THE WRECKONOMICS OF HEALTH CARE
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American Heart Association
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INTRODUCTION

I'm here to talk about health care, and anybody who's been to the hospital lately or had another experience with our healthcare system probably feels the need for some relief ….patients, doctors, anybody involved in health care … today we all want **relief** … but health care is a very contentious, complex and difficult issue.

Before we go any further, let's stop and think about that phrase "health care system" for a moment. It has a nice ring to it, because health is good … care is good … and a "system" sounds organized and efficient. Unfortunately, when you look at what we've got, you realize that the phrase "healthcare system" is really an oxymoron. What we have isn't about health, it's about sickness … it's not as much about care as it is about money … and it's not a system, because the parts don't work together.

Let's begin by talking about the challenges of chronic diseases and our aging population. After that I will talk about three other problems we're wrestling with: escalating costs, a growing number of people who are uninsured and the need for better quality. I'm going to end by talking about our political environment and the issues we have to wrestle with to create a healthcare system that works for us … instead of against us.

There's a lot at stake, because what we do will affect real people, like all of us, our families and our friends.

Consider BJ, a 60-year-old cancer survivor, who recently switched health plans and was denied coverage for the medication that was saving her life. She spent more than $3,000 out of her own pocket during the month she was without coverage.

Or Sandra, who was diagnosed with Alzheimer's disease at age 48. Her doctor recommended that she and her husband, Mike, get divorced to qualify for long-term care coverage. Mike refused, but he may have little choice as Sandra's condition worsens.

How did we get in this mess?

A moment ago I said our healthcare system was more about sickness than health. Let me talk more about that. Our healthcare system was really designed to handle acute disease, but it's being overwhelmed by a different problem — chronic disease.

Chronic diseases are the number one cause of death and disability in the U.S. In case you're wondering about that 75% figure, it means of the $2.1 trillion dollars spent on direct health costs in 2006, an estimated $1.5 trillion was spent on chronic disease.

Chronic Conditions

- More than 133 million Americans (45% of total population) have at least one chronic condition. [1]
- Chronic disease patients account for 75% of our healthcare spending.[2]
- Two-thirds of the increase in healthcare spending is due to increased prevalence of treated chronic disease (e.g., diabetes) and innovations in medical treatment.[2]

Source: ***Centers for Disease Control and Prevention***

Chronic disease is a huge problem, and many Americans don't realize its impact on their health – and their wallets. The payment system was devised 40 years ago and designed for acute disease.

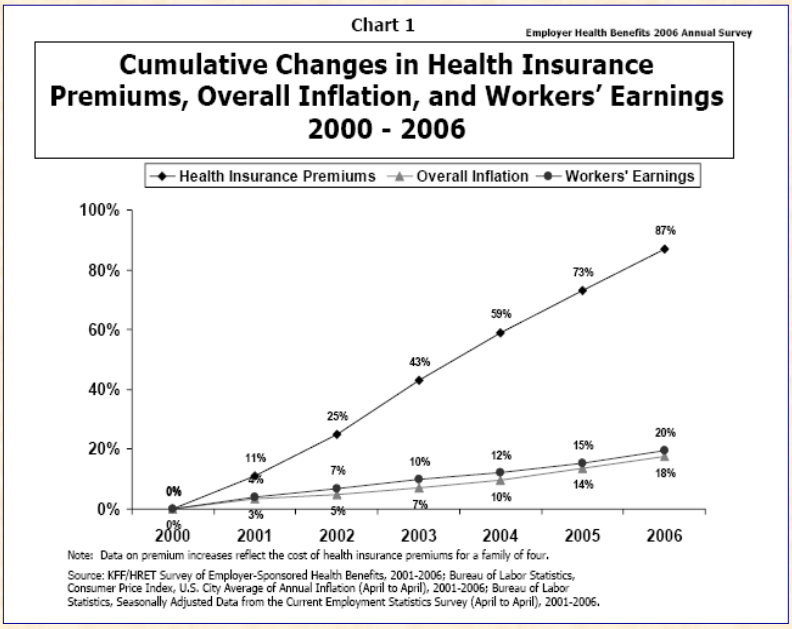
That means that providers don't get paid for encouraging prevention, so it's not emphasized the way it should be. There's little reward so there's little incentive. Greater use of medications may save money by preventing heart attacks, strokes or other serious medical problems, but more prevention efforts would likely reduce the need for drugs.

Prevention

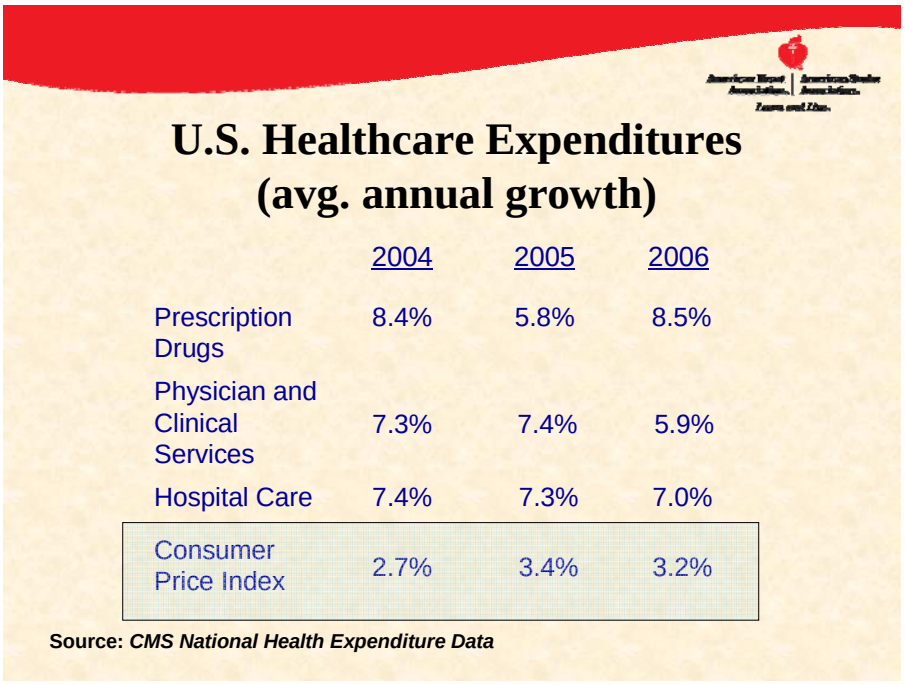
The World Health Organization estimates that 80% of heart disease, stroke, and type 2 diabetes could be prevented if the major risk factors were addressed.

