

Changing Healthcare, Creating Fairness

A fresh approach to solving America's healthcare problems

By C. Edward Brown, MHA, FACHE

Preface

Healthcare professionals have been among the *least* active of all segments of the American society in proposing new ideas for fixing the nation's broken healthcare system. *That's not right!*

We – the professionals running the American healthcare sector -- possess the intellectual capabilities, education and experience to find new ways the world's most affluent nation might guarantee universal access to affordable healthcare for all its citizens. Yet we have not. America's healthcare professionals have been reticent – even reluctant -- to assume leadership of that herculean task. Instead, leaders among physicians, hospitals, nurses and the other healthcare professions have been stuck in the past, yearning – yes, even lobbying -- for the return of antiquated forms of payment and failed processes for caring for patients.

America's largest organization representing physicians – the American Medical Association (AMA) – has historically opposed broad systemic change to the nation's healthcare system. In the 1960s, for example, it opposed establishment of Medicare and Medicaid. Again in the 1990s, the AMA was vehemently opposed to key elements of the Clinton administration's attempt to move the nation toward universal healthcare. Only in the last two years has the 160-year-old AMA begun to support fundamental, comprehensive change.

It is indeed perplexing. While America's healthcare practitioners have led efforts to develop new technology, new drugs and new procedures for caring for their patients, they have abdicated the job of determining how to make them universally accessible. Instead, they have left that task to Congress, the states, politicians, advocacy organizations and special interests. The result: Derision, dissention, diversions and the absence of any broadly acceptable solutions.

Today, an estimated 47 million Americans are without the means to pay for their healthcare. They are dependent instead on the charity of government, private healthcare organizations and extra charges levied on those who can pay. As a result, healthcare costs have spiraled to unsustainable heights and the physical and financial health of Americans has been put at risk. Quite simply, the lack of an effective national healthcare policy in the U.S. has made American society sick. Yet, those charged with caring for them remain largely uninvolved in seeking comprehensive solutions.

America stands at a crossroad. The market approach that has historically characterized our healthcare delivery system has been diluted and

compromised. Likewise, consolidation among providers and payors has marginalized competition. At the same time, federal and state government have assumed responsibility for the healthcare of America's most at risk populations – seniors, children and the poor. The result: A convoluted system that is neither market-driven nor nationalized. And it simply is not working!

Changing Healthcare, Creating Fairness represents an initial effort to engage America's healthcare professionals in meaningful dialogue aimed at finding real, multi-dimensional solutions for providing care for all Americans. Some of the proposals that follow are controversial. Others are nuggets of thoughts needing refinement. Some will require fundamental reshaping of the nation's business or social structures, and some simply may not be politically viable. All of those shortcomings notwithstanding, they hopefully will spark a dialog. Just maybe they will cause America's healthcare leadership to become engaged in what rightfully is their responsibility. That is my intent.

Let the discussions begin!

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A National Problem with International Implications

Few nations on Earth can claim the same high level of medical technology found in the United States. Neither do many possess the abundance of highly skilled healthcare providers found here. Still, despite the nation's superiority in technology and manpower, public opinion polls demonstrate repeatedly that Americans overwhelmingly believe access to quality healthcare at affordable prices is among the nation's most pressing needs.

There is little question why Americans feel that way. They have, quite simply, lost much of their voice in how they receive their own healthcare.

Beginning in 1964 with Congress' establishment of the Medicare program to care for the nation's seniors, the federal government has assumed an ever-increasing share of the burden of paying for the nation's healthcare. With that responsibility has come an increasing role in determining how, when, where and to whom healthcare is delivered in the U.S. Last summer, for example,

Congress passed a new, much richer version of the State Children's Health Insurance Program (SCHIP) that would more than double the cost of the program, raising it to \$60 billion over the next five years. Many advocates of a taxpayer-funded, government-controlled universal coverage system believe that expansion of SCHIP is an important pillar in reaching their goal. Among those opposing that approach is President George W. Bush who vetoed the legislation within 48 hours of its arrival on his desk.* Like other opponents, Bush believed then and continues to believe the legislation is too expensive and moves the nation too close to federalized healthcare.

SCHIP may be an "important pillar" but it is only the beginning step in the march toward taxpayer funded, government controlled healthcare in the U.S. Expenses for Medicare – the program that began the nation's gallop toward a nationalized healthcare system nearly a half century ago – are expected to increase 7.3 percent annually between 2006 and 2014 – to \$728 billion. Still, despite continuing expansion of the programs covering America's burgeoning senior population and its children, the number of individuals uninsured – by either public or private sources – has reached nearly 47 million, according to the U.S. Bureau of Census.

Why such a contradiction? Why is the federal government spending more and buying less? Because as it has passed its escalating cost on to employers and consumers (Congress voted to pay for SCHIP with a 61 cent per pack increase in the federal cigarette tax), employers have countered by providing scaled back benefits to their employees causing the number of uninsured or underinsured to grow. Those same employees, acting as consumers, have then reduced usage of the more heavily taxed products (i.e., cigarettes), thus decreasing the amount of revenue produced to fund the program causing the tax increase to become regressive.

