Reforming U.S. Health Care: Two Stories about Where We'll Be in 2030

Alan Sager, Ph.D.

Professor of Health Policy and Management
Boston University School of Public Health
asager@bu.edu

Two stories

1. Worse: Business as usual, but gradual deterioration

2. Better: Bottom out, gradual improvement, different

1. Worse: Business as usual, gradual deterioration

- Payers cover many more people, but not very well (high OOPs, low fees/payments)
- Caregivers struggle to cope with less money
  - Hospital closings persist; PCP supply shrinks further
- Excess and deprivation continue to grow
- Patients worry about knowledge + $ deficits
- Move problems to ACO instead of confronting
- Finance, delivery more complicated than medicine
  - Shoehorn health care to fit market's requirements
- Economics, not politics: wrong people are money-conscious, and usually in wrong ways
  - Dollars, not deals → incentives → mistrust → lots more documentation → who audits the auditors?

2. Better: Bottom out, gradual improvement, different

- Payers negotiate trustworthy financial-clinical-political deals with doctors, hospitals
  - Budgets and fee schedules
  - Compatible with patient freedom of choice of caregiver
  - Spend money carefully, cut clinical, administrative waste, recycle savings to do more clinical good
  - Protect needed hospitals; boost PCP supply
- Patients enjoy first-dollar coverage or minimal OOPs
- Some ACOs fail; others work; most patients, hospitals, doctors choose to remain outside them
- Professionalism, honor, fiduciary duty, responsibility, financial neutrality, finite dollars largely supplant financial incentives
- Data systems supports right care and careful spending

Core assumptions

1. U.S. health care's environment gradually re-stabilizes
   - Economy and employment recover slowly but only to levels of 1970-1995, not of 1945-1970
     - Federal and trade deficits decline; worries persist
     - Income inequality worsens, but more slowly
   - Political adrenalin and polarization drop
     - Renewal of traditional U.S. pragmatic incrementalism
     - Decline of ideology and of policy-by-spasm

Core Assumptions

2. No discontinuities, benign or horrible

- ACA provisions might or might not be implemented
- Neither cheap, safe electricity from slow fusion
- Nor perfection of simple, intuitive, clinician-friendly, inter-operable, inexpensive EHR
- Nor nuclear attacks
- Nor discovery of unpatentable virus that dissolves coronary artery plaque and prevents Alzheimer's, arthritis, diabetes, and all visible signs of aging

First story:

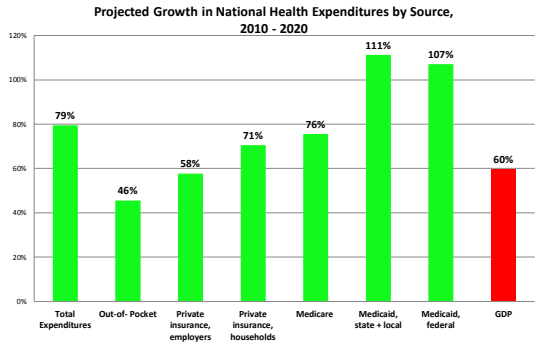
Business as usual, with gradual deterioration

1. Financing/revenue
2. Organization/delivery
3. Caregivers
   a. Hospitals
   b. Physicians
   c. LTC
   d. Rx
4. Access
5. Costs
6. Appropriateness/quality
7. Climate

1. Financing, revenue, 2010-2020

- CMS actuaries project NHE +79%
- Project state/local Medicaid +111%
- Project federal Medicaid +107%

- GDP + 60%
- NHE % GDP up from 17.6% to 19.8%



Sources: www.cms.gov, research, statistics, projections; and Keehan and others, *Health Affairs*, Aug. 2011.
Note: 2010 Medicaid S+L backs out federal ARRA subsidies and assumes S+L share of Medicaid remained at 2008's 41.0%.

How much will revenue actually rise?

- If ACA's Medicaid and individual mandate provisions are implemented
  - States continue to cut Medicaid prices paid caregivers, endangering access and spurring litigation
  - Employers steadily boost employees' OOPs and premium shares → privately financed care volumes fall
  - Some employers with lots of low-income workers save money by dropping health insurance, paying fines, and shifting to exchanges' subsidized insurance
- If ACA overturned
  - hospitals + doctors + insurers see fewer paying customers
  - Medicare cuts to hospitals aren't restored + PCP Medicaid fees drop
- Either way, employers keep boosting OOPs, legitimized by ACA
  - Deter use of needed care and boost hospital/doctor bad debt
- Medicare voucherization unlikely
  - Political resistance from voters, hospitals, physicians
  - Insurers too busy: 16M via exchanges + 9M dual eligibles' managed care
- Smaller cuts instead, such as
  - Adding labor/delivery beds to beds denominator for Medicare IME
  - Accurately risk-adjusting payments to Medicare Advantage plans