Increasing Costs

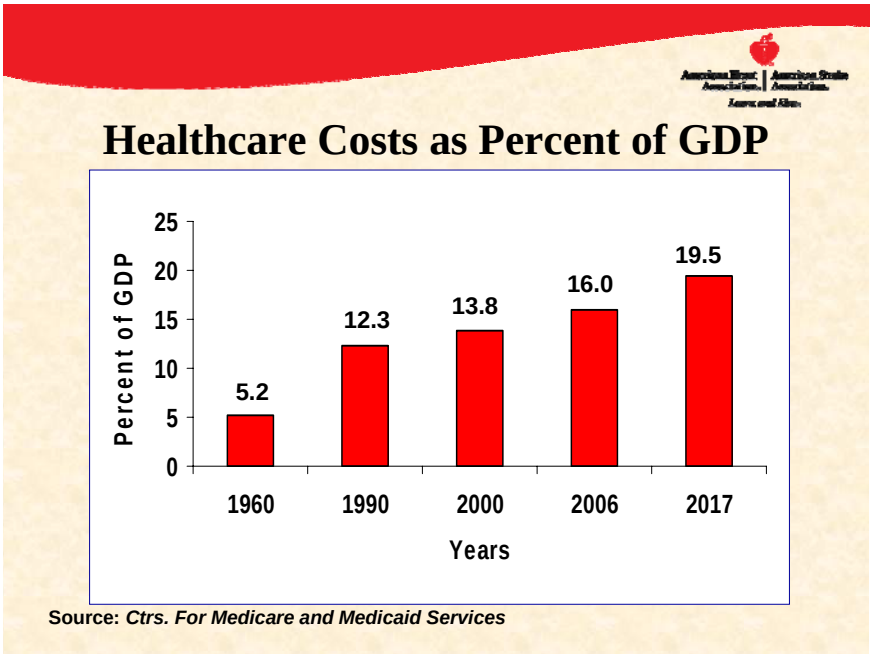
We've touched on costs resulting from chronic disease — now let's look at the problem of costs in more depth. You may have seen this before, but it's still frightening. The steeply ascending line shows the increases in healthcare premiums as compared to inflation and employees' earnings. It's no exaggeration to say that costs are skyrocketing.



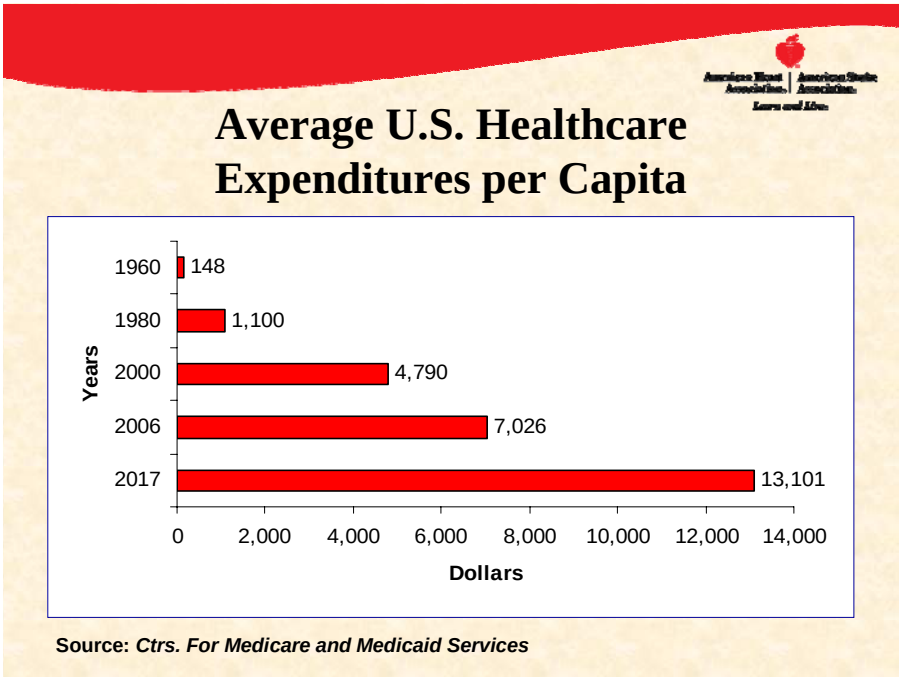
Now look at this table. As you can see, these increases are not limited to just one area of health care. Prescription drugs, physician and clinical services and hospital care all rose significantly compared to the Consumer Price Index.



This graph shows how healthcare expenses have become an increasingly large part of our economy over time. By 2017, they're expected to account for nearly 20% of our gross domestic product.[4] This increase is due to new and more expensive medical technologies (such as imaging) and using healthcare services more often.[5] Part of that could be due to insurance, because when people have insurance, more costs are passed to the insurance company. Between 1970 and 2005, the share of personal health expenditures paid directly out-of-pocket by consumers fell from about 40 percent to 15 percent.

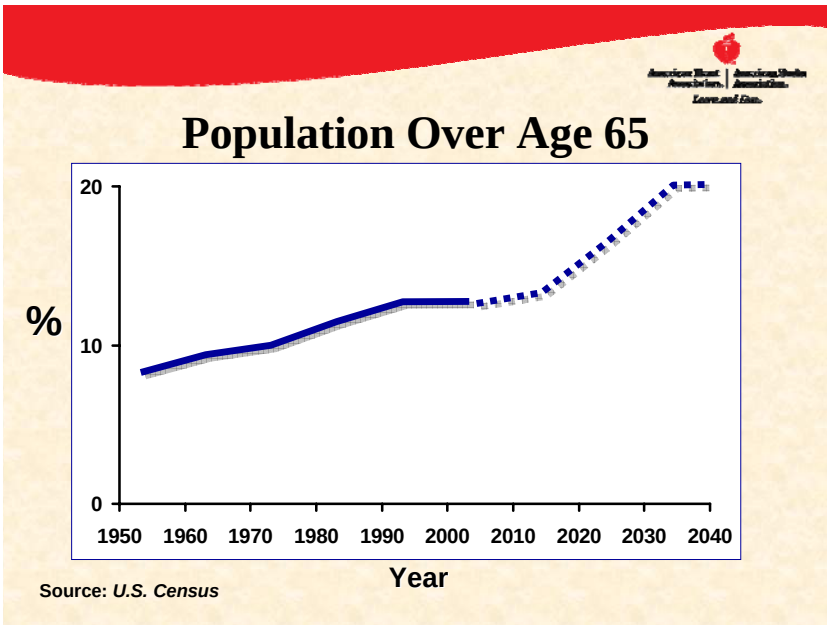


This is the yearly cost per person of health care. It, too, has grown significantly.



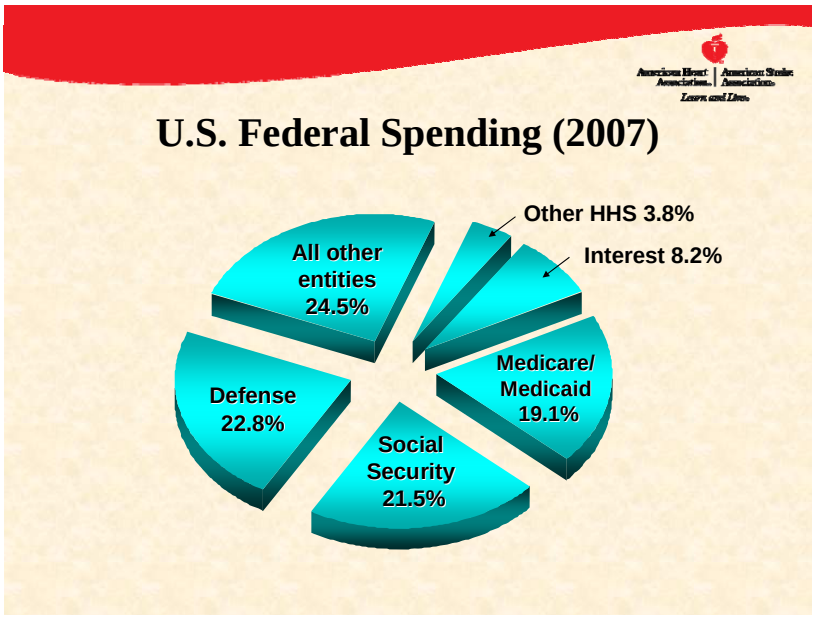
Costs are rising while access to traditional private-employer coverage is declining. Many people think this is due to the aging of the population, but this has only been a minor factor in increasing healthcare costs so far. But that's going to change — and it's going to change soon.

