Healthcare in America 2016
An Introduction to System Reform
Objectives

- To discuss the structure of the US Healthcare System
- To discuss some of the cost and quality consequences of the way US Healthcare System is structured
- To discuss top-down and bottom-up efforts to reform the US healthcare system
- To discuss the ACA as the major top-down reform effort, how its drafters overcame obstacles to reform and how they sought to address system reform
- To discuss the PCMH as a major bottom-up reform and the evolving role of primary care in system reform
Comparative Costs

Health-care expenditure
As a percent of GDP

Australia: 7.0% (1980), 10.0% (2006)
France: 7.0% (1980), 11.0% (2006)
Germany: 8.4% (1980), 10.5% (2006)
Japan: 6.5% (1980), 8.1% (2006)
U.K.: 5.6% (1980), 8.5% (2006)

Data: OECD

http://www.marketwatch.com/health-care/reform/snapshot
Comparative Cost Curves

Figure ES-1. International Comparison of Spending on Health, 1980–2004

Average spending on health per capita (SUS PPP)

- United States
- Germany
- Canada
- France
- Australia
- United Kingdom

Total expenditures on health as percent of GDP

- United States
- Germany
- Canada
- France
- Australia
- United Kingdom


Rankings for Health Outcomes

1. France
2. Italy
3. Singapore
4. Spain
5. Austria
6. Japan
7. United States
8. Slovenia
9. Cuba
Ranking on Selected Health Indicators Among 13 Industrial Nations

The United States ranks an average of 12th (second from the bottom) for 16 available health indicators. Some examples:

- 13th (last) for low-birth-weight percentages
- 13th for neonatal mortality and infant mortality overall
- 11th for post-neonatal mortality
- 13th for years of potential life lost (excluding external causes)
- 11th for life expectancy at 1 year for females, 12th for males
- 10th for life expectancy at 15 years for females, 12th for males
- 10th for life expectancy at 40 years for females, 9th for males
- 7th for life expectancy at 65 years for females, 7th for males
- 3rd for life expectancy at 80 years for females, 3rd for males
- 10th for age-adjusted mortality

Putting it all together

<table>
<thead>
<tr>
<th>Quality Ranking</th>
<th>Country</th>
<th>Ranking for Per Capita</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expenditure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 1</td>
<td>France</td>
<td>4</td>
</tr>
<tr>
<td>• 2</td>
<td>Italy</td>
<td>11</td>
</tr>
<tr>
<td>• 6</td>
<td>Singapore</td>
<td>37</td>
</tr>
<tr>
<td>• 7</td>
<td>Spain</td>
<td>24</td>
</tr>
<tr>
<td>• 8</td>
<td>Oman</td>
<td>62</td>
</tr>
<tr>
<td>• 9</td>
<td>Austria</td>
<td>6</td>
</tr>
<tr>
<td>• 10</td>
<td>Japan</td>
<td>13</td>
</tr>
<tr>
<td>• 37</td>
<td>United States</td>
<td>1</td>
</tr>
<tr>
<td>• 39</td>
<td>Cuba</td>
<td>118</td>
</tr>
</tbody>
</table>

# 1 means highest: quality, highest expenditure per capita
What are some reasons for the Paradox?

<table>
<thead>
<tr>
<th>Costs</th>
<th>Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of universal care</td>
<td>Focus and incentives for responsive rather than preventive care</td>
</tr>
<tr>
<td>Traditional fee-for-service model of care</td>
<td>Patterns of self-referral to specialists</td>
</tr>
<tr>
<td>Over-reliance on and inappropriate use of technology</td>
<td>Lack of coordination among service providers</td>
</tr>
<tr>
<td>Inappropriate services</td>
<td>Poor reimbursement for patient education</td>
</tr>
<tr>
<td>Complex payment schemes in place in the USA</td>
<td></td>
</tr>
</tbody>
</table>
How would you describe the American healthcare system?

According to T.R. Reid’s ‘The Healing of America’, there are four separate systems, and which is system works for you depends on who you are.
How did our HCS evolve?

- Seeds of our system planted during WWII – health insurance held NOT to be wages subject to price controls, and IRS ruling that benefits were not taxable
- Other parts engrafted on the core system of employer-based insurance
- VA for veterans
- Medicare for elderly, Medicaid for very poor
- Many attempts to expand insurance to all
Consequences of employer-based insurance

- It made huge amounts of money available for healthcare
- It created a third-party beneficiary system
- It engrained fee-for-service as the basic feature of healthcare delivery in the US
## Comparing the US and Bismarck Systems

<table>
<thead>
<tr>
<th>US</th>
<th>Bismarck System</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hugh amounts of money available for healthcare</td>
<td>Hugh amounts of money available for healthcare</td>
</tr>
<tr>
<td>3rd party beneficiary system</td>
<td>3rd party beneficiary system</td>
</tr>
<tr>
<td>FSS is the core feature</td>
<td>FSS is the core feature</td>
</tr>
</tbody>
</table>
So what are the differences?

