

Putting the Public Back into Public Health

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Good morning!

Thank you for inviting me to speak with you. I would like to begin by acknowledging with pleasure my many debts to my colleague Deborah Socolar, a 1988 graduate of the Boston University School of Public Health.

Enough merriment.

Some people are unhappy that so great a share—perhaps 90 percent or more—of the health dollar goes to treating people who are sick, and that so little goes to prevention—especially primary prevention—and to early detection. They want more public, preventive health and less private, curative health.

They might well be right.

But I'd like to discuss another aspect of public involvement in health care—the wholesale abdication of public responsibilities for how the curative health dollar gets spent. The abdication has been in favor of private decisions and especially market decisions.

The only serious problem with this is that there is no free market anywhere in health care—with the possible exception of eyeglasses, retail pharmacy, and generic drugs.

If there's no free market, and no effective government presence, we have only one thing—anarchy, the law of the jungle, a Hobbesian state of nature in which life is indeed mean, nasty, cruel, brutish—and short. Especially if you don't have health insurance.

Anarchy favors the powerful, who expect to profit from the absence of either free market competition or government.

How did the market forces get so powerful? Here are three reasons.

1. Starting in the 1970s, some people hoped that governments would control health care costs. The few government actions to contain costs of health care were usually ineffective—partly because they were so politically compromised from the beginning. We asked government to act in ways that it could not act competently. So it failed. The market looked like the realistic alternative.
2. The free market knocked down the Berlin Wall so many of us thought it could do anything. The appeal of the free market is incredibly strong to almost all Americans. Ask anyone who's ever taken Economics 1a. Anyone here? It's like malaria. Once it gets into your blood, you can't get rid of it, and you'll surely break out into fevers and chills of free market thinking. In case you care, I like the free market as much as anyone in this room.
3. Many powerful people in health care realized that they could blow a smokescreen of free market rhetoric, and make or save lots of money by hiding behind that smoke.

But because nothing close to a functioning free market is present—or, I think—can be present on acceptable terms throughout health care, we can't worship the products of the invisible hand. That would be like worshipping a golden calf.

But that's OK. We can do better, if we bring in government to do the things that government can actually do competently.

Let me quickly illustrate this simple theme in four areas:

- Winning affordable prescription drugs for all Americans.
- Identifying and stabilizing all needed hospitals.
- Financing insurance coverage for all Americans.
- Shaping health care competition we can trust with our lives.

A. WINNING AFFORDABLE PRESCRIPTION DRUGS FOR ALL AMERICANS

The world's researchers and drug makers have used public and private money to develop many wonderful medications. Many of us can testify to the great value of these drugs.

But many of us can also speak to the high cost of these drugs. This problem will get worse as the drug makers market hundreds of costly but potentially valuable new drugs in the years ahead.

What is the value of all the research if we can't afford to buy the drugs that can help us?

The challenge is to

- make all needed medications affordable for all Americans, while
- building a durable financial foundation under drug research and delivery.

We can do both, though not if we continue business as usual. But if we are smart, we can prove that winning affordable medications for all Americans is the easiest problem to solve in our nation.

The problem

70 million Americans now lack drug insurance.

And these are the economy's fat years, to paraphrase what Joseph told Pharaoh.

The industry acknowledges that Americans pay the world's highest prices for most drugs even though we are one-third of the world market. Uninsured citizens pay the most.

Fully 17 percent of all Americans—and 42 percent of uninsured Americans—reported not filling prescriptions for financial reasons,

American prescription drug spending per person this year will be the world's highest, totaling 120 billion dollars.

The drug cost problem will worsen. Drug spending in the U.S. has been rising about three times as fast as overall health spending.

And over 1,000 new biotech and other drugs are reported to be in the pipeline.

Why are medications not affordable?

U.S. prices are high because our government does not protect us from the world's drug makers, letting them charge what they wish. This year, Americans are paying at least 16 billion dollars extra for drugs, a hidden subsidy to the other rich nations. This is the world's least-well-targeted private foreign aid.