Here's another steeply ascending line. It shows that in the next 25 years, the number of Americans over the age of 65 will double. In fact, starting in 2011, when the baby boomers begin to celebrate their 65th birthdays…**10,000 people will turn 65 every day for the next 20 years**.



This means more people will be enrolling in Medicare, which will increase government spending on Medicare benefits and also remove from the work force millions of workers who were paying into those systems.

Healthcare costs are highest at the very end of life. In fact, about 27 to 30% of cost is incurred in the last three months of life. In any one year, 20% of the people consume 80% of health care. [6, 7, 8]



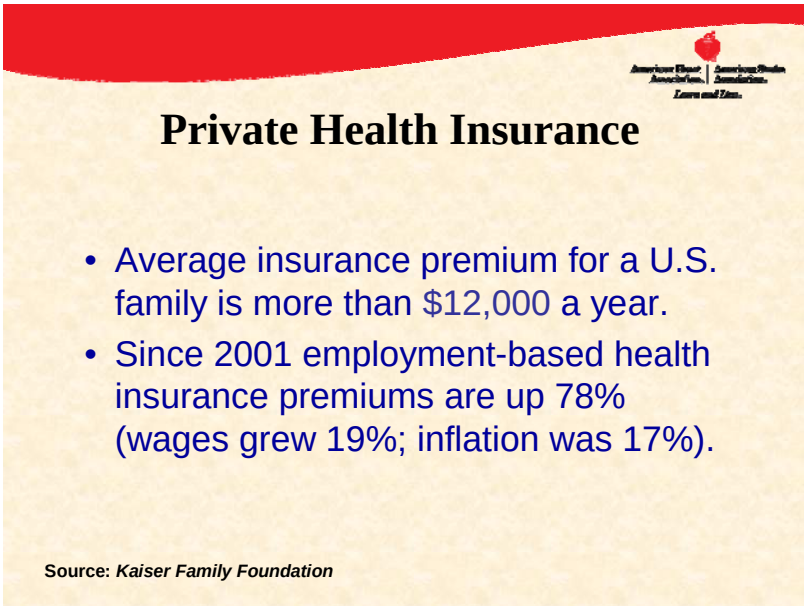
Medicare and Medicaid

Medicare and Medicaid now comprise almost 19% of the federal budget ($556 billion). That's almost equal to Social Security and about $100 billion less than all defense spending.[9] In 2004, Medicaid became the largest state spending program, surpassing elementary and secondary education.

Federal spending on the elderly is plausibly projected to double from 2000 to 2040 as a share of national income. About three quarters of that increase will be health spending – mostly Medicare, but also Medicaid.[10]

Private Health Insurance

A survey last year by the Kaiser Family Foundation found that the average annual premium was about $4,500 for single coverage and $12,000 for family coverage. Since 2001, employment-based health insurance premiums have increased nearly 80% while wages and inflation both rose less than 20%.[11]

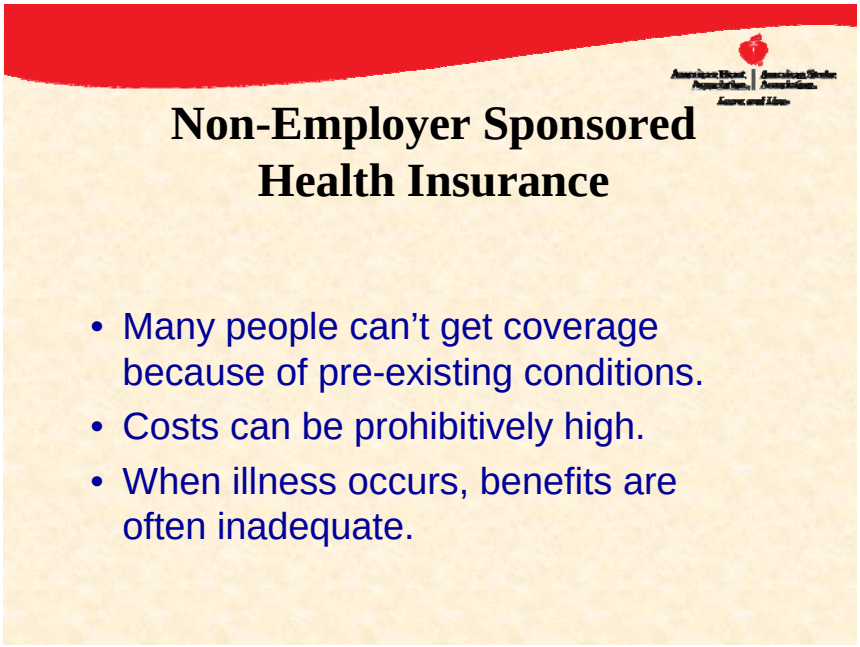


Conventional employer-based coverage in the United States began during and after World War II. Wage and price controls were in effect, so employers couldn't compete for employees by offering higher salaries. Instead, they turned to benefits like health insurance. The effect was a surge in the number of people covered by health insurance, increasing in only five years from 1.3 million in 1940 to 32 million in 1945.[12]

Now, with healthcare costs rising every year, we're seeing a reversal in that growth. The share of Americans with job-based coverage declined from over 63% in 2001 to less than 60% in 2006.[13]

Businesses are struggling because high healthcare costs can put them at a competitive disadvantage, threatening their survival.[14] Some say General Motors has become a healthcare provider making cars to defray health costs.

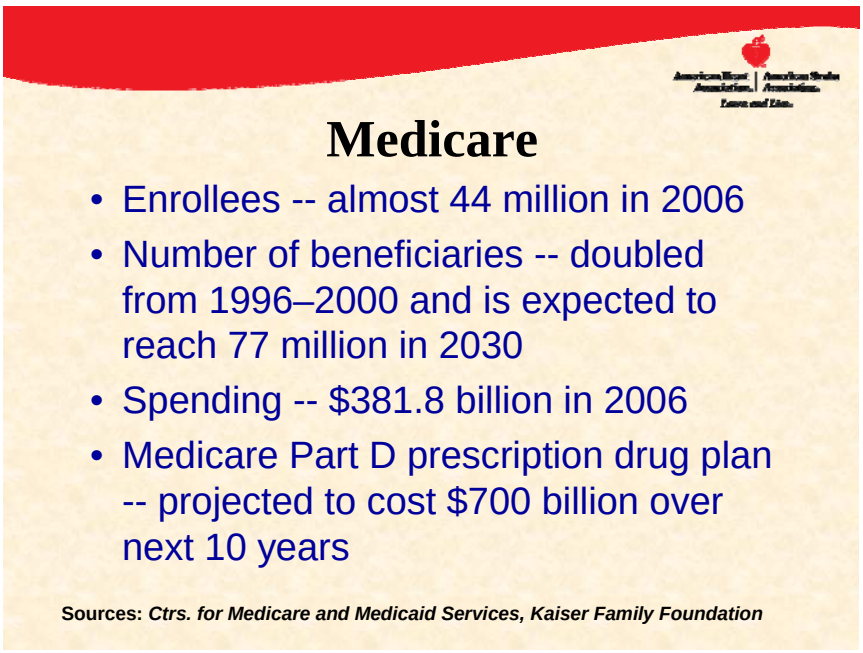
Employers are shifting more of their costs to employees. The average employee contribution to company-provided health insurance has increased more than 143% since 2000.[15] Some employers, particularly small firms, are dropping coverage altogether. [16]



Without help with health insurance from their employer, more people are pushed into government programs or don't get insurance at all. Some do buy policies directly through the individual insurance market, but pre-existing conditions and high costs keep others out. When an illness occurs, some with policies find their benefits are far less than they need.