2. Organization/delivery

- If ACA implemented, hundreds of ACOs get off ground
  - But face high energy-absorbing administrative costs
    - EHR, financial systems
    - Track patients—who's in ACO?—stealth enrollment questioned?
    - Demonstrate adherence to 33 quality standards
    - Tough financial and power questions fought out inside each ACO
  - Hard to obtain valid clinical evidence or valid cost data (average price, average cost, marginal cost?) to make careful cost – value trade-offs and spend money more cost-effectively
  - Some succeed; others fail
- Rise in hospital-employed physicians, but integration is slow
- Patient-centered medical homes + primary care teams remain under-financed, grow slowly

3. Caregivers

a. Hospitals

- Will ACA's expanded coverage offset slower Medicare updates?
- Will prices from Medicaid and exchange-subsidized patients be proportional to added costs of serving these patients?
- If ACA overthrown/repealed, will Congress restore Medicare updates? Or will Ryan budget retain Medicare slowdowns?
- Will financially stressed hospitals find money for EHR, data reporting, patient safety, patient satisfaction, capital?
  - If not, will they suffer Medicare payment penalties?
- Rural hospitals likelier to be somewhat protected
- But erosion of urban non-teaching hospitals will persist
  - Teaching hospitals much likelier to survive—so far
    - Though closing of St. Vincent's in Manhattan (which faces a 45% rise in elderly population by 2030) seems improvident
  - Hospitals in black neighborhoods likelier to close
  - Efficiency doesn't confer survival advantage
  - Access compromised; cost rises; quality—?

CHANCE OF CLOSING RISES AS BEDS FALL AND AS BLACK AREA % RISES, 1997-2003

Hospitals in 52 U.S. Cities

		Hospital beds in 1990			
		3rd quartile	mean	1st quartile	
Area	**% black**	451	339	174	100
1st quartile	5	5%	8%	15%	19%
mean	29	6%	10%	19%	24%
3rd quartile	47	8%	12%	22%	29%
	75	11%	16%	29%	36%
maximum	99	14%	20%	35%	43%
maximum/1st quartile		2.8	2.7	2.4	2.2

Overall, 69 of 555 hospitals (12.4 percent) closed from 1997 to 2003, or one in eight.

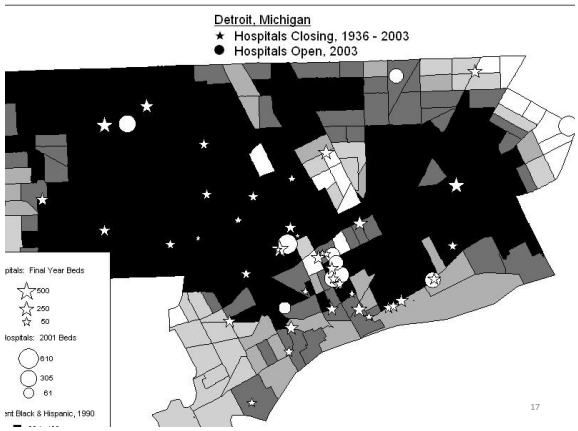
WHICH VARIABLES PREDICT CLOSINGS, 1997-2003?

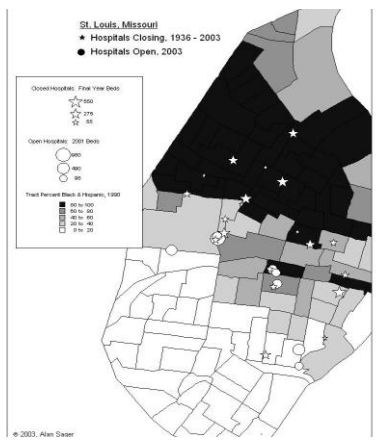
1990 variable	significance
Intercept	0.216332
Beds	0.000004
Area % black	0.048675
Area % latino	0.403682
Area income/capita	0.270617
Hospital total financial margin	0.158566
Hospital cost/patient	0.761498
Hospital fund balance/patient	0.022449

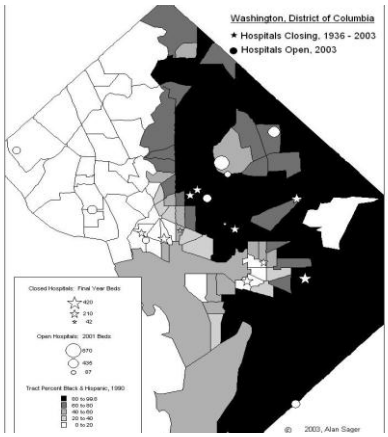
PREDICTING THE CHANCE OF CLOSING, 1997 - 2003

1990 variable	Slope	Value
Intercept	-0.727639	1
Beds	-0.004452	362.1
Area % black	0.010354	29.1
Area % latino	-0.007471	15.7
Area income/capita	0.000019	$14,852
Hospital total margin	-0.019466	1.3
Hospital cost/patient	-0.000024	$4,920
Hospital fund balance/patient	-0.000003	$153,739
Predicted probability of closing		8.2%

Values are means for each variable except intercept.