The drug makers paralyze government action by claiming

- that today's prices and profits are legitimate products of a free market;
- that high U.S. prices and profits are needed to finance vital research; and
- that any restraint on prices or profits will collapse the drug makers' financial house of cards.

Not so. This decade, the big drug makers' returns on equity were two and one-quarter times the average for all U.S. industries.

Such returns are not justified by a genuine free market. Instead, they derive from anarchy—the anarchy produced by market failure combined with government inaction.

That is why PhRMA, the drug makers' trade association, spreads a fog of fear—PhRMA's Fog of Fear—to try to paralyze government action and preserve pricing power.

If the looming cost and coverage crises intensify, a future Congress—spurred by anger and fear—might legislate harsh price and profit controls, which could gut needed research.

What solutions are possible?

The manufacturers optimistically hope that new drugs will reduce spending. I expect no more than a one-time savings at best. No matter. We must plan against the contingency that costs will actually rise.

By any sound standard, we spend enough to buy all the drugs that all Americans require. So the first challenge is to protect all people without spending more money. The second challenge is to pay the drug makers enough money to protect research.

I. ***Internationally***, we should negotiate a drug peace treaty. All wealthy nations would pay the same fair prices.

II. ***Domestically***, I see only two alternatives. Either:

A. We could fight for years over drug prices, profits, and coverage while people suffer.

OR

B. We could make a package deal including these two pieces:

1. Payors and drug makers negotiate returns on drug makers' equity—returns adequate to finance research and attract capital. Developers of valuable new drugs earn premium profits.
2. In exchange, drug makers produce enough medications to fill all prescriptions doctors write. The increased production would be cheap. That is because drug makers face tiny marginal or incremental costs to make more of most drugs once they cover the high fixed costs for research and setting up manufacturing plants.

In conclusion

Winning affordable drugs in ways that stymie research is dangerous. But developing useful drugs that people can't afford is tragic. And Americans can't keep subsidizing other wealthy nations.

Moderate action and compromise today will protect both American patients and vital research tomorrow. We can do this only through reasonable government action, with government intervening surgically do what it can do well.

B. IDENTIFYING AND STABILIZING ALL NEEDED HOSPITALS

In the beginning, the United States had too few acute care hospitals and beds. In the wake of the Second World War, government feared that a renewed Depression would accompany demobilization, so one of the public works projects it legislated was Hill-Burton to build hospitals. Later, Blue Cross and Medicare's generous cost-reimbursement of hospital capital built more capacity. Then we had too many beds.

Government tried to regulate additional bed-building and equipment-buying through certificate of need, but political support for CoN was understandably limited, and hospitals drove through it like an 18-wheeler through a crepe paper tape.

Then we had even more beds.

Then technology changed and we had CTs, MRI, laparoscopic surgery, and less need for hospital beds.

Some evidence suggested that more beds meant higher cost, and that closing hospitals was the best way to save money. Since closing hospitals was politically unpopular, government could not do it. So some smart people—watch out for them—thought we could get HMOs to compete for patients and that the HMOs would then have to get hospitals to compete for patients as well. So hospitals would have to become more efficient, and the efficient ones would survive. And we'd all be better off.

But the evidence that Debbie Socolar and I have been collecting and analyzing suggests otherwise.

We find new evidence on the dangers of excessive hospital closings and bed reductions. With the population's aging, need for hospital beds is likely to outstrip bed availability by early in the next decade, with a great gap by the year 2025. Massachusetts hospital costs are very high, but hospital and bed closings are not effective remedies for these high costs. To minimize the cost of rebuilding and the dangers of over-crowding and denying care, we urge careful conservation of our state's remaining acute hospital beds.

Specifically,

- Massachusetts has 77 acute hospitals this year, 39.4 percent fewer than in 1970.
- Conservatively, we project a loss of 12 more hospitals by the year 2005. Recession, a lack of payment increases, or lower hospital use by HMOs would close even more.

