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PROVIDING QUALITY HEALTH CARE FOR EVERYONE: THE OPTIONS FOR CHANGE

Today's principal health care concerns include the unsustainable rise in health care costs, the plight of the uninsured and the quality of the care being provided. These issues are interrelated. For example, escalating health care costs must be controlled if universal health care coverage is to become a reality. This article explores the options for controlling costs while providing quality care for everyone.

BY DR. PEARL M. KAMER,
LIA Chief Economist

The Dimensions of the Problem

The United States currently spends an estimated $2.3 trillion annually on health care. This is equivalent to more than 16 percent of the nation's $14 trillion economy. On average, health care spending has been rising 2.5 percent faster than the nation's gross domestic product (GDP) since 1970. U.S. health care spending is expected to double to $4.1 trillion and consume 20 percent of the nation's GDP by 2016. Knowledge generated by the human genome project and individualized patient treatments are expected to accelerate rather than slow the rise in medical spending.

Employer-based health insurance still provides care for much of the nation's population but the premiums associated with these plans have been rising faster than wages and faster than consumer inflation. Such premiums increased 87 percent since 2000 while wages increased by only 20 percent and the consumer inflation rate was 18 percent. The gap between health insurance premiums, wages and inflation shows no signs of narrowing. In 2007, the cost of health insurance premiums paid by workers and their employers increased by 6.1 percent, significantly faster than wage growth, 3.7 percent, or inflation, 2.6 percent. The average 2007 premium for family coverage was $12,106, of which the worker's share was about $3,281.

Although employer-based health insurance still accounts for a significant chunk of the health insurance market, the type of health care insurance offered by employers has begun to change. Although nearly all companies with 50 or more employees still offer traditional health care coverage, many have converted to consumer-driven health insurance plans linked to health reimbursement accounts or health savings accounts or to cost sharing plans with in-network and out-of-network deductibles. These plans have relatively low premiums but high deductibles and co-payments. Consumer-driven plans are particularly suited to small businesses. The LIA Health Alliance offers a full menu of both consumer-driven plans and cost sharing plans.

In the future, the federal government is expected to shoulder more of the financial burden for the nation's health care. This is already happening. A recent government study found that Medicare spending increased by almost 19 percent in 2006, its fastest pace of growth since 1981. By 2016, the government will be paying almost 49 percent of the nation's health-care bill, up from 38 percent in 1970 and 40 percent in 1990. The Congressional Budget Office projects that if current trends continue, spending on Medicare and Medicaid alone will account for almost 25 percent of the federal budget by 2050, crowding out essential spending on education, environmental protection and national security. It is projected that the Medicare system will become insolvent by 2019 unless a financial fix is implemented. Medicare currently obtains its funds from payroll taxes, general government revenues and premiums from beneficiaries. A clause in the 2003 law that established the new Medicare drug program mandates that no more than 45 percent of total Medicare spending can be derived from general government revenues. Medicare is currently approaching that cap, which will force Congress to find new ways to finance the Medicare program.

Spending Comparisons With Other Developed Countries

Health care costs are far higher in the United States than in any other advanced nation, whether measured in terms of dollars spent, as a percentage

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of the economy or on a per capita basis. America relies on costly specialists and advanced technologies to a greater extent than many other advanced countries. America's fragmented health care delivery system compounds the problem by resulting in higher administrative costs and marketing expenses.

Higher U.S. health care spending has not resulted in better health outcomes. Life expectancy in the United States remains lower than in other advanced countries and infant mortality remains higher. Moreover, an estimated 47 million people, almost 16 percent of the U.S. population, lacked health care insurance in 2006. The lack of health care insurance has increasingly become a middle-class problem. Two-thirds of those who became uninsured between 2005 and 2006 lived in households with pretax incomes of at least $75,000.

Options for Improving the Nation's Health Care System

Today's health care reform proposals fall into three categories: retaining the current system of private health insurance but creating tax and savings incentives to make private health insurance more affordable; creating a new government program that would provide universal coverage; and, extending existing programs to cover more people or lower their out-of-pocket costs. Most analysts agree that none of these proposals will work unless escalating health care costs are brought under control.