19

b. Physicians

- If ACA implemented, how well will physicians be paid?
  - Medicaid at Medicare rates - PCPs and general surgeons
  - Exchange-covered patients' rates uncertain – near Medicaid?
- Continued erosion of PCPs and rising panel size
  - Death spiral?
  - Market and public failures
    - Market forces don't respond to PCP shortages by bidding up prices
    - Federal, state loan forgiveness, pressure may slow PCP decline
  - More MD + DO training in U.S. won't alone boost PCP supply—may even lower it by displacing IMGs from residencies
- Will there be enough NPs, PAs, SWs, case managers, others to supplement PCPs on primary care teams in medical homes?
- Will teams be able to coordinate well—and will patients accept them instead of relationship with one physician?

PCPs/K people in 29 rich democracies, 2009

	All physicians	PCPs
Median, 29 OECD nations	3.2	1.6
U.S.A.	2.4	0.8

→ The U.S.A. has half as many PCPs/thousand citizens as the median OECD nation.

Note: 1/3 of US physicians are PCPs (HUS 2010); OECD mean PCP share seems to be close to 50%

Source: OECD Health Statistics, Frequently requested data, http://www.oecd.org/document/16/0,3746,en_2649_33929_2085200_1_1_1_1,00.html

c. LTC

- CLASS gone from ACA – law's standard was unattainable –
  - HHS secretary could never certify law would be self-sustaining, financially sound for 75 years, and affordable
  - Parallels non-certification of safety of reimporting meds from Canada
- Capitation for dual eligibles may yield better care, but risk-adjustment tricky and patients often very vulnerable
- Erosion of private LTC insurance, reverse annuity mortgages?
- Medicare LTC benefit unimaginable today.
  - Yet some OECD nations have social insurance for LTC
  - Others have means-tested LTC benefits with fairly high income ceilings
  - How can they afford it? Spend less on acute care?
- Families give about 80 percent of in-home LTC
  - So a 10% drop in family effort (80 to 72 percent) → 40% rise in need for paid substitutes (20 to 28 percent)
  - Risk of destabilizing in-home care if families less available, able, willing
- LTC is inherently tough problem – so much time is needed, it's costly if those hours have to be paid for, and the work is demanding

d. Rx

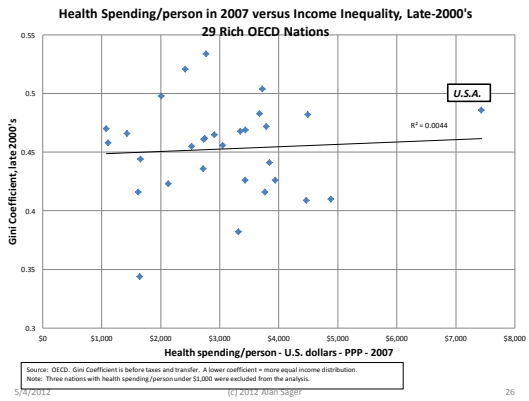
- ACA would gradually fill donut hole – black hole of death
- Ironic that brand name prices so high, when marginal cost of making more pills is usually so low (for small molecule drugs)
- When price is high, way to save is by suppressing volume of brand-name drugs
  - Rising OOPs, formularies, patent expiration/generic substitution have slowed Rx spending rise
- Pharma long relied on 3Ms + boosting prices to sustain profits
  - Mergers + acquisitions, me-too's, marketing + advertising
  - Now lacks durable business plan—innovation weak, partly owing to weak incentives
- Supply shortages– mixed causes – no obvious solutions
- Looming affordability gap for new high-priced, big-molecule meds
  - Many years of high prices owing to slower generic entry
  - Anticipate more stories about rationing
- Many physicians (and patients) unhappy with
  - Time spent on step therapies
  - Begging for exceptions, waivers
  - Soaring OOPs that impose penalty on chronically ill
  - Formularies shifting like staircases in a Harry Potter movie
- PBMs powerful but can we trust them to act in our interest as patients or payers?
- Affordable equity for pharmaceuticals should be our easiest-to-fix health care problem—low marginal cost once research done and factories built

4. Access—coverage

- Massachusetts
  - Probably 95-97% covered in 2011
  - About 90% in 2005
- U.S.A.
  - If ACA implemented, could drop to 15 million uninsured in 2014 (95% covered)
  - 2010 baseline was 50 million uninsured (84% covered)