- The number of acute care beds in Massachusetts fell from 23,966 in 1970 to about 14,599 beds this year, we estimate— a drop of 39.1 percent.
- We project a continued steady decline to roughly 12,000 beds by the year 2005, and then a leveling out. But continued hospital closings would drop the total even lower.
- Inadequacies in current data collection procedures make it difficult even to learn how many acute hospital beds actually operated or available here in a given year.
- Since 1989, this state has fallen below the national average in acute hospital beds per 1,000 citizens— with just 87.5 percent of the average in 1997.
- Hospital spending per resident here was still 36.5 percent above the U.S. average in 1997. Hospital and bed closings have not eliminated the state's excess costs.
- There is almost no recognition that population aging means rising need for hospital capacity. The rise will not be sudden, when baby boomers hit age 65, but gradual— hospital use by Americans aged 45-64 is nearly double that for ages 15-44.
- Using Massachusetts population projections and national age-specific hospital use rates, we project that the bed supply will soon fall substantially below the need. A conservative measure shows shortfalls of 1,650 beds (12%) by the year 2005 and 4,009 beds (25%) in 2025. Under a more adequate use rate, the shortfall would be 3,063 beds (18%) in 2000 and 9,418 beds in 2025 (44%).
- We hope that these huge shortfalls will not actually materialize. We expect some patients will be denied needed services, some hospitals will become crowded (as has occurred recently), and some hospital capacity will be taken out of mothballs.

Government needs to step in in an intelligent way.

This is vital for at least four reasons.

First, many of the wrong hospitals have been closing. There is no free market for hospital care. Decade after decade, efficiency has had no link to hospital survival—except that the more efficient hospitals—the less costly hospitals—have actually been more likely to close. And hospitals with more money in the bank have been more likely to survive. Oops. This is certainly not survival of the fittest. But it might be called survival of the fattest.

Second, the politics are a mess. The hospitals that expect to survive—the hospitals that dominate the Mass. Hospital Association, for example—applaud all this. The faster their competitors close, the faster they will enjoy regional monopolies and the faster they will be able to raise their prices. Just watch. We see regional monopolies already in Fall River – New Bedford, and on Cape Cod. We'll soon have more in Berkshire County, the north shore, and maybe even all of Worcester County.

Price competition is the state's main purported tool for holding down hospital costs. Competition requires competitors. Advocates of hospital closing sometimes forget to hook up all of their free market synapses.

Third, price competition is corrupted in hospital care for another important reason. We are under-using hospital beds even when they are the cheapest alternatives. (You may still want to avoid the hospital whenever possible, but that's another matter that needs to be considered.) Hospitals are forced to under-price for costly days and over-price for recuperative days. Consider the typical OB hospital stay.

When price and cost of care are not even kissing cousins, price competition can't win any of the benefits that it would in a legitimate free market. There's too much static on the wires. Payors buy by price, so they ignore real costs. But real costs are what matter. That's why moving care out of the hospital—out of beds that look so expensive—actually tends to increase spending.

That's because the cheaper beds are likelier to close, and because cutting out the cheaper days saves much less than the price of the substitute care in post-acute, nursing homes, and even many home care settings.

Fourth, as mentioned earlier, we face a looming bed shortage.

What can we do?

First, restoring capacity will be relatively inexpensive if hospitals maintain beds under license and plan for their re-activation. It will be much costlier if it requires extensive rehabilitation to bring delicensed beds up to today's codes— or if closed hospitals or units must be rebuilt, as has been the case with many public schools nationwide. So we need a law to allow mothballing of hospitals and beds.

Second, state government has to decide which hospitals and beds are needed. No one in the state has a clue today.

Third, we need methods to stabilize all needed hospitals. In the short run, this means a revolving trust fund financed by a one-quarter of one percent

assessment on each hospital's revenue. It would be used for technical assistance and cash grants to needed hospitals. In the long run, we have to pay each needed hospital enough money to keep it open as long as it is operated efficiently.

Fourth, this will mean requiring that all hospital prices fairly reflect the real costs of care. This will make it impossible for third party payors to play games with hospitals by ducking their fair shares of hospitals' fixed costs. It means that hospitals will be paid fairly.

Fifth, we desperately need a receivership law for hospitals. This will allow the commissioner of public health or the attorney-general to petition a court to put a hospital in receivership to conserve its assets. This way, communities will not be punished for the mistakes of administrators or trustees.

