



NEW AMERICA FOUNDATION

HEALTH POLICY PROGRAM

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OUTLINE OF THE NEW AMERICA VISION FOR A 21ST CENTURY HEALTH CARE SYSTEM

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Every day, more Americans find health care and health insurance harder to afford. Our system is complex and debates are confusing, but we *can* improve our entire health system dramatically. Creative providers, payers, employers and politicians are already showing the way. We must improve our health care system's efficiency if it is to serve all Americans, and not just some.

We have three linked problems. They *cannot* be solved with incremental reforms. They *can* be addressed with a bold, integrated approach that is consistent with American values. The cost of inaction is very high. We simply can no longer afford to postpone comprehensive health system reform.

The Problems

- Our problems are: low value for dollar, uneven and low average quality, and inequitable access to care.

- **Low Value for Dollar:** We spend 15% of GDP on health care,¹ 7 percentage points more than the OECD median. We also spend over twice as much per person as the OECD median.² Despite being 1st in spending, the World Health Organization ranks the performance of the US system at 37th overall.³ Our life expectancy, for example, is 24th.

- **Uneven and low average quality:** We have some of the best physicians, nurses, and hospitals in the world, yet Americans get appropriate care in doctor's offices about 55% of the time.⁴ Almost 100,000 Americans die from errors in hospitals each year,⁵ and an additional 40,000-80,000 die from poor quality care throughout our system.⁶

- **Inequitable access to care:** Some don't acknowledge it, but in America today we ration life-sustaining care by income and by insurance status. Since health costs are growing faster than wages, each year health insurance as we know it is getting farther out of reach for more working families. A family insurance policy cost 8% of median family income in 1987; today it is 18%⁷.

Employer-sponsored coverage rates among the near poor (those with incomes between poverty and twice poverty) have declined 7 percentage points since 1987, but remain unchanged for those living at more than 4 times the poverty standard.⁸ The number of uninsured would have risen by 3 million in 2004 had Medicaid enrollment not increased by 2 million.⁹ And Medicaid is straining state and federal budgets, so it can't be the only long run solution. Still, we know the uninsured seek care less often, later in disease progression, in expensive sites of care like public hospital emergency rooms, and they suffer prolonged illness, lost productivity and even premature death because of their lack of insurance.¹⁰

What Won't Work?

- Incremental reforms do not work because they do not impart a sense of urgency to change behaviors, nor do they change our perverse incentives that encourage providers to deliver far more services than add clinical value. Our linked problems exacerbate each other, as poor quality, poor information about clinical value, and uncompensated care all raise costs. High costs retard coverage and access, and poor access makes good quality impossible. The primary driver of health care cost growth in the long run is technology, and we have too few mechanisms to ensure prudent use. It is valuable in general, but many technologies are grossly overused as well.

- While better patient incentives are part of any solution, higher patient cost sharing across the board cannot be the silver bullet some claim. Most spending occurs long after even high deductibles are met. Ten percent of any insured population incurs 70% of total health care costs. Most of this is very intensive care far beyond simple decisions to visit a doctor or have a test or use a generic drug. Increasing cost sharing may help improve incentives in some cases, but the US has long had the highest cost sharing in the world and the highest spending per capita, by far. So higher cost sharing alone cannot be the answer.

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What Will Work?

- So what do we need? Four elements: a **moral** case, to create the political space for a national conversation; an **economic** case, to impart the proper sense of urgency; a **culture of value** in the delivery system, to institutionalize smarter wiser resource allocation; and a **credible policy design** that can attract the support of stakeholders, political leaders, and most importantly, the American people.

- **The moral case:** There are 10,000 technical issues involved with health system reform, but one fundamentally moral question: who shall be allowed to sit at our health care table of plenty? Many scriptural traditions and considerable humanistic philosophy admonish communities to feed the hungry. Food was once the only indispensable commodity, the only thing one human being could give to another to sustain life. Health care has long since joined food as a unique gift, necessary to sustain and enrich lives stricken with certain kinds of illness. The Institute of Medicine recently concluded after an exhaustive review of the scholarly evidence that roughly 20,000 people die each year because they lack access to timely high quality care due to their lack of insurance. Our safety net providers try hard with limited resources but they cannot compensate if patients present too late in disease progression over cost concerns. Therefore to deny health insurance because of cost is tantamount to denying food to the starving poor. Few ethical teachers would approve. At the same time, no community can be expected to starve itself to care for one member; balanced stewardship of health resources is also a central value of moral communities.

- **The economic case:** Employer health costs are growing faster than revenues, and they are forcing wages, profits, and investment down. Thus excess health care costs reduce our standard of living and threaten economic growth and the sustainability of middle class jobs.

- **Culture of value:** America's delivery system can be far more efficient with three innovations. First, an electronic health information system backbone would enable us to monitor and improve the clinical value of what we are buying. Second, smarter incentives for providers and patients can align private interests with more efficient choices. Third, comparing new technologies to existing treatments on a wide range of potential patients can help target current and future technologies toward those patients with the most to gain.

- A **credible policy design** that can attract broad support includes: a mandate for all to enroll in public

programs when eligible or purchase private health insurance when not; organized pools through which private insurance can be purchased efficiently; and shared responsibility for appropriate subsidies for the low income population. The mandated benefit package must be evidence-based and mindful of stewardship constraints, and those who want to must have the liberty to purchase uncovered services on their own. Targeted subsidies to individuals and a delivery system culture of value can help preserve the parts of our employer based insurance that work well and minimize required new public subsidy dollars over time.

How do we move forward?

- It will take skillful and committed leadership to assemble the coalition of the willing that can make this vision come true. The alternative is to live in a land where fewer and fewer of us have adequate access to our health care system over time, and that is the moral and economic imperative that will enable a coalition to grow. This coalition will include those who care most about our moral commitment to access for all, employers who shrink from the unsustainable future they see, governors and state legislators who shrink from the polarized future they see, providers who want to lead the creation of a culture of value, workers who realize they pay for employer contributions out of wages, and together they will embolden national politicians who want to lead our nation to a better future than that foreshadowed by the dynamics of our status quo. We can do better, but we must start doing the right things, this afternoon.

¹ Center for Medicare and Medicaid Services, <http://www.cms.hhs.gov/statistics/nhe/historical/t1.asp>, data cited are for 2003, the most recent year available, downloaded 10/26/05.

² G. Anderson et al. "Health Spending in the United States and the Rest of the Industrialized World," *Health Affairs* 24(4): 903-914 (July/August 2005).

³ World Health Organization, http://www.who.int/whr/2000/en/annex01_en.pdf, and http://www.who.int/whr/2000/en/annex05_en.pdf, downloaded 10/26/05.

⁴ E. McGlynn et al, "The Quality of Care Delivered to Adults in the United States," *New England Journal of Medicine* 348:26 (2003) pp. 35-45.

⁵ Institute of Medicine, *To Err is Human: Building a Safer Health System*, National Academy Press, 2000.

⁶ National Committee for Quality Assurance, *The State of Health Care Quality, 2005*.

⁷ Premium data from KFF/HRET <http://www.kff.org/insurance/7315/sections/upload/7375.pdf>, downloaded 10/26/05, income data from Census, <http://www.census.gov/prod/2005pubs/p60-229.pdf>.

⁸ Center for Studying Health System Change analysis of Current Population Survey data.

⁹ Census, <http://www.census.gov/prod/2005pubs/p60-229.pdf>.

¹⁰ Institute of Medicine, *Care Without Coverage*. National Academy Press, 2002.