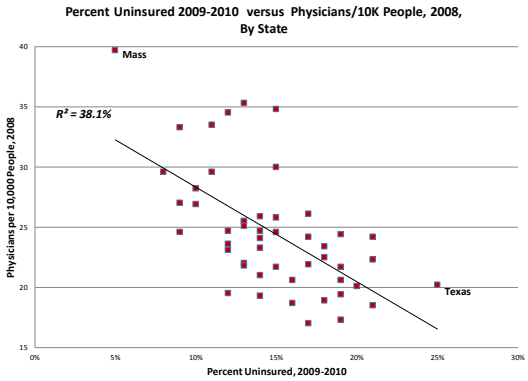
Access—financial

- For many patients, new coverage through exchanges = catastrophic insurance, with high OOPs
  - High deductibles and 20% co-insurance up to high annual OOP standard—same as HSAs
  - Proposed rule on affordability for employer-offered insurance calibrated to 9.5% of household income for employee only—ignoring cost of covering dependents
  - Holds down federal cost of subsidizing premiums but leaves millions badly protected
- Coverage through job sees rise in OOPs and employees' premium share
- Not surprising: in U.S., protecting all means hauling heavy loads of money a long distance
  - U.S. health cost/person 2.25 times rich democracy median
  - But 5th-greatest income inequality



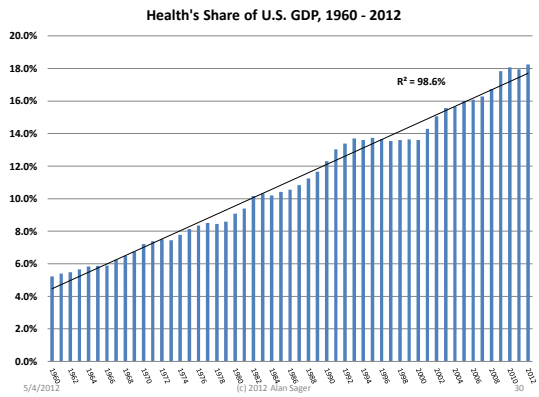
Access—caregiver capacity

- For many hospitals, Medicaid DSH $s could drop faster than needs of uninsured patients
- Recent Massachusetts experience
  - Mass. has nation's highest physicians/capita
  - After implementing 2006 law, still saw reports of
    - Rising appointment waits
    - More closed practices
    - Higher ER use
- Across 50 states, physician capacity varies very inversely with numbers of newly-insured patients



5. Costs

- Under control?
  - Yes
  - No
  - Only in *New York Times*
- ACA
  - ACO
  - IPAB—strikingly unpopular to many
  - Primary prevention
  - MLR – minimum care share
  - Silver plan standard (70% of costs), as Massachusetts
- Overlays, escapes, or direct attacks on costs?
- Costs rise as plateaus and jumps as % of GDP



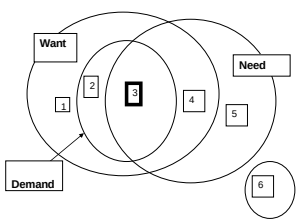
If GDP growth resumes

- Health spending could surge
  - Especially if backlash against high OOPs and low Medicaid fees
  - Caregivers make up for deferred revenue growth
- Could lead to renewed pressure for financing arrangements that contain cost
  - Effective national remedies unlikely soon
  - Some states seek and may win permission to experiment with either 1-payer or, likelier, all-payer consolidated purchasing

6. Appropriateness/quality

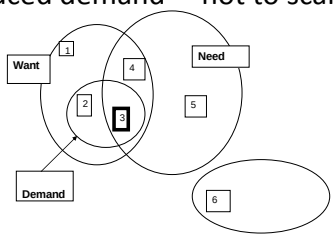
- Fewer people seek care when needed, deterred by
  - Lower disposable income
  - Higher OOP
  - Growing PCP shortage and deterrents to using ER bar entry to care
- Some will hail this as sign that market controls are working
- Well-located caregivers may be tempted to over-serve well-insured and higher-income patients, to whom deductibles, co-pays, co-insurance, or fixed-dollar OOP caps mean relatively little

Initial want, need, demand – not to scale



1. Wanted, but not demanded or needed.
2. Wanted and demanded, but not needed.
3. Wanted, needed, and demanded. ***Yes!***
4. Wanted and needed, but not demanded.
5. Needed, but not wanted or demanded.
6. Supplier-induced demand—neither wanted nor needed, but demanded.

Growing unmet need and supplier-induced demand —not to scale



1. Wanted, but not demanded or needed.
2. Wanted and demanded, but not needed.
3. Wanted, needed, and demanded. ***Yes!***
4. Wanted and needed, but not demanded.
5. Needed, but not wanted or demanded.
6. Supplier-induced demand—neither wanted nor needed, but demanded.