Medicare

Medicare provides health insurance coverage for seniors over 65 and the disabled. Virtually all Medicare spending – 96 cents of every dollar – is spent on chronic disease care and treatment.

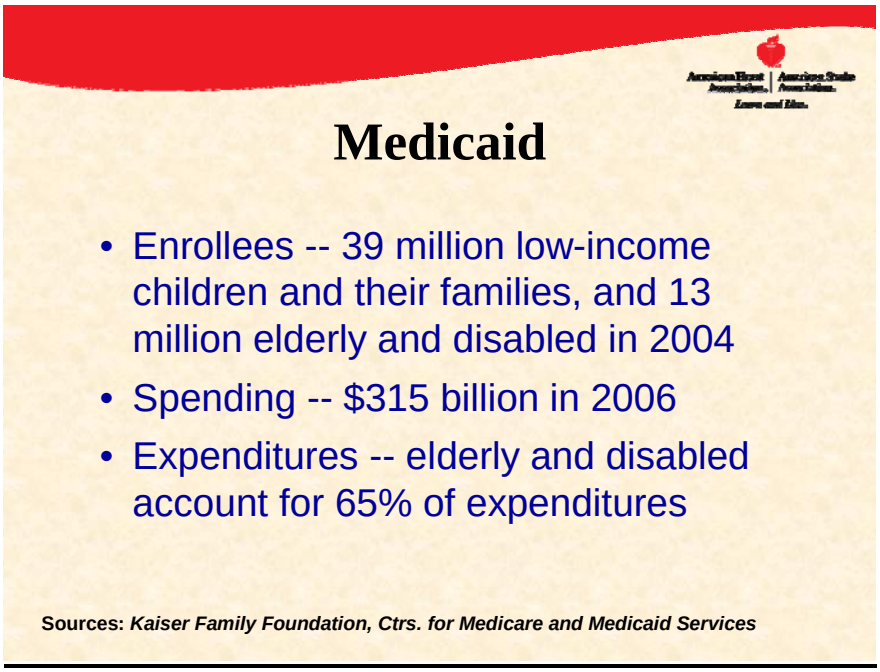


In 2006 there were almost 44 million enrollees.[17] From 1996 to 2000 the number of beneficiaries doubled, and by 2030 their number is expected to reach 77 million.[18] Medicare spending totaled a little over $380 billion in 2006.[19]

In addition, the new Medicare Part D prescription drug plan is projected to cost more than $700 billion over the next 10 years.[20]

Medicaid

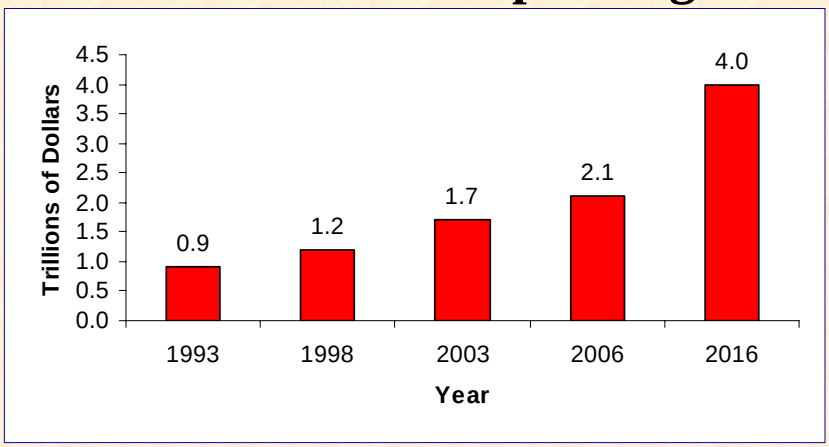
Medicaid is the nation's public health insurance program for low-income Americans and people with disabilities, financing health and long-term care services. Financed and operated jointly by the states and federal government, Medicaid accounts for roughly one fifth of the nation's healthcare spending and nearly half of all spending on long-term care.[26] For Medicaid, 83 cents of every dollar is spent on chronic disease and treatment.



Medicaid served 39 million low-income children and their families, and 13 million elderly and disabled enrollees in 2004.[22] Medicaid spending totaled $315 billion in 2006.[23] The elderly and disabled account for 65% of expenditures. [18]

Overall spending on health care in the U.S. reached $2.1 trillion in 2006, or about $7,000 per person.[24] That's more than 4 times the amount spent on national defense.[25,26] U.S. healthcare spending is expected to increase at similar levels for the next decade, reaching $4 TRILLION in 2016.[4,27] Given these numbers, concerns about the costs of health care overwhelming our economy do not seem farfetched.

Overall Health Spending



Source: ***U.S. Census Bureau***

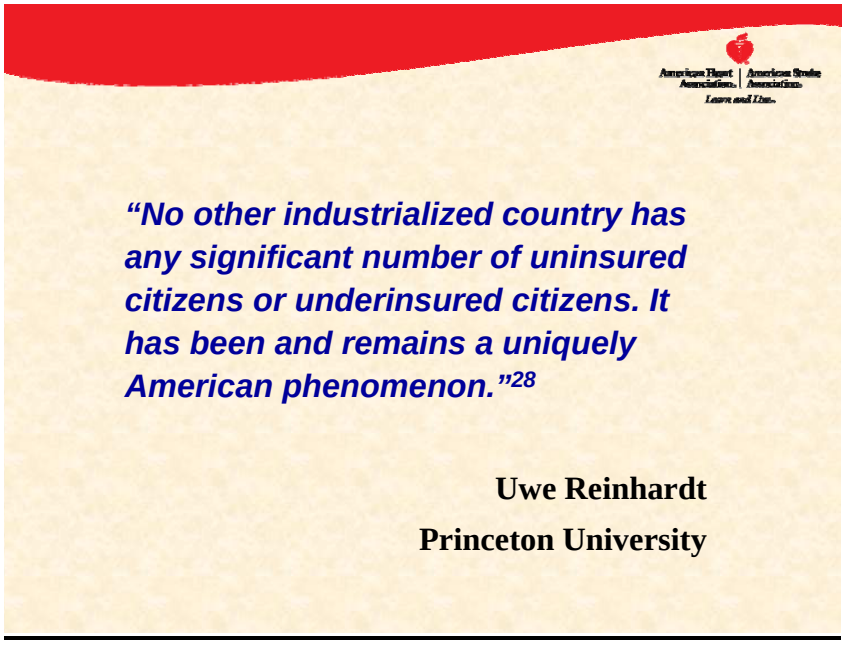
The high taxes needed to pay for Medicare and Medicaid may ultimately produce the unintended effect of lowering economic growth. Paying so much for these programs will also mean there's less money to spend on other programs. There may also be pressure to cut benefits to reduce costs.