There is no silver bullet for controlling health care costs. The solution will require a multifaceted approach including more emphasis on preventive care, better coordination of patients suffering from multiple chronic illnesses, broader use of electronic medical records to eliminate errors and increase efficiency and efforts to reduce drug costs.

The Focus on Preventive Care. Instead of limiting patient access to specialists and prescription drugs, an approach that was popular during the 1990s, both Medicare and many private insurers are focusing on preventive care and now promoting early testing and intervention and the management of chronic illnesses. As part of this "wellness" movement, insurers have incorporated coverage for glaucoma screenings, medical nutrition therapy, cardiovascular and diabetic screenings and smoking and tobacco-cessation counseling. Many insurers also cover vaccines for influenza, pneumonia and hepatitis B, mammograms, tests for cervical and prostate cancer, bone density screenings and training for diabetes self-management.

Employers have joined the wellness effort. Some now offer free lifestyle and nutrition coaching, stop-smoking programs, fitness centers and stress management counseling. Instead of simply urging their workers to exercise and engage in other health promoting activities, some have developed specific benchmarks for weight, blood pressure and cholesterol. Employees who meet these targets may be rewarded with discounts on their health insurance coverage.

The wellness movement is part of the reorientation of the health care system to prevent rather than treat disease. It reflects the realities of today's health care market. For example, spending on diabetes and other diseases related to obesity accounted for 34 percent of the increase in U.S. medical spending between 1987 and 2004. It is estimated that preventing rather than treating disease could result in 40 million fewer cases of cancer, heart disease and other chronic illnesses during the next fifteen years. This could reduce the cost of medical care and lost productivity by an estimated $1.1 trillion, an amount equivalent to half total U.S. healthcare spending in 2005.

The Need for Electronic Medical Records. Few industries are as information dependent as health care. Yet, health care information is currently created and collected in a fragmented manner. According to the Healthcare Information and Management Systems Society, 80 percent of U.S. doctors and more than 75 percent of U.S. hospitals still rely at least partially on paper charts and records. Every clinic, hospital and doctor's office has its own systems for generating and storing information and these systems generally don't communicate with each other. This makes it virtually impossible for a doctor to assemble a complete picture of a patient's health and to make fully informed treatment decisions. The inability of health care providers and researchers to share information means that treatment is not always based on the best available scientific knowledge and that diagnostic tests may be repeated needlessly. If physicians had scientific information on which treatments work best for which patients and whether the benefits justify the costs, there would be less needless treatment. Electronic medical records would also allow patients to access their medical records more easily so that they can make informed medical decisions.

Information technology spending by U.S. hospitals was about $30 billion in 2007, far less than what is needed to fully switch to electronic medical records by 2014, a goal of the present administration. The administration is attempting to speed the

Health Care Costs and Outcomes, United States vs. Selected Countries

Country	Life Expectancy In Years	Infant Mortality Per 1000 Births	Health Care Spending as a Percent of GDP
Australia	80.6	4.6	9.5
Britain	78.7	5.0	8.3
Canada	80.3	4.6	9.8
Germany	79.0	4.1	10.7
Netherlands	79.8	5.0	9.2
New Zealand	79.0	5.7	9.0
United States	77.9	6.9	16.0