C. FINANCING INSURANCE COVERAGE FOR ALL AMERICANS

A confession: I consciously chose to work in health care in graduate school early in 1973 because it was clearly the easiest problem to solve. I still think so. Because we have enough money to provide all the care that works to all the people who need it. Housing, education, job training, infrastructure, environment, and everything else you care about probably needs more money to do the job.

Think of it! National health spending this year will be very close to \$1.2 trillion.

And in Massachusetts alone, we are looking at close to \$36 billion in 1999, or roughly \$5,700 for every person this year. This is roughly 30 percent above the national average.

But how to get to health care for all? I'd urge avoiding the more convenient-seeming paths:

- Incremental coverage improvements that add complexity and try to pack more people into tinier and tinier eligibility boxes. People lacking insurance today lack it for a reason. Also, buying new coverage requires new money.
- Employer mandates that seem politically brilliant because they avoid new taxes, but that arouse fierce business resistance. That's mainly because the employers who don't cover everyone fail to do so because they are usually in low-profit-margin industries with lots of workers earning low wages, so insurance mandates mean big rises in costs of doing business and also a tax on jobs—and a regressive one at that. Mandates may improve coverage, but at the price of higher spending. We don't have to pay that price.
- Traditional single payor, financed with a big rise in taxes to replace private insurance and out-of-pocket dollars. Traditional single payor makes great sense because it does save enough wasted administrative and clinical dollars to finance care for all while lowering total spending. But it, too, is a political buzz-saw. First, the dollars involved would equate to a \$644 billion tax increase this year, which would almost double the federal income tax. Sound attractive to you?

There's a powerful asymmetry between pain and gain. The people who'd save money would forget you in a flash, but the people who'd pay more would hate you forever. Recall that we have three times as many bad dreams as happy ones. Recall that President Lincoln said he hated making patronage appointments because, each time, he disappointed nine former friends and ended up with one ingrate.

Instead, how about this:

- Pool all existing public dollars in one reservoir.
- Add to the reservoir all current dollars paid for private insurance. Checks are written to the reservoir. Require employers and employees to maintain 1999 private insurance payments in perpetuity, but in current dollars only. so they lose purchasing power and also become less burdensome to payors each year. This retains today's inequity, but it gradually erodes over the years.
- Over time, compensate for the lost purchasing power of the capped private insurance dollars with an income or payroll tax, against which premiums are a credit, so smaller businesses gradually begin to pay their fair shares—but in a way they can afford.
- Replace some of today's \$200 billion in out-of-pocket payments with new tax dollars as well—perhaps at once and perhaps gradually.

Use the money in the reservoir to finance care for everyone. It's enough. We then get cost control, with health care for all, right away. We then assemble all the money in one place, which is what single payor really means (recall, please, that the Canadians certainly don't have single, unitary, ways of raising the money). And we have much smaller tax increases.

Option: do all this in a few states that are willing to experiment. Congress isn't moving for a while, so why even talk about federal action? A national plan would have to respect the needs of rich and poor states, states with high and low health costs, and states with high and low rates of coverage today. Further, even if Congress did want to do something, it would not know how. We really don't know how to adapt single payor principles in this nation, how to run the program, how to pay hospitals, how to get doctors and other clinicians comfortable, and how to reassure all the patients who'll be told in lots of ads on TV that reform will kill them. So we need to tinker and experiment.

I'm suggesting that the Clintons failed to win health reform in 1993 and 1994 in large part because lots of people became nervous about their proposals because no one really knew how they would work in practice. They'd been designed by smart people without enough practical experience.

In Massachusetts, we estimate that this approach would cut administrative and clinical waste by over \$5 billion. It would use \$1 billion of the savings to cover all uninsured people. It would use \$3 billion of the savings to increase home care, nursing home, prescription drug, and other benefits for people who already have insurance. And it would cut \$1 billion out of health care all together.

Again, we use government to do what the market can't—to cut waste—the financial death by a thousand paper cuts. There would be a little \$3 billion tax cut to win all these benefits. We'd have to work that one out.