7. Climate

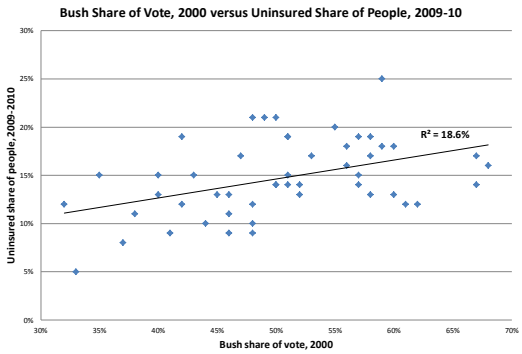
a. Homeostasis or anarchy
b. Trust or corrosive suspicion
c. Professionalism, politics, or incentives
d. Medical security

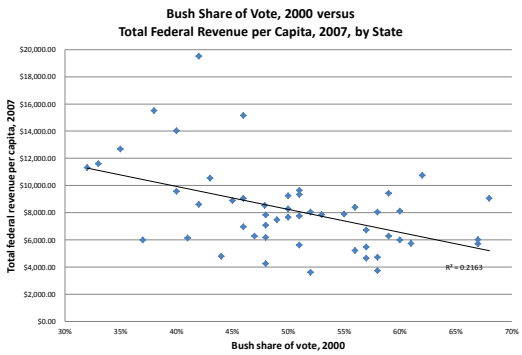
a. Anarchy!

- Absent functioning market or competent government action, anarchy increasingly pervades U.S. health care.
- Some respond: stop relying on mixture of government and market: choose one and let it work or make it work
- But probably not reasonable to expect that either traditional markets or traditional government action can fix most U.S. health care problems

Not by government

- In U.S.A., governments have successfully (+/-) provided more money to cover more people
- Public planning and regulation to contain cost or improve configuration of hospitals or doctors have seldom worked well or durably
  - Persistently weak political support
  - Inexperience (stemming from episodic, unsustained engagement)
- Pushing more effective government action founders on lack of consensus about need for that action, its aims, or its methods
- Voters in some higher-income, higher-cost, mainly blue states with fewer uninsured people rebel
  - against paying to improve coverage in lower-income and mainly red states
  - while paying extra taxes on their high-cost "Cadillac" insurance stemming from high-cost care





And not by markets

- 6 requirements for functioning markets lacking in health care, and probably can't be retrofitted
- Efforts to retrofit foundations for functioning market seldom work and often make other things worse
  - Greater patient suspicion of doctors and hospitals, cognitive overload, and bankruptcy risk
  - Physicians increasingly think about money at wrong times, in wrong ways, in excessive detail

REQUIREMENTS 1 - 3 FOR ANY FREE MARKET TO WORK WELL	BARRIERS TO FREE MARKET WORKING WELL IN HEALTH CARE
1. Many small buyers and sellers, so all parties are price takers, not price makers. The market makes the price. No one has power in the market to extract a higher or lower price.	In many regions, a few hospitals dominate delivery of acute care and seek higher prices. Often, a few large private insurers, HMOs, or public programs demand lower prices.
2. No artificial restrictions on supply, demand, or price. Consumers decide how much to demand; producers decide how much to supply. Their interactions determine price. Consumers of care are sovereign—they make the decisions and spend their own money as well as they can.	Most patients are patients, not consumers. They are worried and inclined to listen to well-trained experts. Also, when patients have insurance, they are not spending their own money, so they are not aware of the price or total cost of the care they get. Little agreement about which measure of price or cost is the right one.
3. Easy entry and exit to and from the marketplace. If a producer or provider gains a monopoly, which allows it to extract fat profits, those profits attract new providers, which bid down prices to free market levels.	Once some hospitals close or consolidate in a region, it can be very costly or hard for new hospitals to open. Insurers, similarly. Also, drug makers have legal monopolies (patents) on new drugs.

REQUIREMENTS 4 - 6 FOR ANY FREE MARKET TO WORK WELL	BARRIERS TO FREE MARKET WORKING WELL IN HEALTH CARE
4. Good information about price and quality informs the decisions of consumers and producers.	Patients and families often have trouble finding valid information. And many people are worried when sick. Caregivers have much greater access to information. Meaningless to shop by price and quality anyway, until know if care is needed.
5. Constant mistrust or suspicion—"let the buyer beware!")	But patients are likelier to seek care promptly, or to recover quickly, other things equal, when they trust their doctor, nurse, or other caregiver. Trust of PCP particularly important.
6. Price tracks cost closely, so when you buy something with a low price, you almost always buy something that has a low cost of production. Price is a signal for cost, so buying at low price rewards efficiency.	Often, health care prices are not even close to cost of care. Some prices are much higher than cost, and others are much lower.

b. Corrosive suspicion

- Financial incentives to over- or under-treat arouse suspicion in payers and patients
- Many patients already worry because of high OOPs
- *Caveat emptor* – watchwords of market – undermine trust
- Miscast actors
  - Too many economists playing politicians
  - Too many politicians playing economists
  - Too many patients playing doctors
  - Too many doctors playing MBAs

c. Incentives

- **For patients**, belief that over-insurance begets moral hazard, which begets over-use
  - Promote higher OOP payments to incentivize careful shopping by "consumers"
  - "Skin in game"? Not game for most patients.
  - Despite evidence that higher OOPs result in indiscriminate reductions in use regardless of need
  - Reinforced by failure of almost every other cost control, so let's turn patients into kamikaze pilots

c. Incentives

- **For physicians and hospitals**, change payment to incentivize desired behavior
  - Promote P4P
  - Add RVU, productivity, patient satisfaction measures
- Ignores evidence that financial reward generally
  - Extracts more effort when the work is physical labor or mechanical performance
  - Undermines performance when cognitive skills are required
- Professionals value **autonomy, mastery, purpose**
  - So, how to pay physicians in ways that allow us to trust them to spend carefully?

d. Medical security?