Source: Centers for Disease Control as shown in Businessweek, November 12, 2007

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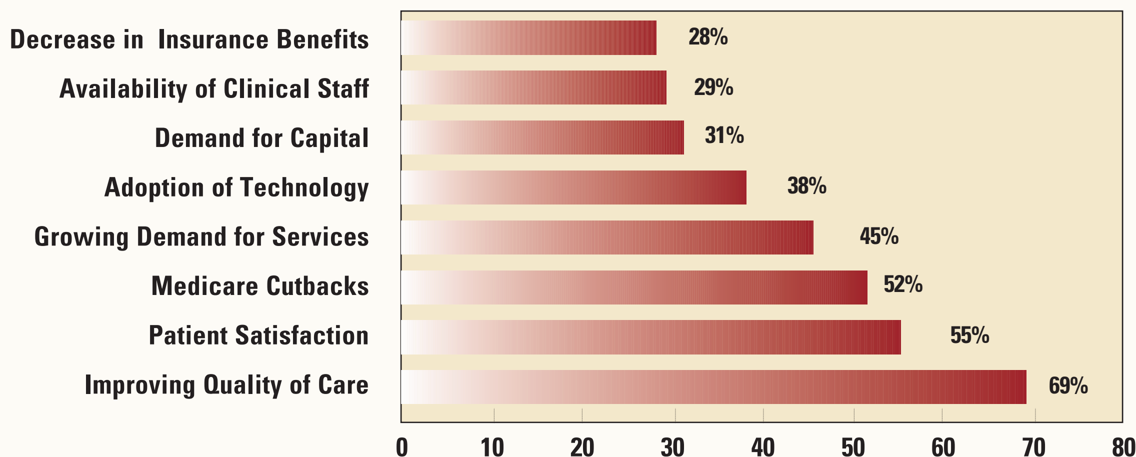

transition to electronic medical records by helping 1,200 doctors nationwide switch to electronic medical records in exchange for higher Medicare reimbursements. Medicare will pay these physicians extra for ordering prescriptions or recording lab results on line. A recent study by PriceWaterhouseCoopers concluded that modern health information technology, including electronic medical records, could save the U.S. more than $160 billion annually through improved care management, fewer missed work days, lower death rates from chronic diseases and fewer preventable medical errors.

Medication errors have become a major health care problem. They kill at least 7,000 Americans annually. According to the Institute of Medicine, Americans average one medication mistake for every day of hospitalization. One reason for this high error rate is that 95 percent of prescriptions are transmitted using pen and paper. Of the more than three billion prescriptions written each year, one billion require follow-up between the medical provider and the pharmacy for clarification. E-prescriptions could change this. When a physician writes an electronic prescription, a computer can warn of potentially dangerous interactions with other medications and tell the physician whether the drug is covered by a patient's insurance and whether an alternative generic drug exists.

Innovative new hardware and software is making it easier for medical personnel to manage medical information electronically. Microsoft recently launched HealthVault, a free online health portal that allows patients and their doctors to securely upload their medical records to the web. Another system, WorldVistA, is an open-source computer system that's low cost, easy to use and readily available. It is based on the system currently used by the Veteran Administration. Thanks to this system, the costs for patients treated by the VA are 32 percent lower than they were a decade ago in real terms. There are also new tablet PCs that resemble traditional medical clipboards and can be used by doctors and nurses to electronically capture patient information on the spot.

Several Long Island hospitals are now using electronic medical records. For example, in the emergency room of Bay Shore's Southside Hospital, doctors and nurses make notes on a computer rather than on an old-fashioned clipboard. The North Shore-Long Island Jewish Health System utilizes "computers on wheels" (COWs). These laptop computers that are wheeled around on carts allowing doctors and nurses to record patient information at the bedside.

Holding the Line on Drug Costs. The escalation of drug costs has begun to slow because many of the top-selling branded drugs are losing patent protection. As a result, physicians and insurers have been able to switch patients to cheaper generics. Drugs with $20 billion in annual global sales are expected to lose patent protection in the next year. As a result, two-thirds of the prescriptions dispensed in the U.S. this year are expected to be generics, up from 50 percent in 2003.

According to a recent study by the Centers for Medicare and Medicaid Services, spending on prescription drugs rose 8.5 percent in 2006 following six consecutive years of slow growth. The increase was fueled by the Medicare prescription drug plan, which was introduced at the start of 2006. However, the Medicare prescription plan has also encouraged patients to switch from brand name to generic drugs to avoid the "doughnut hole", the name given to the gap in Medicare prescription drug coverage. This year, Medicare beneficiaries will encounter the hole when their drug costs reach $2,510. Beneficiaries must then absorb 100 percent of out-of-pocket drug expenses for the next $3,216 or until