"By 2016, Social Security, Medicare and Medicaid alone will consume over one-half of federal spending." [22]

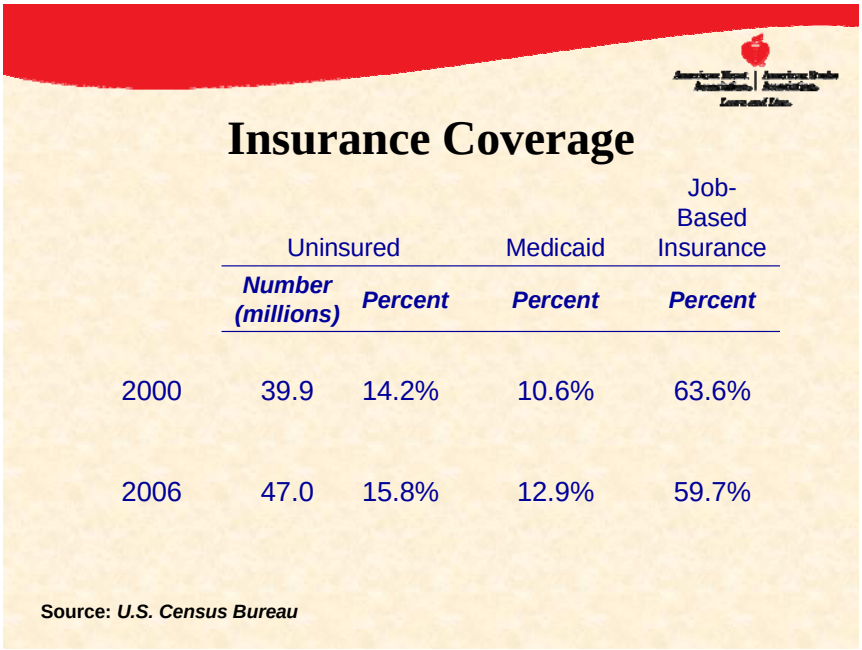
Douglas Holtz-Eakin
Former Director,
Congressional Budget Office

The Uninsured and Underinsured

Now let's talk about another problem — the uninsured and underinsured.



As costs continue to rise, another problem peculiar to the United States becomes worse. The ranks of the uninsured are swelling. Medicaid's growth in recent years is partly due to the unraveling system of employer-based insurance, as the uninsured working poor seek coverage.



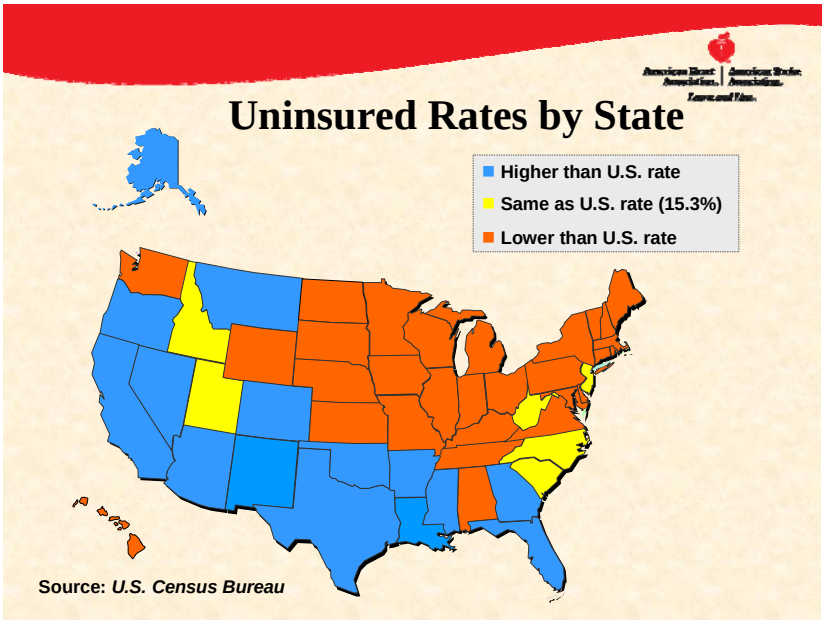
Insurance Coverage

	Uninsured		Medicaid	Job-Based Insurance
	Number (millions)	*Percent*	*Percent*	*Percent*
2000	39.9	14.2%	10.6%	63.6%
2006	47.0	15.8%	12.9%	59.7%

Source: *U.S. Census Bureau*

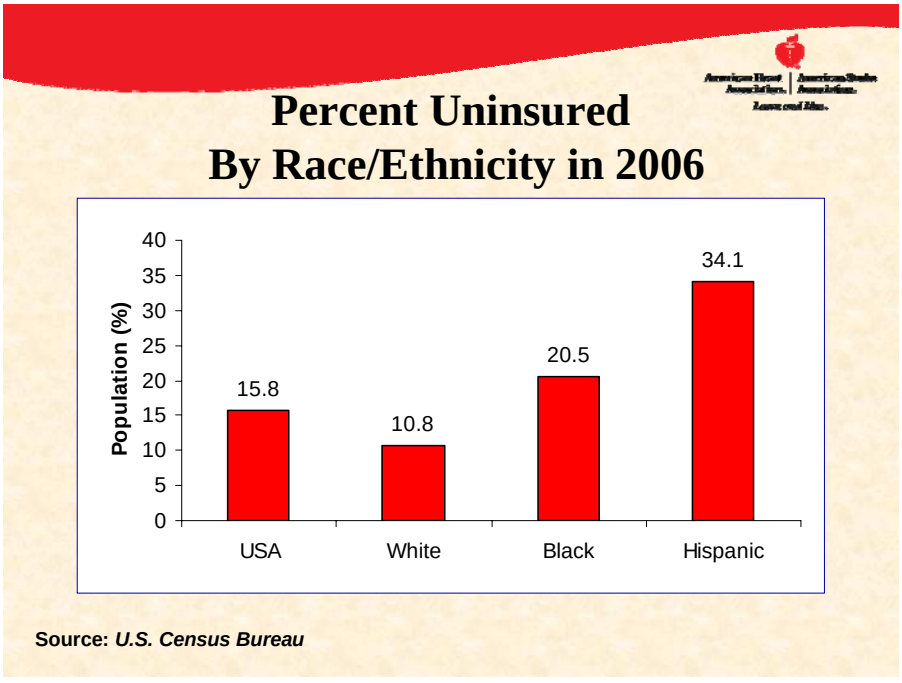
Between 2000 and 2004 the number of Americans covered by Medicaid rose by 8 million people. Over the same period the ranks of the uninsured rose by 6 million people. So without the growth of Medicaid, the uninsured population would have exploded. [29]

In 2006, 47 million people — nearly 16% of the U.S. population — didn't have health insurance coverage.[30] The vast majority of those families have jobs, but not insurance. Most of the uninsured either work full-time or have someone in their immediate family who does. However, 81% of the uninsured are employed by firms that don't sponsor health benefits or they aren't eligible for their employer's plan."[36] About nearly 18 million of the 47 million are people who likely can afford health insurance but don't have it, and about 10 million are not U.S. citizens. [13]