Policy expert Grace-Marie Turner of the Washington-based Galen Institute spoke to the issue in an August 30, 2007 newsletter. Referencing the Census Bureau's new estimate of the number of uninsured (47 million), Turner wrote: "The most noticeable drop in insurance coverage overall was among those with job-based insurance, down to 59.7 percent. As we argue over and over," Turner wrote, "the policy of tying health insurance to the workplace isn't working for millions of Americans in a mobile, 21st century economy. We need new incentives for people to get health insurance that is portable from job to job and that allows them to make choices among plans that offer more affordable coverage."

Private insurance has offered little relief. State and federal governments today provide 50 to 60 percent of revenue earned by doctors, hospitals and other providers. Its growing dominance has forced mass consolidation and decreased competition among private payors. The result: Commercial insurance generally has followed the standards set forth by the federal government with similar outcomes. As benefits have been expanded and payors have consolidated, usage and costs have soared. At the same time, consolidation within the commercial insurance industry has rendered it essentially non-competitive on a regional basis. Those cycles have become constantly spiraling ones that experts agree threaten not just the health of the nation but its economy as well.

Healthcare Costs Make U.S. Less Competitive

"High healthcare costs are affecting job creation, and high healthcare costs are hurting our ability to compete in global markets," says Larry Burton, executive director of the Business Roundtable. A *Bloomberg News* report

written earlier this summer by Jeff Green cites the impact healthcare costs have on the international automobile market as an example.

Green writes that retiree health benefits add about \$1,000 to the cost of each of General Motors Corp's Silverado pickups. Meanwhile, Toyota Motor Corp, which is expected to overtake GM this year as the world largest automaker, is spared almost all such expenses. The difference: Union contracts and the rich healthcare benefits they grant retirees.

Some would argue that America's "healthcare problem" has international implications. A threatened U. S. economy, they reason, would negatively affect international politics and the tenuous balance of power that global stability hinges upon.

Only the Beginning?

The international implications of the rising cost of healthcare in the U.S. may be only the beginning of the nation's economic ills. Many experts believe failure to control healthcare costs will result in the nation facing broader and more immediate consequences. They contend that healthcare costs are, quite simply, devouring our nation's economy. They cite the fact that total healthcare spending consumed only about eight percent of the U.S. economy in 1975 but today accounts for 16 percent of the nation's Gross Domestic Product (GDP).

Beyond the present, healthcare's share of the economy is projected to reach nearly 20 percent of the GDP by 2016 and continue to rise until it reaches 25 percent near mid-century. Some 50 percent of that amount is publicly financed, and that share of the expenditure will certainly rise as the

nation ages and is forced to face the long-term implications of pervasive chronic conditions such as obesity.

Drs. Peter R. Orszag and Philip Ellis of the Congressional Budget Office (CBO), which provides budgetary and economic analyses to Congress, wrote in the November 1, 2007 edition of the prestigious *New England Journal of Medicine* that “The long term fiscal condition of the United States has been largely misdiagnosed. Despite all the attention paid to demographic challenges, such as the coming retirement of the baby-boom generation, our country’s financial health will, in fact, be determined primarily by the growth rate of per capita healthcare costs.

“Yet, discussions of Medicare and Medicaid policy as well as broader healthcare reforms, have not seriously addressed the issue of how to slow growth in spending.” Instead, Orszag and Ellis contend, “Recent debates have focused on how much to increase spending for the Medicare prescription drug benefit, how to expand coverage for children, and how to avoid scheduled cuts in Medicare physician fees.”

Clearly, there is a monumental problem. America’s healthcare expenditures are trending toward 25 percent of the GDP a figure that is unsustainable for a service industry that manufactures no sustainable goods, and still leaves many Americans uninsured. Those two statistics alone demonstrate that America’s healthcare system is both ineffective and too expensive. Together, they present a national crisis that threatens America’s social and economic structures. It must be fixed and fixed soon.

Not for Lack of Trying

That such a problem continues to plague our nation well into the 21st century is, in itself, puzzling. The United States was built on resourcefulness. Give its people a problem, they will solve it. Indeed it was resourcefulness that founded the U.S. and resourcefulness has served it well during world wars, economic depressions, multitudes of natural disaster, and a threat to its financial system spawned by the September 11, 2001 attacks. It is a paradox then, that with all that resourcefulness, the U.S. has been unable to find a meaningful solution to its healthcare issues that is equally fair to patients, providers, insurers and the employers who ultimately pay the bills.

Certainly, it is not for lack of trying. Millions, perhaps billions, of dollars have been spent seeking a solution equally as permeating as the problem. Academics have tried, providers have tried, politicians have tried and so have the policy experts who guide them. Free market experts have touted their solutions, as have those who advocate nationalizing healthcare.