"Confidence that we'll get needed, timely, competent, and kindly care without worrying about the bill when sick, or about losing coverage—ever"

- Growing medical insecurity may lead to
  - Using less care to avoid medicogenic bankruptcy
  - De-valuing medical care and seeking alternatives
  - More realistic expectations of medical cure

Second story: Bottom out, gradual improvement

1. Financing/revenue
2. Organization/delivery
3. Caregivers
   a. Hospitals
   b. Physicians
   c. LTC
   d. Rx
4. Access
5. Costs
6. Appropriateness/quality
7. Climate

Main impetuses (five)

1. Patients/citizens rebel against

- Money problems
  - Rising medical excess and deprivation, as services increasingly follow ability to pay, not need
  - High OOPs that deter care-seeking
  - Medical bankruptcy/debt if seek care
- High stakes but low information → most Americans not effective consumers
  - Don't know what's needed to diagnose, treat
  - Lack valid, useful data on price or quality
- PCP shortage, lack of coordination/continuity, increased paperwork/confusion/claims denial

2. Doctors demoralized and angered by

- Falling real incomes
- Static fees, OOPs, claims denials/delays, EHR cost
- Annual SGR/sword of Damocles ritual
- Loss of autonomy and professionalism
  - Payers' and hospitals' reliance on financial incentives and performance monitoring
  - Ever-heavier burden of financial-clinical documentation—unrelieved by ever-lighter I-Pads
  - Alienated by under-serving badly covered and over-serving well-covered
- Difficulty PCPs face in staffing and coordinating primary care teams to serve patients effectively

3. Surviving hospitals besieged by

- Resurgent bed shortages in many regions, partly offset by financial barriers between patients and needed care
  - More older people and fewer hospitals
  - Capital cost of replacing hospitals @ $1 - $4 million/bed
- Greater ER crowding and capacity problems
  - Growing PCP shortages, and legacy of hospital closings
- FTC/DoJ anti-trust suits to reverse both vertical and horizontal integration—if ACOs lose public's or payers' favor
- Growing tension between serving citizens' clinical needs and generating revenue—in face of widening inequality of insurance coverage
- Difficulty of serving patients (and physicians) displaced by closing of stressed hospitals
- Payers' occasional efforts to deny payments

4. Politically, Congress either

- Crafts political compromises
  - Slashing OOPs and medicogenic bankruptcies
  - Protecting all needed caregivers
  - Containing costs by
    - Creating mechanisms to negotiate physicians fee schedules and hospital budgets
    - Squeezing/recycling waste
- Or, unable to enact national remedies, abandons efforts to oblige mainly red states to accept ACA money from mainly blue states, and grants states opportunities to go their own ways (medical secession?)
  - Some pursue market more aggressively
  - Some try single payer with top-down public regulation
  - Others pursue homeostasis in third way
  - Hard to answer same questions 50 different ways

5. Dean Vernon Wormer:

- "Fat, drunk, and stupid is no way to go through life, son."
  - Or, $2.8T/nation and $9K/American = enough

Key elements

- Focus on clinical and financial medical security
  - (not certainty)
  - Growing recognition that
    - Immortality isn't goal
    - Trade-offs inevitable—squeeze out waste and recycle it
- Shaving peaks of excess to fill valleys of under-care
- Homeostasis that doesn't depend on markets or traditional government action or mechanisms like ACOs
  - Budgets and fee schedules
  - Financial neutrality
  - Professionalism
  - Real, old-fashioned primary care
  - Protection for all needed hospitals

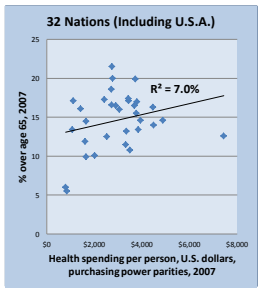
1. Financing/revenue

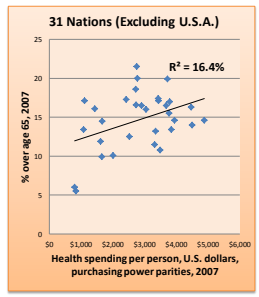
- Suppose 2030 revenue flowing to health care remains stable at 2020's 20% of GDP
  - Despite aging of U.S. population
  - Resulting in pressure to do more for needier people with less constant-dollar spending