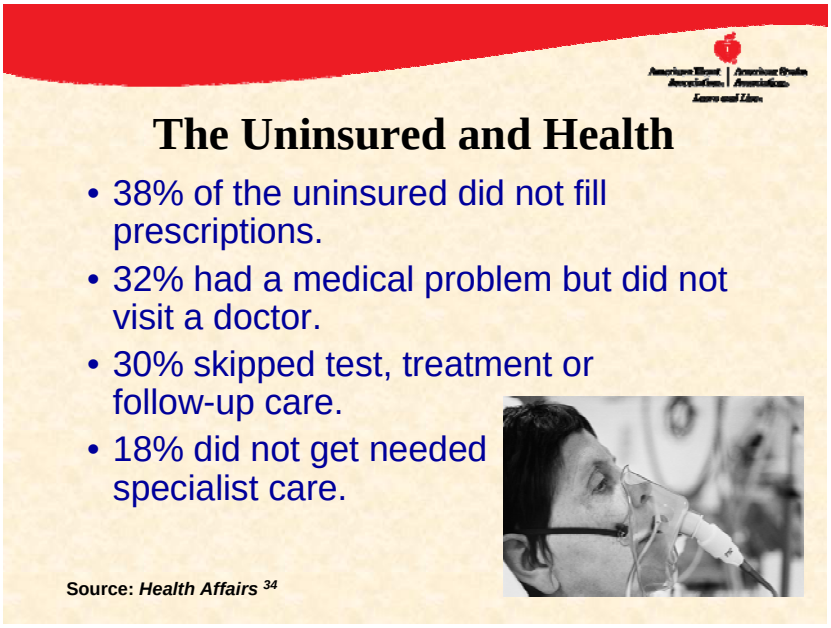
There is considerable variation by state with regard to the uninsured. Rates of uninsured are highest in the South and lowest in the Northeast and Midwest. For example, 21% of Mississippi residents are uninsured compared with 9% in Rhode Island.[32] Fifteen states are higher than the national average; 29 are lower.

Lack of coverage disproportionately affects poor people and people of color, so the gap between the Haves and the Have Nots in our society widens.



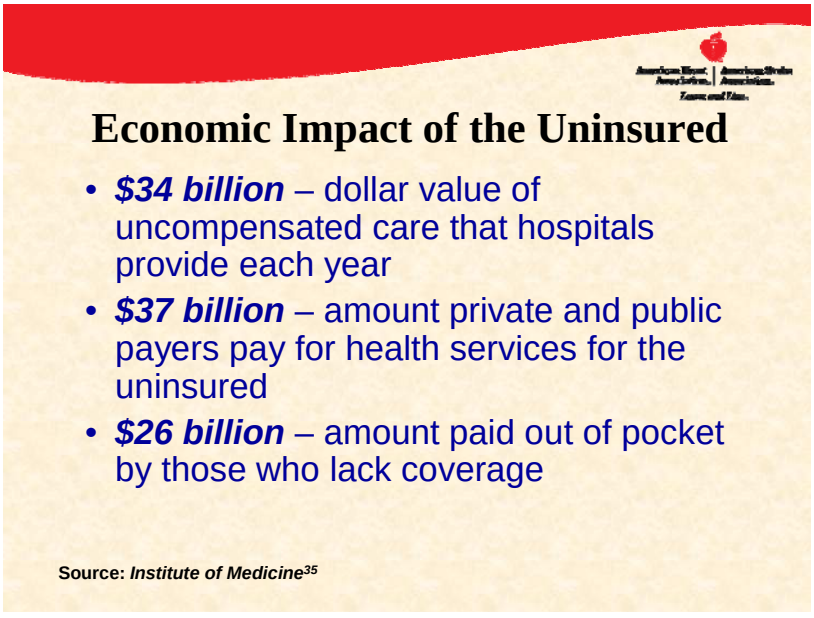
The uninsured are up to three times more likely than those with insurance to report problems getting needed medical care. The growing ranks of the uninsured and underinsured means millions of Americans' only medical resource is a hospital emergency room. This is a plausible explanation of why waiting times at emergency rooms have increased — they're often clogged with uninsured patients seeking routine charity care.[33]

The uninsured are less likely to receive timely preventive care. Anticipating high medical bills, many of the uninsured don't follow recommended treatment. [5]

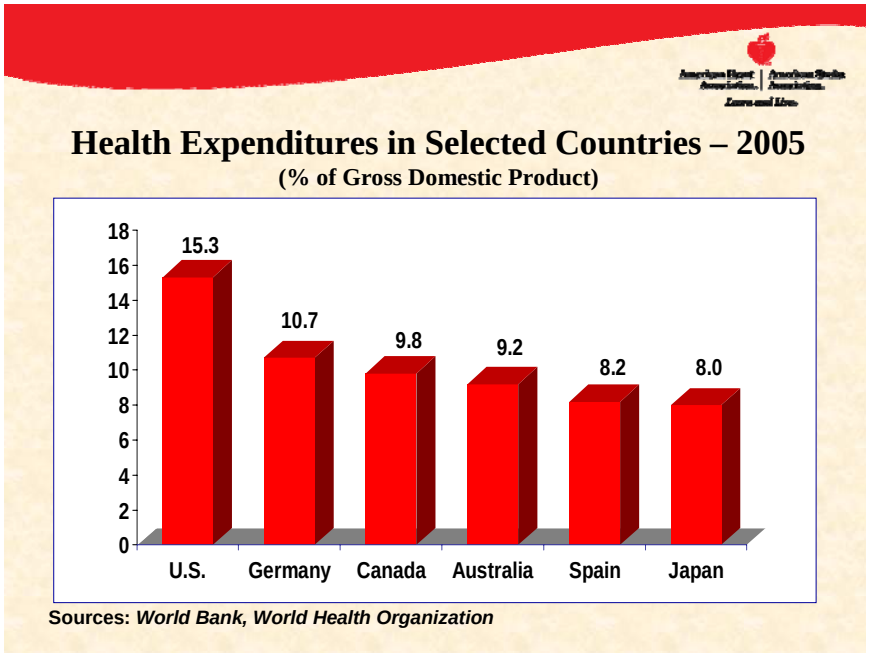


Being "uninsured" does not necessarily mean you don't get health care. The United States spends nearly $100 billion per year to provide uninsured residents with health services, often for preventable diseases or diseases that physicians could treat more efficiently with earlier diagnosis.

This is the tab for the uninsured. The point here is that uncompensated care is not free; it's a 'hidden tax' that we all pay.

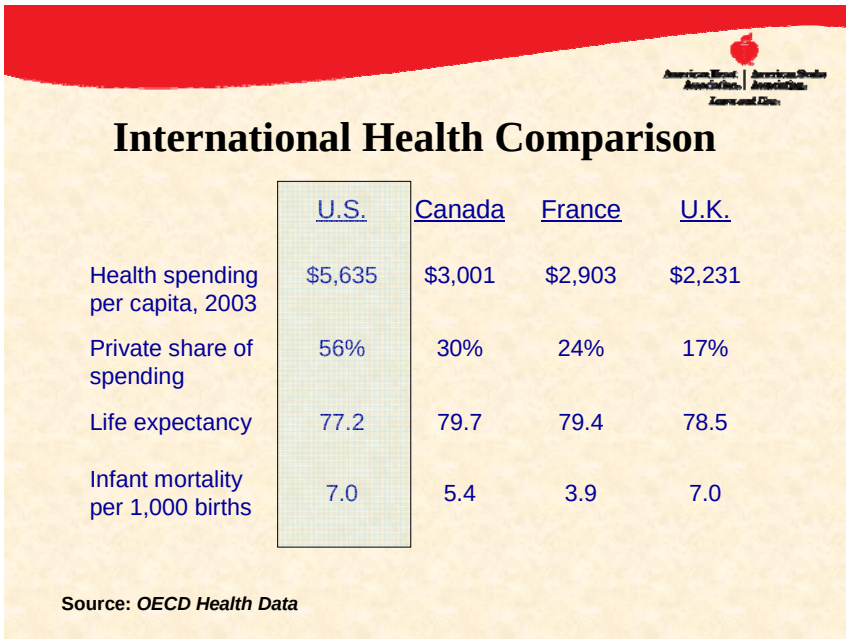


We've talked about the economic effects of high costs for health care, and the growing ranks of the uninsured and underinsured. Now let's consider the quality, safety and efficiency of our system — and see what we're getting for the money we spend.