Since the national elections of 1996, healthcare reform has been a key issue in the campaigns of those seeking our nation's highest office. Every four years, Presidential candidates of both major parties have offered a variety of ideas. But each has failed to mold them into a comprehensive program or achieve the level of consensus necessary to successfully affect systemic change.

The infamous Clinton Health Plan proffered by President Bill Clinton early in his first term offered an opportunity for meaningful change in how Americans receive and pay for their healthcare. Inclusiveness and preventive care were at its vortex, and providers would be rewarded for efficiency and effectiveness. However, the Clinton Plan was conceived in secret and lacked sufficient vetting to win stakeholder confidence and support. It was, as they

say in Washington, “Dead on Arrival.” As a result, valuable momentum toward reform was lost and it would be more than a decade before it could be regained.

Like the Clinton Plan, other proposals have shown promise but have been unable to muster the political strength nationally to sustain viability. Others were tried and withdrawn because while they were beneficial to one segment of the healthcare marketplace, another perceived them as harmful.

As interest in healthcare policy has increased among the general population, fragmented solutions have been proffered to gain political favor. Almost daily, we see television images of presidential candidates presenting their version of systemic healthcare reform. Most assure coverage and portability for all Americans, and many offer creative new ways of paying for it. The question then is, do the candidates or the American people, for that matter, possess the political will to actually implement such change?

And what of the American people...the consumers....the patients? Those same people who respond to public opinion surveys by saying that draconian change must come and come soon? Well, they do want change, to be sure but they are steadfast in wanting assurance they will continue to receive what they have come to expect - indeed demand: The best healthcare available provided when they want it, where they want it, how they want it and paid for by someone else.

Michele Mekel, an attorney with a master’s in health administration and a visiting professor at Drake University Law School, Des Moines, IA, summarized the situation well in an op-ed piece written September 2, 2007 for the *Des Moines Register*. Mekel wrote: “...We must accept that we cannot have it all –universal coverage, near-perfect quality, near-absolute freedom of choice and near-immediate access to the full continuum of care options, from

preventative and primary care to the latest-and-greatest high-tech interventions – and have it all for nearly nothing.

“There will be tradeoffs, and there will be costs. Are we as a people, ready, willing and able to accept them?” Mekel wrote.

Four Legged Conundrum

Healthcare as an industry is unique among the components of the American free enterprise system. When a loaf of bread or an automobile are exchanged in the U.S., the buyer – who, generally, is also the consumer -- and the seller come together, agree on terms, and the commodity or service is exchanged. That is not the case with healthcare.

Since the advent of Medicare, the *patient/consumer* has been separated from the *provider/seller* by the insurance industry or -- in the case of Medicare, Medicaid and other government-sponsored programs -- the government. The sponsoring, *taxpaying employer* also has a voice in what care his *employee/patient/consumer* will receive and at what price.

The patient has been largely removed from this important social contract and that removal has fostered a lessening of individual responsibility for using healthcare resources judiciously.

That kind of disenfranchisement must not continue. In the final analysis, the only participants who can make the nation’s healthcare system both more efficient and more effective are the patients and the providers who care for them.

That is not to say that patients/consumers are solely – or even primarily – responsible for the economic conditions surrounding healthcare today. They simply are not. Neither should we belittle positive efforts to restore individuals’

ownership in the quality of their own health by increasing out-of-pocket expense or providing wellness initiatives. But limiting patient involvement to deductibles and co-pays illustrates why solutions focusing only on a free market approach are not viable. Likewise, it is why healthcare as a *traditional* government sponsored enterprise is not affordable.

Any meaningful solution to America's healthcare puzzle must restore patient responsibility, remove financial liability from employers and assure that providers, insurance companies and patients all remain financially secure. A tall order indeed and one that can be achieved only through greater patient involvement and education.

Mekel, in her op-ed piece, demonstrated a grasp of the comprehensiveness of the problem writing, "That despite the fact that some people point to the health-care systems of Canada, various European nations and even Cuba as commendable models, we must acknowledge that there is no one-size-fits all solution that we can carte blanche apply to magically cure all that ails our system. Instead, we must appreciate, in the process of creating a new health system (or, more likely, redesigning the existing one), those core values and characteristics that make America uniquely American – rugged individualism, self-reliance, personal freedoms and individual liberties, diversity, tax aversion and capitalism with minimal-to-moderate governmental intervention."

Even the labor movement, which over the past half-century has fostered the concept of healthcare insurance as an employer obligation, is calling for major structural change.

Recent contracts covering retirees of the nation's automobile makers have shifted responsibility for providing health insurance from the Big Three

automakers (Ford, Chrysler and General Motors) to a trust fund the automakers would establish to be administered by their union, the United Auto Workers (UAW). In so doing, the automakers have effectively abdicated responsibility to assure their workers' good health and have ceded that responsibility to their union. The result: The automakers have surrendered their seat at the healthcare table to the unions, thus taking away one free enterprise vote and strengthening a reliable single payor voice.