D. SHAPING HEALTH CARE COMPETITION WE CAN TRUST WITH OUR LIVES

Today, to contain cost, we have unleashed market forces to get HMOs and hospitals and doctors to compete by price. When financial incentives to underserve corrupt clinical judgment and open up gaping holes in perceived quality and decency of care, we ask government to regulate to bandage up quality.

This is profoundly silly. Price competition has not contained cost and can't be trusted to do so. That's like trying to cut down a tree with a hammer. It's the wrong tool for the job.

And government is equally bad at micromanaging to protect quality. That's like trying to grow a tree with the hammer.

Both will be increasingly discredited by this attempt.

If the bad KGB of old had been asked to redesign health care to undermine Americans' trust in the last institution we still trusted the most, they would have used to market to contain cost and government to protect quality.

We can do better. We can recognize that capitation and competition are important and even, perhaps, indispensable tools—if used reasonably. So is a thin layer of smart public action. Adam Smith recognized that only government can sustain competition. We should act accordingly. Here is a twelve-step plan for state governments:

1. Sponsor new and geographically-focused HMOs organized around-- but not dominated by-- individual hospitals or other networks of caregivers. Seek to restructure existing HMOs along the same lines.
2. Cap HMOs at around 50,000 to 100,000 members, depending on the size of the region. Competition requires competitors, the more the better. The evidence that researchers and HMOs compile about what care is needed by which patients should be viewed as a public good which should be disseminated freely. The managerial, legal, information systems, and financial systems infrastructures needed to run HMOs should also be regarded as public goods. These two steps would radically cut the overhead costs of small HMOs.
3. Require by legislation that all HMOs be operated not-for-profit, making it clear that caregivers will work for patients, not stockholders.
4. Finance each HMO with an annual operating budget for care of its patients.

5. Oblige each HMO to expend that entire budget. Then, the only reason to deny a medical service to any one person is to liberate funds to care for another person in greater need. No HMO makes more money by giving less care.
6. Calculate operating budgets fairly. Pay all HMOs the same price per member, adjusted only for the riskiness (age or other cost-associated qualities) of their members, and perhaps for the cost of doing business in a given region. Then, HMOs could not compete by price.
7. Pay HMOs by a flexible budget. This means paying fixed costs once, only. Recognize volume changes at incremental or variable costs, only. This removes the incentive for wasteful marketing, since an HMO's bottom line is not affected by how many members it has. It instead focuses managers and clinicians on competing by giving needed care efficiently, since tolerating waste in serving one patient necessarily results in denying needed care to another patient. It also stabilizes the finances of HMOs that are losing members—which gives them resources needed to reform and rebuild. This keeps competitors open, which is useful since (again) competition requires competitors.
8. Similarly, HMOs would contract to pay their physicians, hospitals, and other caregivers in financially neutral ways. (Hospitals, for example, could get their own flexible budgets, financed by HMOs in proportion to their shares of a hospital's admissions, adjusted for case mix to prevent gaming.) Then, caregivers would have no financial incentive either to withhold needed care or to give unnecessary services.
9. Under these circumstances, HMOs would compete for members by compassion, competence, and quality—which is the only way left for them to compete, and which is also how we want them to compete. (All organizations do compete, even if they are non-profit. Should they not compete vigorously, they will lose members, and the CEO will be fired. The successor CEO will try harder.)
10. Residents of the state choose which HMO to sign up with. They have choice because HMOs' service areas would overlap appreciably, as those of hospitals do today.
11. Total annual spending on the state's residents is capped by cooperative agreement among payors, not as a by-product of competition in a failing market. (Care for visitors from out-of-state would be financed as it is today. Out-of-state care for residents would be financed much as most large HMOs do today.)

12. As mentioned earlier, all revenue from existing third party payors is pooled in one or more reservoirs, from which money is drawn to pay the HMOs. Each state resident receives a uniform, standard card certifying eligibility.

Together, these twelve steps give us prompt universal coverage, with cost control and with protections for quality. Trustworthy competition protects quality of care. Thin, tough, and flexible layers of government action are designed to preserve competition and contain spending.

So we have looked at four different areas. I conclude that it will be vital to put the public back into public health. What do you think?