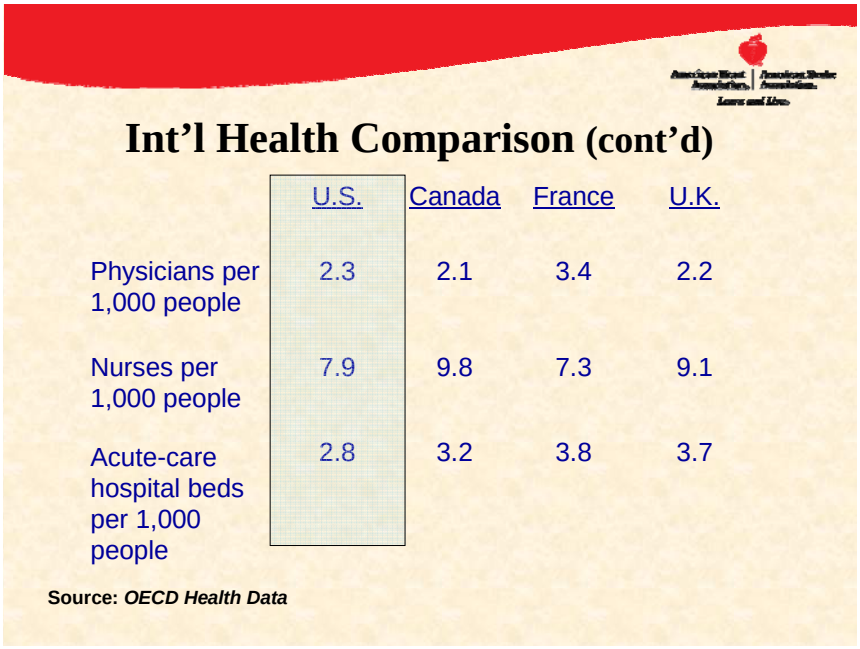


We spend a lot more for healthcare than other countries do. We're spending almost twice as much of our gross domestic product on health care as Japan does. Here's another comparison.

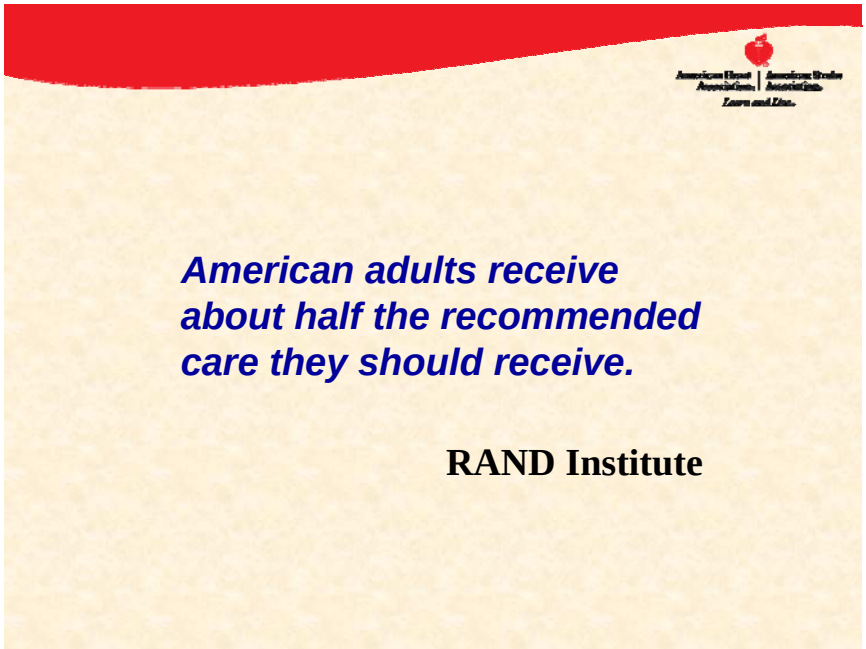
Look at how much more we're spending than our neighbors to the north, or the French or British. Now look at life expectancy and infant mortality. For the additional dollars we're spending, wouldn't you expect better results?



The same is true here. The number of physicians per 1000 population isn't dramatically different. In fact, we have fewer physicians than the French. And we have fewer nurses per 1000 population than you'd find in Canada or the United Kingdom.



RAND researchers have documented that on balance, American adults receive about half the recommended care they should.[35, 36]



Shortfalls in quality of care were very similar in all communities studied … quality varied substantially across medical conditions … quality varied across communities for the same condition … no community consistently had the highest or lowest performance … and everyone was at risk for poor care. [37]

Medical errors are another problem. The Institute of Medicine estimates that about 100,000 Americans die every year from medical errors.

More than half of physician care is not based on best practices. And best practices take too long to become established. For example, Carolyn Clancy of the Agency for Healthcare Research and Quality makes the point that today virtually everyone who has a heart attack receives a beta blocker. But the first clinical trial to demonstrate this effectiveness was 25 years ago. It's taken us 25 years to have this universally accepted. On average it takes 17 years for research on best practices to be widely used clinically.

Also, there's often insufficient attention to benefit-cost trade-offs, so costly tests may be done that offer a very remote chance of benefit.

While we're all at risk of less-than-optimal care, racial and ethnic disparities in care are pervasive. According to the Agency for Healthcare Research and Quality, American blacks receive poorer quality of care than whites on about two-thirds of quality measures and have worse access to care than whites for about 40% of access measures. Hispanics receive lower quality care than non-Hispanic whites for half of quality measures and have worse access to care than non-Hispanic whites for about 90% of access measures. [37]

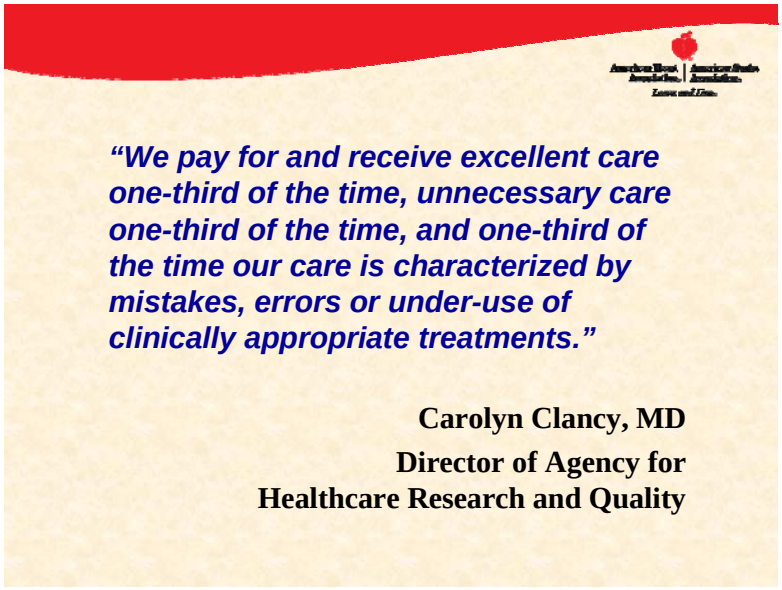
RAND's study of the Veterans Affairs Health System shows the potential for systemwide improvement. The VA has one of the country's best electronic medical record systems … decision-support tools at the point of care … automated order-entry systems to guide prescribing … and routine measurement of and reporting of quality. It also has managerial accountability and financial incentives for good performance. The result is that quality of care is strikingly better in the VA system, and patients receive about two-thirds of recommended care. [37]

We can learn a lot from "integrated" systems, like the VA. They are not fragmented like our current system, so all medical records are in one place and various doctors can easily discuss how to best treat a patient. Our current system pays for units of care (piecework), not outcomes. We are organized around supply, not patients, and our system is sequential, not integrated. We have good science and good talent, but we lack good structure and delivery.