One of the nation's strongest union leaders, Andrew Stern, president of the Service Employees International Union (SEIU) told a Senate hearing in summer 2007 "It's time to recognize that employer-based (healthcare) coverage is dead." Stern instead believes the federal government should become much more active in funding healthcare.

Several key Senators stand ready to oblige Stern. In his first week as chairman of the Senate's Health, Education, Labor and Pensions Committee, Massachusetts Democrat Sen. Edward Kennedy, for one, began pushing for extension of Medicare to cover all Americans. Likewise, Senate Finance Committee Chairman Max Baucus of Montana began a series of five hearings on "Moving toward Universal Coverage" by saying "I believe healthcare should be a right and I believe America is big enough and rich enough to guarantee that right.

By the time the early 2008 presidential campaigns began, all candidates had proposed some form of universal healthcare and most – even Republicans – were calling for their own hybrid form of single payor system.

And What About Providers?

The healthcare industry itself has been disgracefully reluctant to embrace change, fighting instead for the more profitable status quo, or the even more traditional practices of the past. As a consequence, providers -- physicians and hospitals, in particular -- have been largely disenfranchised and have lost their voice in the debate. And, they have paid dearly for their reluctance to engage change.

Compensation increases for most medical specialties in 2006 did not keep up with inflation, according to a recent Medical Group Management Association (MGMA) survey of 2,334 medical practices representing some 52,000 physicians. While the Consumer Price Index (CPI) saw a 3.2 percent increase in 2006, primary care physicians saw their median compensation grow by only 2.03 percent to \$171,519. For specialists, median compensation rose 1.78 percent to \$322,259.

Similarly, another study notes that doctors are generating less revenue for the hospitals where they practice. "Physicians generate an average of nearly \$1.5 million in net revenue each year for the affiliated hospitals," the report notes. "That figure has dropped significantly in recent years as a result of increased competition. Of the 17 physician specialties examined, full-time invasive cardiologists topped the moneymaking doctors with an average of about \$2.7 million in net revenue for their hospitals," according to a survey by Irving, Texas-based Merritt, Hawkins and Associates. "Other big earners (for hospitals) included orthopedic surgeons, about \$2.3 million a year; noninvasive cardiologists, about \$2.2 million, and neurosurgeons, about \$2.1 million."

The average figures for all specialists was about \$100,000 lower than in a similar survey done in 2002, and approximately \$360,000 below the total in

2004. The overall decline, the survey surmises, is attributable to “increased competition from surgery centers and specialty hospitals,” which the physicians themselves have opened to offset declining practice revenues stemming from lower payor reimbursement. The efficiency of physician-owned specialty facilities is well-established. However, the potential exists for inappropriate utilization unless those centers are monitored closely by regulators.

While physician incomes still achieve levels that average Americans can only dream of, they have declined substantially the past decade. That decline, many experts agree, now threatens the nation’s supply of doctors and with it, Americans access to quality healthcare.

A Utilities Approach

The question then is not whether America should continue down the road toward a government-run health system or revert to the strong market place system of the past. There is no choice. The forward momentum of the rush toward a government funded single payor system cannot be stopped, nor will it permit a reversal of course allowing a greater focus on marketplace solutions.

America cannot rely solely on either. The nation simply has become too dependent on federal health programs to ever again function without them. Likewise, what remains of the marketplace approach to healthcare is too meager to ever again become the dominant approach.

While many of our nation’s political conservatives decry the rush toward a federally based single payor system, lobbying instead for a return to a pure

market approach, they fail to recognize that massive federal involvement in our healthcare system is inevitable in either case.

Recommitment to a more pure version of the free enterprise system in healthcare would require a massive “undoing” of the current system’s structures. Massive consolidation in the provider and payor communities, for example, has been the hallmark of the past two decades. Re-emergence of a market-based healthcare system would require “deconsolidation” in order to re-establish a competitive marketplace. Likewise, the private sector would have to assume government’s role as an insurer. Thus, even a return to a market-based system of healthcare would be achievable only through massive government intervention.

The inevitability of inclusion of the federal government as a major player in America’s healthcare system offers our nation a unique opportunity to retain the best of both the market place and government controlled approaches while eliminating the worst features of each, thus shaping them into a coordinated comprehensive healthcare approach.

So, what is the best vehicle for movement toward a more consolidated payment system that is more comprehensive in its coverage? Congressional Democrats and some leading Republicans believe it is SCHIP. Others believe expansion of Medicare offers a more viable means of moving toward a single payor. The Galen Institute’s Turner reminds us that in any state-controlled system, “Individual responsibility in using healthcare resources most efficiently is replaced by rationing by the state.”

The term “rationing”, as used by Turner, represents another challenge to meaningful reform. “Rationing” has become a red flag – a red herring, for that matter – thrown around by those who would demagogue the issue and

intended to mobilize the public against change and particularly movement toward a single payor system.