Population over Age 65			
	2012	2020	2030
U.S.A.	13.5	16.3	19.7
OECD median	15.3	18.0	21.5
U.S.A. rank	7th-lowest	6th-lowest	5th-lowest

- High U.S. health spending unjustified by population needs (or by outcomes)

Health Spending per Capita, U.S. $s, PPI, versus Percent Over-65, OECD Nations, 2007





Two options—nationally or in some states

- Either ACOs might prove acceptable to patients, doctors, and hospitals—and they might succeed in slowing spending increases while improving outcomes, coordination, continuity, and primary care access
- Or all payers together negotiate with
  - State hospital associations over flexible budgets
  - Physician organizations over fees or incomes
  - Providing special enhancements for needed but endangered hospitals and for PCPs

2. Organization/delivery

1st alternative to ACOs: groups of 5-20 PCPs join together

- Accept full risk-adjusted capitation for patients who voluntarily remain with them
- Three annual budgets in three watertight compartments
  - Pay PCPs
  - Pay specialist physicians
  - Pay hospitals, meds, LTC, mental health
- No way to make money by withholding care
- Separate support for clinical decision-making and trade-offs, budget management
- Pay hospitals, drug makers at nationally/regionally negotiated standard prices that cover variable costs only
  - (fixed costs paid separately by all payers in unison)

2nd alternative to ACOs: Negotiated fee schedules and budgets make health care safe for loosely-organized care delivery

- Negotiated national or regional fees for PCPs, other physicians in ambulatory practices
  - Designed so a productive doctor earns target income
- Flexible budgets for all needed hospitals
  - Gradually including in-hospital specialist physicians
  - All payers together make lump sum payment to cover fixed costs
  - PCP networks pay variable cost/discharge
  - So do payers for unaffiliated patients

3. Caregivers

a. Hospitals

- Identify and financially stabilize needed hospitals
  - Requires a little trust between hospitals and payers
- Maryland-style all payer—but a little less complex
- Budgets flexible by volume and case mix
  - Financial neutrality
  - Make money by internal efficiency, not by boosting volume selectively
  - All patients equally profitable—by diagnosis, procedure, and payer—to liberate caregiving by clinical need and value of care, not by financial considerations

b. Physicians

Primary care

- Without more money, patient-centered medical homes and medical teams are only rhetoric
- It is not yet clear whether an adequate supply of clinicians will emerge—clinicians who are able and willing to provide continuous and coordinated care on this model

The inverted primary care pyramid

Chart X: the traditional health care pyramid, resting on a broad and solid primary care base.

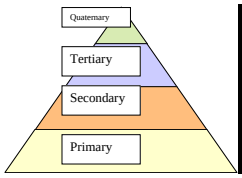
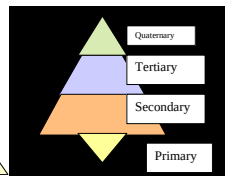


Chart Y: Today's inverted primary care pyramid, in which growing pressure and disruption are imposed on primary care doctors by health care delivery and financing.



Alternative

- Train and secure ~ 310K FTE PCPs
- Drop panel size to 1,000 from today's 2,400 ++ (310M/1,000 = 310K)
  - Make room for phone, text, e-mail visits + 30- to 60-minute office visits
- Recognize that primary care is hardest job in medicine
  - Requiring breadth/depth of clinical knowledge
  - Patiently addressing minor or chronic problems while remaining alert to rare and dangerous acute problems
  - Combining love of science with enjoyment of human relationships
- Therefore deserving and demanding incomes commensurate with those of procedure-performing specialists

Budget requirements for 310K FTE PCPs

	Practicing primary care physicians in U.S.A.	Average net income, 2012 $s	Total cost, 2012 $s	Share of 2012 health spending
2010 - actual	**209,000**	**$180,000**	**$37,620,000,000**	**1.3%**
2010 – 1,000/PCP	**350,000**	**$280,000**	**$98,000,000,000**	**3.5%**
difference	**141,000**	**$100,000**	**$60,380,000,000**	**2.1%**
2012 health spending			**2,823,900,000,000**	

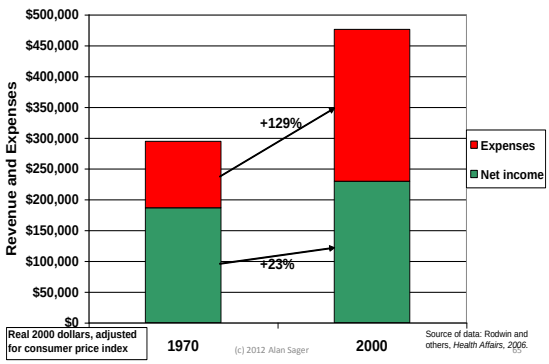
Source: 209,000 practicing primary care physicians in U.S.A. In 2010
AHRQ, "The Number of Practicing Primary Care Physicians in the United States," October 2011, http://www.ahrq.gov/research/pcwork1.pdf

Note: 350,000 practicing PCPs should yield about 310,000 FTEs, enough to drop average panel size to 1,000 patients.