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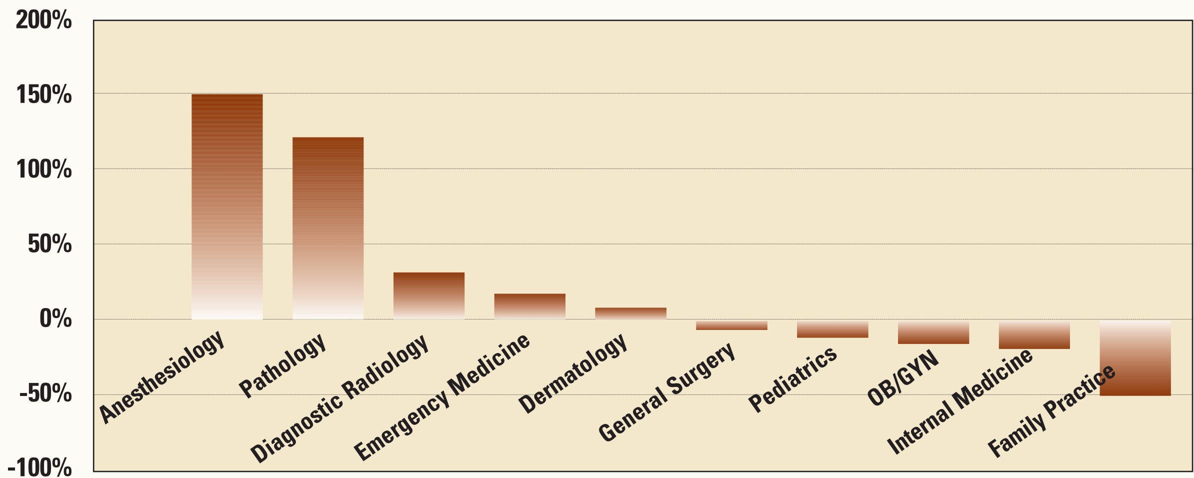

total annual costs reach $5,726. At that point, Medicare's catastrophic drug coverage kicks in and Medicare covers 95 percent of future drug costs for the year. With careful planning and the use of generics, some Medicare beneficiaries have been able to avoid the doughnut hole.

There are those who believe that drug costs could be reduced further by allowing the reimportation of drugs from abroad. Others believe that drug costs would fall if Medicare were allowed to negotiate drug prices with pharmaceutical firms. These options could be pursued as part of future efforts to reform Medicare.

New Models for Financing and Delivering Health Care

While waiting for more comprehensive health care reform, new models for financing and/or delivering health care services are emerging. Some patients are turning to prepaid health clinics. For a flat monthly fee, these clinics provide unlimited primary and urgent care. This approach is helpful to the uninsured and is consistent with the growing emphasis on preventive care.

Retail clinics in drug stores and similar venues are another recent development. There are more than 700 such clinics nationwide. No appointment is necessary and waiting times are short. Many insured patients use the clinics because of their convenience. In New York, the nurse practitioners that staff these clinics must work closely with a physician, who oversees the practice but whose presence is not required. Because of their low overhead costs, these clinics charge lower fees than a typical doctor's visit.

The recent agreement between the United Auto Workers and General Motors to offload retiree health care benefits to a Voluntary Employee Beneficiary Association (VEBA) may provide a new corporate model for retiree health care coverage. General Motors funded much of the trust and the UAW will allocate these health care funds to its retirees and their dependents. This will allow GM to eliminate the drain of retiree health care benefits while ensuring that retirees are protected from the loss of health care benefits in the event of corporate bankruptcy.

Several large states, including California, Illinois and Pennsylvania, have attempted to provide universal health care coverage for their residents. It is difficult for states to implement universal coverage because of a lack of consensus concerning who should pay for it. A universal plan is already in place in Massachusetts, where every citizen must either get health insurance from an employer or buy their own health insurance. Low-income residents receive state subsidies to purchase private health care insurance. New York State is the latest state to move in this direction. Governor Spitzer has asked the Superintendent of Insurance and the Commissioner of Health to develop a strategy for universal health care.

There is a general consensus that the nation's health care system is broken. Future arguments concerning how to fix it will involve a tug-of-war between those who advocate a government-administered universal care system and those who want to retain private health care insurance. The outcome of the debate will affect the health care options of millions of Americans.

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