The Utilities Approach would incentivize, rather than diminish, personal responsibility by allowing subscribers to earn additional benefits (say fitness center memberships or discounted premiums) for achieving personal health goals.

Rationing would unquestionably occur under the Utilities Approach, as well it should. If – as we suggest – healthcare is a national resource and should be treated as such, then it must be dispensed carefully and in a manner that meets the greatest needs. That concept calls for rationing at some level and to some extent. However, under the Utility Plan, much of the rationing would routinely be limited to high-end elective procedures, and would consist mostly of delays of service, due to the evaluation of medical necessity, not deprivation. One alternative being put forward is to allow patients wishing to avoid such rationing to do so by submitting to higher deductibles and co-pays for high-end procedures.

Rather than expansion of any existing federal program, healthcare in the United States must be structured and managed in ways similar to those used to manage our nation's utilities and the natural resources that feed them.

Utilities in the U.S. are regulated and consumers' interests protected through federal policies established by Congress and administered by agencies such as the U.S. Department of Energy, the Federal Energy Regulatory Commission, the Federal Communications Commission and the National Association of Regulatory Utility Commissioners. Combined, they set and administer national policy for the generation and distribution of natural gas,

electricity and telecommunications in the U.S., along with the research associated with those industries.

However, it is the responsibility of the states to ensure that reasonably priced, reliable and safe utility services are available to support the public as well as foster economic growth and opportunity. In Iowa, for example, it is the Iowa Utilities Board, whose members are selected from the public, that assures:

- *Consumers receive the best value in utility services;*
- *Utilities receive an opportunity to earn a fair return on their investment;*
- *Services are provided in a safe, reliable and environmentally conscious manner;*
- *Economic growth is supported by utility services adequate to meet consumer demand;*
- *Competitive markets develop where effective, and*
- *All market participants receive fair treatment.*

A healthcare system patterned after the Utilities Approach must guarantee patients access to quality care at reasonable cost while retaining the right to choose their doctors and hospitals. Doctors, hospitals and delivery systems of healthcare must be assured a fair income that offers an equitable return on their educational, financial and physical investments. Government must be assured resources are distributed appropriately and used frugally by consumers. And payors, released from the role of bearing risk, must develop better ways of

measuring the quality and efficiency of medical care, and focus on distribution of coverage.

Core Features of the Utilities Approach

The success in any planning process is dependent upon it having comprehensive detail and consistent implementation. The “devil” is, as they say, in the detail. At this point in its development, we freely acknowledge that the Utilities Approach lacks both detail and the processes for implementation. That is not the intent of this paper. Rather, our intent, as stated in the *Preface*, is to provide a skeletal structure and motivate our colleagues to join us in filling it out. With that in mind, the core features of the Utilities Approach include:

- *Establishing a new single-payor or limited-payor (similar to that provided federal employees), universal approach to healthcare in the U.S. to be funded by the federal taxes and fees but operated privately;*
- *Providing basic coverage for all Americans;*
- *An income based means testing would be applied to establish fees for coverage within the basic plan.*
- *A portion of the current employer based healthcare contributions would be rolled into employee income and employers would be given a tax credit based upon this contribution.*
- *Enabling subscribers to “buy up” at their own cost to a series of plans with increasingly improved benefits;*
- *Assuring portability regardless of changes of employment or geographic location;*
- *Controlling cost through regional and national councils charged with implementing policies relating to costs, utilization management, provider fees, facilities development, technology acquisition, education and manpower;*

- *Retrofitting private insurers to function as non-risk bearing enterprises charged with claims management, quality enhancement and assurance, value assessment, and administration;*
- *Utilizing Electronic Health Record featuring consistent technology standards in order to promote high quality and safe medical care;*
- *Enhancing transparency within the clinical care system;*
- *Promoting integrated delivery systems that better coordinate patient care;*
- *Incentivizing both patients and physicians for achieving prescribed wellness standards;*
- *Incorporating evidenced-based medicine, including chronic care management, through the use of clinical pathways, into providers' practices, and*
- *Establishing a subscriber funded, federally managed liability pool for patients wrongfully harmed and who have been awarded damages through the judicial system.*

National and Regional Resource Management

The key to equity and effectiveness of a government funded, single payor system lies not in the source of funds but in the processes employed to spend them. The Utilities Approach would, for the first time in our nation's history, place authorization authority for medical manpower, facilities, equipment, payment rates, fees, and programs in a national coordinating council that would function much as utilities boards do. It would measure, on a national scale, existing regional resources, and limit the development of new healthcare services and facilities to communities where the need is demonstrable. It also would balance medical manpower training and education with geographic and disciplinary needs, and provider fees would be weighed against local economies

and limit increases to pre-established percentages of the regional cost of living indices.

Such a national coordinating council would consolidate the jurisdictions of various federal and state regulatory bodies and claim authority currently vested in the U.S. Department of Justice and CMS as well as assume the states' Medicaid and Certificate of Need responsibilities.