<table>
<thead>
<tr>
<th>US</th>
<th>Bismarck</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completely free enterprise</td>
<td>Tight control of services and fees</td>
</tr>
<tr>
<td>Insurance companies are for-profit</td>
<td>Insurance companies are not-for-profit</td>
</tr>
<tr>
<td>Healthcare coverage is available only to certain defined segments of the population</td>
<td>Healthcare coverage is universal</td>
</tr>
</tbody>
</table>
Reforming the US Healthcare System
Major Modern Trends in Healthcare

- Proliferation of new technologies and services
- Increased costs as new technologies emerge
- Increasing share of costs borne by government
- Increasing focus on cost control by employers, government, and insurers seeking to maximize profit
- Insurance as risk underwriting rather than risk sharing as more people drop out of the insured pool
- Emergence of healthcare as a right rather than a commodity
Some consequences of these Trends

- Increasing focus on documenting for reimbursement rather than care
- Increasing complexity of regulations to make up for the deficiencies of the 3rd PB model
- Cost shifts that have been borne by the private insurers, hospitals and physicians for uncompensated care
- Increasing numbers of citizens who are uninsured or underinsured - vicious cycle
US System has created many powerful constituencies or stakeholders

- Pharmaceuticals – represented by PhRMA
- Medical Device Manufacturers – by AMTA
- Health Insurers – by AHIP
- Hospitals – by AHA
- Physicians and other providers – by the AMA and specialty societies
- Plaintiff’s Bar – by the ATLA
What were the goals of the policymakers designing the ACA?

- Expand coverage – universal care is ultimate goal
- Improve health outcomes, quality of care
- Bend the cost curve
What political tactics did ACA drafters adopt to achieve their goals?

- Finance the expansion costs without increasing general income taxes
- Separate negotiations with each major stakeholder in the industry for give backs in exchange for demonstrated increases in revenues from the expansion
- Bending the cost and quality curves through imbedding measures such as pay-for-performance, meaningful use and ACO’s
Affordable Care Act (ACA)

<table>
<thead>
<tr>
<th>Provision</th>
<th>Problems addressed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mandate and elimination of pre-existing conditions in insurance contracts</td>
<td>Universal healthcare – risk sharing vs underwriting</td>
</tr>
<tr>
<td>Minimum Insurance Requirements</td>
<td>Underinsurance</td>
</tr>
<tr>
<td>Modest Cost Controls</td>
<td>Charge master abuse</td>
</tr>
<tr>
<td>Ceiling on insurance company profits</td>
<td>Cost controls</td>
</tr>
<tr>
<td>Pay for Performance and ACO’s</td>
<td>FFS and wasteful services</td>
</tr>
<tr>
<td>Incentives for preventive care</td>
<td>Improve outcomes long-term – quality and cost</td>
</tr>
<tr>
<td>Greater emphasis on primary care and comparative effectiveness research</td>
<td>Cost and quality control measures</td>
</tr>
</tbody>
</table>
Health System Reforms

- Vertical integration of health care delivery to control costs at all levels of care, Eg HMO

- Provider networks – negotiated rates with insurers

- Accountable Care Organizations – shared cost savings with the insurer or government payer

- Merging of healthcare delivery and insurance
Primary Care Reforms

- PCMH model – provider driven to improve responsiveness through team delivery of care

- DPC model – provider driven to circumvent the complexities of insurance reimbursement and invest the savings in improved responsiveness
Reform Trends in Primary Care

- Population Management – panel management of major determinants of health
- Preventive care – immunizations and appropriate screenings
- Cost controls through fewer and better tests, fewer and better specialty referrals, fewer and better procedures
- Coordination of care in a complex system to increase system responsiveness and decrease redundancy
Evolving role of Primary Care in an Evolving Healthcare System

- PC will play more central or hub role in health systems

- PCP’s role will evolve to be a health team leader managing healthcare and outcomes for a defined panel using computerized systems for capturing data and communicating – FFS reimbursement and independent practice will diminish and eventually go away

- Patient engagement, prevention and evidenced-based acute and chronic care will become critical pieces for success of a health system
New PC Physician Skill Sets to support an evolving role

- Preventive Care
- Chronic disease management model
- Disease registries and proactive intervention
- Continuous quality improvement
- Point of care research – understanding evidence based recommendations
- Communication skills that build relationships over time and involve the patient in self-management – motivational interviewing and patient-centered interview skills