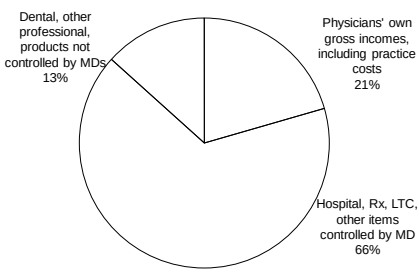
Of the $60 B rise in PCP net income,

- 1/3 ($20.9B) stems from raising net incomes of today's 209,000 PCPs by $100K
- 2/3 attributable to boosting number of PCPs by 141,000, or 67%
  - But this won't actually raise NHE at all
    - This change will not depend on training still more physicians than increases already planned
    - So, adding 141,000 PCPs means a drop of 141,000 specialists, paid an average of $280K
- And more PCPs will probably lower the cost of care
- We can boost PCPs'—or all physicians'—net incomes just as well by cutting expenses as by raising payments
- (Do need to address hospitals' needs for residents or other physicians)

U.S. Physician Net Revenue and Expenses, 1970 + 2000



PHYSICIANS RECEIVE OR CONTROL 87% OF U.S. PERSONAL HEALTH SPENDING, 2010



Peace treaty with doctors vital

Doctors get
- Liberated from thinking too much about money—restore professionalism
- Negotiated fee schedules
  - Fees calibrated to generate target incomes to reasonably productive physicians
  - Fees uniform across payers
- 90% cut in payment-related paperwork and its cost
  - Boost trust
  - Standard national (or state) rules, forms, and formulary
- No PPOs—only ACO and capitated PCPs can restrict networks
- Sued for actual torts only
  - No need to sue for medical costs, lost income, pain + suffering
- No longer squeezed, manipulated, or ignored by payers

In exchange, doctors give
- Commitment to care for all patients with total dollars available
  - Recognize that pathology is remorseless but dollars are finite
- Discriminate only by need and clinical effectiveness
- No discrimination by payer, diagnosis

c. LTC

- Recognition that paid and family helpers are complements, not substitutes
  - Like two halves of a stone bridge, holding up one another
- Better spending of Medicare/Medicaid dollars frees up public money for long-term care
- Time banking/service credits, and other innovative ideas mobilize more unpaid help by creating market for good deeds by enabling helpers to offer time when they have it—which may not coincide with when parents need it

d. Rx

- Meds can be prescribed in light of their efficacy, safety, and marginal cost
- For existing meds, peace treaty with drug makers—exchanging lower prices for higher volumes
- For innovative new meds, rich democracies award prizes in proportion to clinical value, safety
  - Sell at marginal cost of manufacturing
  - Win both innovation and affordability

4. Access

- Each legal resident fully insured, with very small OOPs
- Complex band-aids to relieve pain of high OOPs
  - Boosting insurers' payments for out-of-network care, or limiting caregiver balance billing (New York)
  - Bills proposing caps on OOPs for costly drugs (20 states)
- Give way to cohesive and forceful state legislation to protect citizen-patients
  - Some states opt for steeply income-scaled OOPs that start very low
  - Others rely on clinical triage by PCPs to replace financial self-triage by patients and adopt very low OOPs

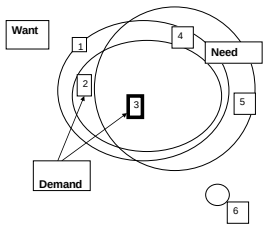
5. Costs/waste

- Costs controlled directly by negotiations between organized payers and organized caregivers
  - Essential: professionalism, honor, and fiduciary duty
- Market economics gives way to politics
  - Patients no longer deployed as cost control battering ram
- Squeeze 4 types of waste and their causes to convert fat into clinical muscle without undermining needed care or caregivers
  - Clinical
  - Paperwork
  - High prices
  - Theft

6. Appropriateness/quality

- More people seek needed care—easy access
  - First-dollar coverage
  - Easy access to PCPs by phone/text/e-mail/visit
- Those seeking unneeded care are discouraged by a PCP they trust (and who's financially neutral)
- Caregivers radically shrink supplier-induced demand to focus on people with real needs
  - All patients covered and all at pay same price

Want, need, demand better aligned



1. Wanted, but not demanded or needed.
2. Wanted and demanded, but not needed.
3. Wanted, needed, and demanded. ***Yes!***
4. Wanted and needed, but not demanded.
5. Needed, but not wanted or demanded.
6. Supplier-induced demand—neither wanted nor needed, but demanded.

7. Climate

a. Homeostasis or anarchy
b. Trust or corrosive suspicion
c. Professionalism, politics, or incentives
d. Medical security