Most importantly, the national coordinating council would be charged with designing a comprehensive, Medicare-like basic health program covering all U.S. citizens. In addition to the basic plan, subscribers would be able to buy into one of a series of upgraded plans for additional geographic and risk balanced fees set by the council.

Physician selection under the Utilities Approach would be left with the subscribers/patients who would be free to select a primary care physician from among the participating panel, much as they have the past 25 years through Preferred Provider Organizations (PPOs).

Recommendations to the national coordinating council would be made upward through a network of state and regional (multi-state) councils formed of individuals with experience and expertise in all aspects of healthcare delivery and payments. Regional council responsibilities would mirror those of the national council but function on a geographically smaller scale, just as state utilities boards do. Assessment of local needs and requirements would be conducted by local people using local criteria to determine the needs of their communities and states, then applied to national standards and resource availability.

Obviously, the composition and functionality of the regional and national councils will be critical to the success of the Utilities Approach. Healthcare

under the plan should function much like a Government Sponsored Enterprise (GSE). Although it would be funded by the government, it would be managed and operated privately.

The non-partisan councils would be formed upwardly in a grass-roots fashion – similar to those governing our Federal Reserve System - with the national council consisting of representatives from the various regional councils. The national council, in turn, would select future members of the regional councils for rotating terms consisting of a fixed number of years – regardless of which political party has control of Congress or the White House.

A Building Boom!

In addition to providing universal healthcare insurance, the utility approach to managing healthcare would also control run away development of facilities in the healthcare industry. Construction of new medical facilities in the U.S. has reached near epidemic proportions, making it **the** major factor in cost escalation. The National Healthcare Expenditure, as reported by CMS, shows a 42 percent increase on total expenditures for healthcare facilities and equipment in just eight years – increasing from \$45,817 billion in 1997 to \$79,672 billion in 2005.

In order to manage healthcare costs and direct assets where they are most needed, capital development in the healthcare industry must be managed in a way that reflects the public interest, rather than the interests of individual providers and organizations.

Capital planning is not a new idea. There was a time when governments did require applications for new facilities and services to undergo rigorous state

and regional reviews. But with the mid-eighties and the shift of Medicare from cost-based reimbursement to a Prospective Payment System (PPS), the planning process was discarded as an antiquated relic. Since then, facility costs have skyrocketed.

But it is not simply the capital cost of facilities that has ballooned. So too has their use. A fundamental rule of marketing states that the greater the points of distribution of a product or a service, the larger the volume that will be distributed.

Nowhere in the healthcare community is that principle more evident than in the field of imaging technology. Between 2001 and 2006, the number of freestanding imaging centers in the U.S. grew from 4,159 to 6,037, according to MedPac, Congress' advisory panel on Medicare. During that same period, Medicare's imaging costs have increased 16 percent compared to a 9.6 percent increase for all physician services. Similarly, MedPac reports six percent more cardiac surgeries and nine percent more bypasses occur in markets with freestanding specialty hospitals than in those with none.

The proliferation of freestanding outpatient specialty facilities corresponds with government's withdrawal from oversight of capital expenditures. In 1987, 49 states required Certificates of Need or other regulatory approval processes before new or replacement facilities could be built. Today, only 37 states have such statutes and many of those that do exist have been diluted to the point of uselessness.

The financial impact of unregulated capital expenditures on the cost of healthcare can be seen in a 2002 study by Dr. Bruce Wellman of the Carle Clinic in Urbana, IL. Wellman's research shows that even though little more than 12 percent of the nation's population is over age 65, the U.S. spends 13

percent of its Gross Domestic Product (GDP) caring for them. In highly regulated Sweden, on the other hand, nearly 18 percent of the population is 65-plus but only eight percent of its GDP is required to care for them.

Without new approaches to healthcare management, the imminent retirement of America's baby boom generation will further skew and exacerbate the disparity between resources used and population covered.

The Role of Medicare

Since its inception, the role of Medicare and its administrative agency, The Centers for Medicare and Medicaid Services (CMS), has steadily migrated from management of payments for healthcare received by seniors and the medically indigent to effectively establish what U.S. health policy becomes.

As the nation's major healthcare payor, Medicare payment policies routinely dictate the payment practices followed by the commercial insurance industry. If Medicare refuses to pay for mammograms for women under 50 years of age, for example, so too will private payors. It is a role for which the agency is ill-equipped and one too greatly influenced by Congress' lack of expertise in healthcare and its desire to cap healthcare costs and its always present political considerations.

The role of CMS has effectively become one of determining what care will be available to Americans, rather than what will be paid for that care. It is a role that leaps far beyond the intent of enabling legislation, one that is too easily influenced by key individuals in Congress, and one that the agency is ill-equipped to provide. A more independent agency or board with a strong citizen voice, widespread provider participation, and the authority to establish

comprehensive healthcare policy, rather than shaping it through payment practices, should conduct such policy functions, and would under the Utility Approach, manage the nation's healthcare resources.

