autonomy requires that individuals have the freedom to spend their own money as they see fit to pursue their life plans.
- If they want to spend on education or vacation or fine wine they should be able to as long as they leave “as good and as much” for other people.
- They must not deprive other people of basic goods needed to pursue their life plans.

Ethics of Tiering

- To preclude tiering and prevent the rich from buying more medical services is a form of “leveling down” and seems to be based on envy not justice.

Political Feasibility

Many barriers to change:

1) **Rule of Satisfaction**—85% of Americans have health insurance and many are satisfied.

2) **James Madison Rule of Government**—American government was designed with many places for special interests to kill legislation. With 16% of the GDP, health care has many special interests.

Political Feasibility

3) Machiavelli Rule of Reform

“There is nothing more difficult to carry out, nor more doubtful of success, nor more dangerous to handle, than to initiate a new order of things. For the reformer has enemies in all those who profit by the old order, and only lukewarm defenders in all those who would profit by the new order.”

Political Feasibility

4) Rule of Second Best

A majority of Americans are for health care reform. But they are divided among many different plans. After their preferred reform, their second choice is the status quo.

Political Feasibility

Change requires 4 things to coalesce:

- 1) A **problem** attracts widespread public and political attention.
- 2) A **proposal** to solve the problem is agreed on by the major actors.
- 3) There is a major actor or set of actors who vigorously **champion** the policy proposal.
- 4) A **transforming political event** creates an open policy window to enact the agreed upon proposal.

Political Feasibility

- Growing recognition that there is a problem.
- Political opportunity is unpredictable. We must be ready when the policy window opens.

Political Feasibility

Aim now must be

- Cultivate powerful constituency to champion reform.
- Develop agreed upon policy option.

Political Feasibility

- Need to have businesses, state governors, and patient advocates agree on the Guaranteed Healthcare Access plan.

More Information

- Politically Engaged

www.healthcareguaranteed.org

- Policy Wonks

www.FRESH-Thinking.org



HEALTHCARE, GUARANTEED

A SIMPLE, SECURE SOLUTION FOR AMERICA

"Dr. Emanuel's bold prescription is thoughtful and will challenge everyone involved in healthcare. As America addresses our unsustainable cost, quality, and coverage problems, we must heed Emanuel's call to act."

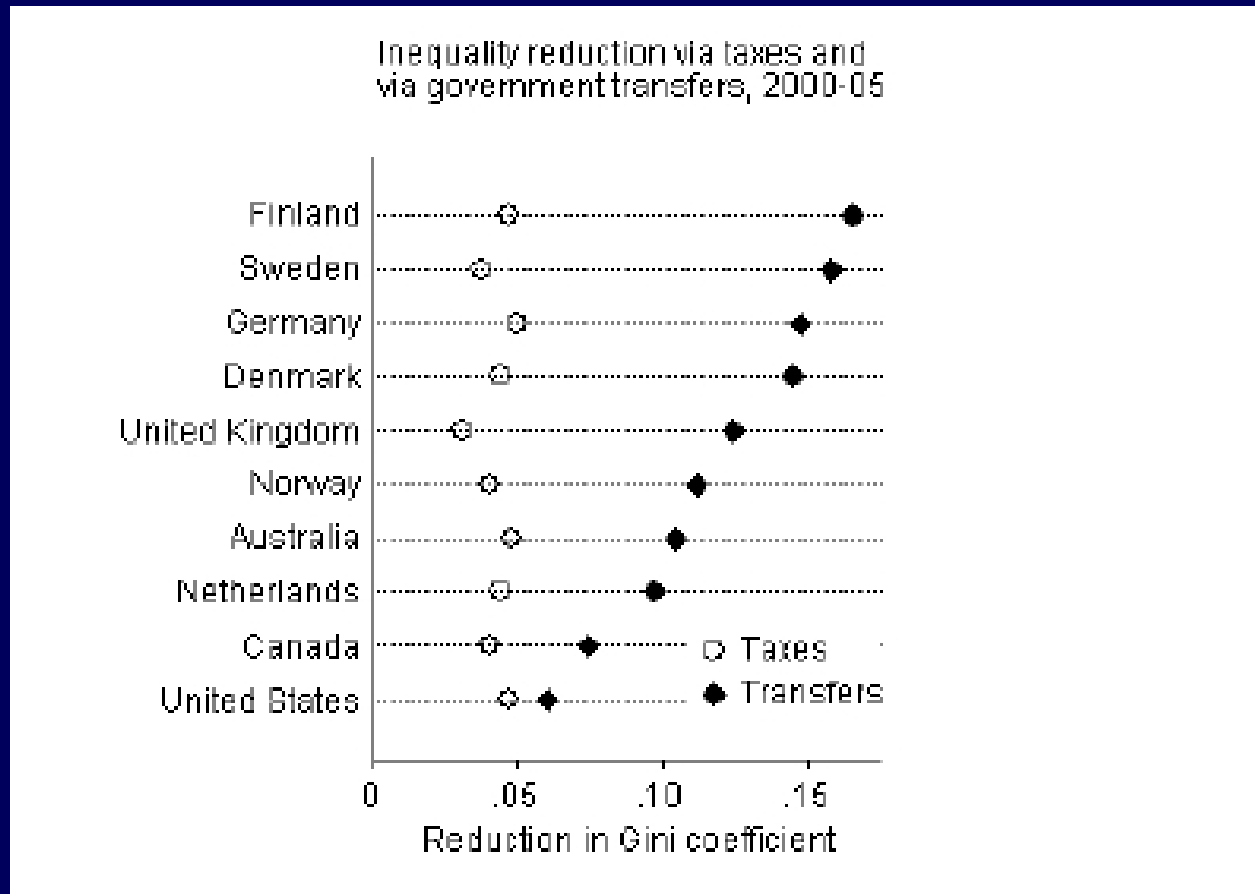
—Andy Stern, president, SEIU

"I wish I had a magic wand to make Emanuel's plan happen. It would create a huge improvement in the competitiveness of American business and reap massive rewards for the health of our economy."

—Steve Miller, former CEO, Delphi Corporation

EZEKIEL J. EMANUEL, M.D., PH.D.
WITH A FOREWORD BY VICTOR R. FUCHS, PH.D.

Reductions in Inequality by Taxes and by Government Programs



The Regressivity of VAT

“None of the countries achieves much inequality reduction via taxes. Instead, to the extent inequality is reduced, it is mainly transfer that do the work... Taxes fund the transfers that reduce

The Regressivity of VAT

“What lesson should Americans draw for tax reform? In my view, the key one is that a national consumption tax as a supplement to the income tax, not a replacement for it, is worth consideration...a national consumption tax on the order of 5% that is earmarked to fund universal health care.

Lance Kenworthy

University of Arizona 2008