The Role of Payors

Commercial health insurance in the U.S. has become consolidated to the point of effectively eliminating competition. A decade ago, hundreds of mostly local companies were providing health insurance to their communities. Their mission was to assure care for the people of their towns and villages. Today, only 22 regional BlueCross® BlueShield® plans remain. The balance, along with other small insurers, have been merged, purged or financially driven from existence by the likes of United Healthcare, Anthem or WellPoint. Their mission, by contrast, is to make money.

With that consolidation, the health insurance industry has gained enormous power over providers and the patients they serve. Today, decisions about medical care are influenced significantly by standards imposed on providers by insurers. A new, single payor system – or even a federally managed limited payor system – will drastically reduce the financial risks borne by insurance companies. With their risk reduced, insurance companies will no longer have a need to manage their subscribers' care. Instead, that function can be returned where it belongs – to the subscribers' physicians and other providers functioning within pre-established guidelines set by regional councils.

Limitation of risk will also minimize the need for payors to accumulate huge financial reserves required to protect them from subscribers' routine and catastrophic claims. As consolidation has occurred health insurers' reserves

have grown astronomically. Those excess reserves represent funds taken from the health system that are no longer available to pay for care for those who need it.

The role of payors under the Utilities Approach would no longer include policy direction. Rather, it would be limited to risk management, oversight and administration, much as it is today in instances when payors function only as third party administrators while other entities bear risk. The role of telling providers when and what treatments can be given to their patients must be shifted to those with more knowledge of the medical implications and less financial interest. Most importantly, providing administrative management of health insurance to Americans must no longer be viewed as an enterprise that needs to produce investor profits.

Assuring Safety & Assessing Liability

Improving patient safety and retaining patients' rights to recover damages when medical errors do occur must be at the core of any acceptable health reform plan. However, we must recognize the role both have played in the escalation of costs. An overly aggressive trial bar, outrageous jury awards, practitioners' insistence on practicing their "own wrong way" and their hesitancy to embrace evidence-based medicine and proven best practices have resulted in both astronomical malpractice judgments and costly defensive medicine. The Utilities Approach would include processes, which would preserve patients' rights while reducing errors along with their medical and legal cost.

A physician and hospital payment plan that incentivizes utilization of broadly accepted evidence-based medicine will reduce medical errors

throughout the system. Likewise, implementation of a modest fee paid by subscribers to the system would create a risk pool adequate to pay adjudicated damages awarded through our existing judicial system. Cost saving from such processes would come from elimination of astronomical medical liability insurance premiums and the reduction of medical and legal costs associated with medical errors.

The Delivery System

Systemic change in how we establish policy and administer and pay for healthcare delivery must not overshadow the importance of the healthcare delivery system itself. A highly integrated delivery system featuring coordinated care across a broad spectrum of services is at the heart of successful healthcare reform. Key to an improved delivery system through the Utility Approach is the acceptance and use of best practices recorded in a commonly structured and universally portable electronic medical record (EMR).

Americans must no longer be subjected to substandard care delivered in the absence of information. Likewise, they should not be expected to re-create their medical and personal data with each visit to a new provider, nor should their health and safety be at risk because a medical record is not immediately available to those who provide them care.

Numerous studies have demonstrated that high quality coordinated care can best be provided by integrated medical groups (IMGs) that employ sophisticated electronic medical records. "Because physician groups are composed of the actual providers of care, they are better situated to improve the quality of care for their patients," according to the American College of Physicians.

The superior care provided by IMGs was documented last year by the College in a study that it subsequently published in *Annals of Internal Medicine*. That study (*Annals of Internal Medicine* 2006; 145:826-833) concludes that “Patients cared for in IMGs generally received higher quality primary care than those cared for by independent physicians. Having an EMR and the implementation of quality improvement strategies did not explain the differences in quality. These findings suggest that physician group type influence health care quality.”

Caring for Chronic Disease & Other Exceptional Care

Caring for chronic diseases such as diabetes and chronic obstructive pulmonary disease (COPD) consumes a disproportionately high amount of America’s healthcare resources. Similarly, it is the patients suffering from chronic disease who most frequently find themselves without adequate health insurance.

Under the Utility Approach, chronic disease and other exceptionally expensive care such as transplants and experimental care would be “carved out” of the payment system in order to assure they receive more intensive clinical care and coordination

At What Cost?

Public programs such as Medicare, Medicaid and SCHIP today account for approximately one-half of the nation’s \$2 trillion in annual healthcare expenditures and cover about one-third of the U.S population, according to the Galen Institute. Recently passed legislation would increase that amount by

adding \$35 billion to SCHIP*. Add to that \$210 billion in tax subsidies paid to employers as incentives to provide insurance for their employees and the total reaches an amount adequate to create a reserve pool that can be used to underwrite a government financed, but privately operated single payor system.

Additional revenue would be obtained by allowing subscribers to buy up to better coverage at their own expense, as well as applying means testing to determine who is eligible for core benefits.

Providing health insurance for the nation's 47 million uninsured or under insured will require re-establishing national priorities and spending our healthcare dollars more effectively and efficiently. With those tasks accomplished, additional funding will not be necessary.

Achieving Change

Large-scale change in the American healthcare system has not occurred since the establishment of Medicare more than four decades ago, and the federal government and the states have been unable to achieve the changes necessary to keep it current. Neither has the industry itself or the payors who support it. Change in a democracy such as ours requires a broad level of consensus and that, most often, comes excruciatingly slow. All perspectives must be heard, weighed, evaluated and a common acceptable position identified and agreed to. Systemic changes such as those proposed here that create fundamental improvement in our society are even more difficult.

Development of a Utility Approach to healthcare will require vision, leadership and commitment. It must begin with America's grassroots, backed by committed leadership from federal, state and local governments and industry

stakeholders. Only after it is drawn through a participatory process, thoroughly vetted, and backed by leadership from all relevant sectors of our society should it be debated in the halls of Congress. It must not be allowed to become a solely political process. Policy cannot again succumb to politics.

While the healthcare industry's performance has to date been largely lackluster in finding solutions to the nation's healthcare needs, a few provider organizations have produced commendable work endorsing proposals similar to those included in the Utilities Approach. Notable among them is the internationally acclaimed Mayo Clinic in Rochester, MN. Last year, Mayo released a 250-page report compiled over two years by more than 400 national thought leaders, policy analysts and other experts. That report calls for a structure similar to the nation's Federal Reserve System. Its core recommendations include development of consensus-driven principles to guide the reform process.

Like this effort, the Mayo report encourages providers, academics, medical industry leaders, business people, insurers, political leaders and patient advocates to come together to focus on universal insurance coverage, coordinated care, value, portability and payment reform. More specifically, it recommends:

- *Providing health insurance and access to basic healthcare for all Americans -- regardless of their ability to pay.*
- *Coordinating patient care services across people, functions, activities, sites and time in order to increase value. Patients must be active participants in this process.*
- *Increasing quality and patient satisfaction. Decrease medical errors, costs and waste.*
- *Changing the way providers are paid in order to improve health and minimize waste.*

There are significant differences between Mayo's *Federal Reserve Approach* and our *Utilities Approach*. The Mayo plan, for example, fails to address the systemic changes and massive consolidation required to effectively change how healthcare in the U.S. is managed. Likewise, it fails to substantively change the roles within the system – and therefore the influence – of payors.

But there are striking similarities between the two approaches (Mayo's *Federal Reserve* and our *Utility Approach*) as well. Both would remove healthcare from our nation's political and economic processes and return it to the social sector of society where it belongs. Likewise, both understand that such systemic changes can be made only through a broad-based consensual process led by the provider community but including all stakeholders.

Others promoting change suggest different approaches. The Heritage Foundation, a Washington, DC – based conservative think tank, for example, favors more individual incentives to bolster a free enterprise approach to change. Health Savings Accounts and Association Health Plans are at the core of The Heritage Foundation recommendations to make American healthcare less employer-based and more individual-based while avoiding a government-sponsored and financed single payor system.

Individuals and organizations representing a wide variety of approaches concur that radical, systemic change is necessary and that all Americans must have ready access to healthcare that is individually-based, rather than employer-based, and thus highly portable.

There is little choice. The rate of growth of healthcare as a percentage of the nation's GDP is simply unsustainable and threatens the very foundation

of our nation's economy. Likewise, the existence of 47 million uninsured Americans creates a societal class system that is contrary to the principles of American democracy.

So great is the healthcare problem that leaders in society and business who generally represent opposite ends of the opinion spectrum are in agreement on the need for drastic changes. Wal-Mart Stores, Inc.'s CEO H. Lee Scott and the SEIU's Andy Stern, for example, have been locked in battle over unionization of the giant retailer's employees for a decade. Yet they were able to share the stage earlier this year at a Washington, DC news conference during which both called for systemic change focused on shifting the emphasis away from employer-based healthcare plans.

With such problems come opportunities. As opponents unite, new and creative approaches and a climate for their acceptance will emerge. In the words of former U.S. Senate Majority Leader Howard Baker, who also served as chief-of-staff to President Ronald Reagan, "Things get done when their time comes. This is the time for healthcare reform."

However, proponents of change universally believe that in order to "get things done" we must engage the previously unengaged healthcare industry and encourage it to put its house in order. Facilitating such change is the purpose of this paper because only by doing so can we restore America's confidence in its healthcare system's ability to keep its citizens healthy and safe in an affordable and accessible manner.

So, let the discussions begin!

*President Bush vetoed the SCHIP legislation on October 3, 2007. A measure to override the veto was defeated on October 18, 2007. Efforts by Congressional Democrats and other supporters of the legislation to pass altered SCHIP legislation had not been successful of year's end. SCHIP funding will continue at its present level through September 30, 2008 as a result of passage of the Omnibus Reconciliation Act of 2007 passed by Congress and signed by the President just prior to the end of 2007.

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