Defensive medicine is another problem. It occurs when doctors order tests, procedures or visits, or avoid high-risk patients or procedures, mainly to reduce their exposure to malpractice liability.[39]

A study in 2006 by Price Waterhouse Coopers, performed for America's Health Insurance Plans, estimated that costs associated with medical liability account for between 7 percent and 11 percent of health insurance premium dollars; direct costs of litigation and widespread practice of defensive medicine increase healthcare spending by 10 percent, with a disproportionate increase in outpatient and physician costs.[40]

I think this quote sums up the situation.



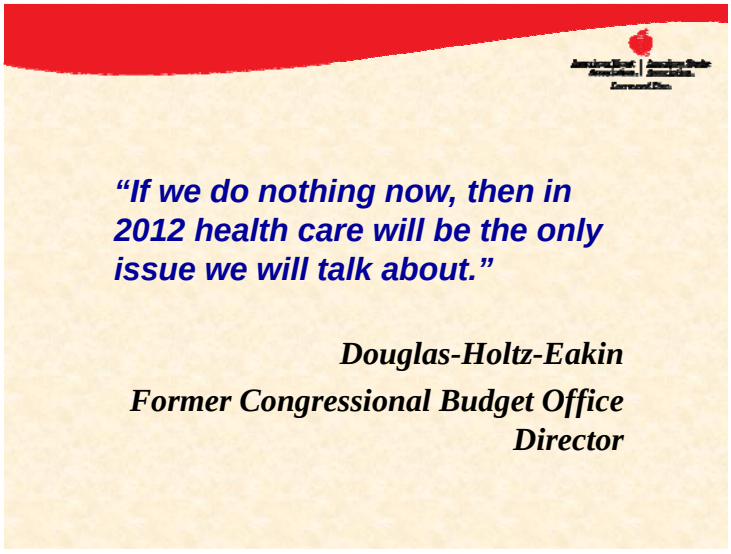
So what can we do? Let's look at reform.

Reform

There have been lots of reforms at the national level. Presidents Truman, Johnson and Nixon all spearheaded reforms with limited success.

Because the federal government has been slow to act, states are taking action. The National Conference of State Legislatures reports that in 2007–2008, at least nine states are considering universal health care systems.[43] States with some form of health insurance legislation in place include Maine, Vermont, Hawaii and Massachusetts.

So what should we do? Should we do anything? I think we have to act -- we need **relief**. But we can do better than ask for random shots at solving the problem.

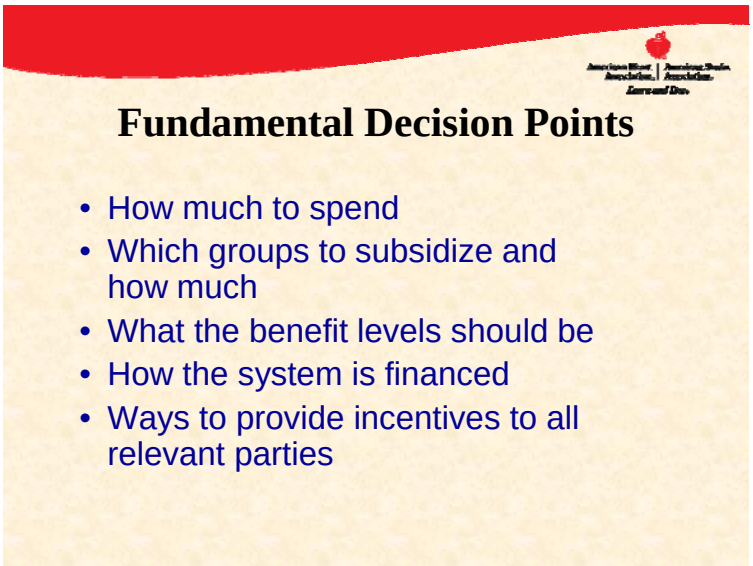


We can't afford to do nothing. The longer we wait, the higher the cost. And we all have a stake.

Before we can talk about reform, we need to define our objectives.

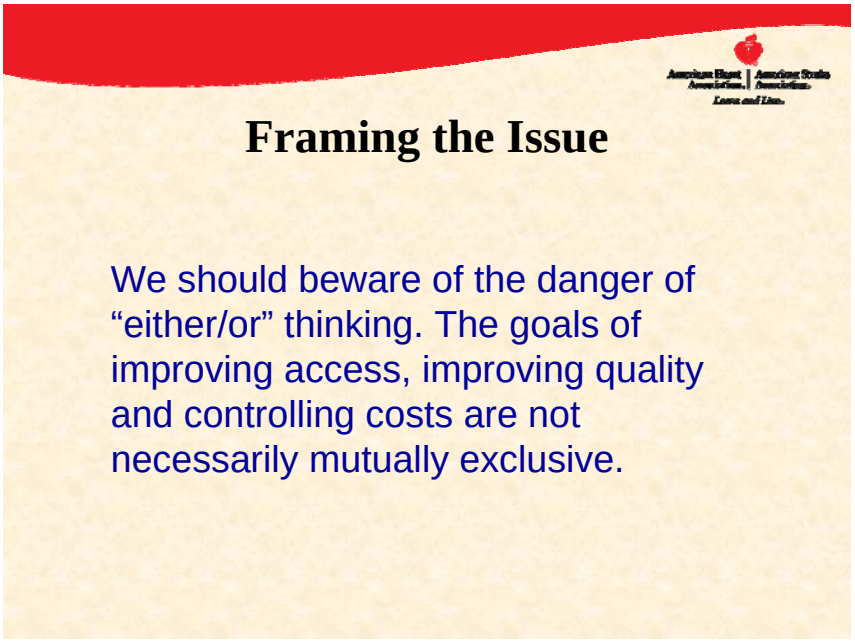
Elliot Wicks, of the Economic and Social Research Institute, suggests there are a series of fundamental decision points that must be addressed when debating any health care reform proposal.[44] These points include:

- How much we're willing to spend
- Which groups to subsidize and to what degree
- What we think the benefit levels should be
- How the system is financed
- We'll also need to look at ways to provide tangible incentives to physicians, hospitals and others to motivate them to act in ways that will further stronger health care.



These sorts of issues lead to bigger issues, like the balance between state and federal government … how you divide responsibility between the public and private sectors … how much movement you want to make away from the status quo and thus your tolerance for risk.

How we frame this discussion is important. There will be tradeoffs, but we should not be too quick to assume oppositions where there may be none. For example, increasing access may reduce disease and overall costs by allowing quicker care and avoiding expensive, late-stage treatments. Similarly, improving quality and efficiency also has the potential to produce savings. Reducing costs in some cases can also spur innovations that produce greater efficiencies and higher quality. So the goals of improving access, improving quality and containing costs may not be mutually exclusive.



Potential Cost Advantages of Public Health Insurance

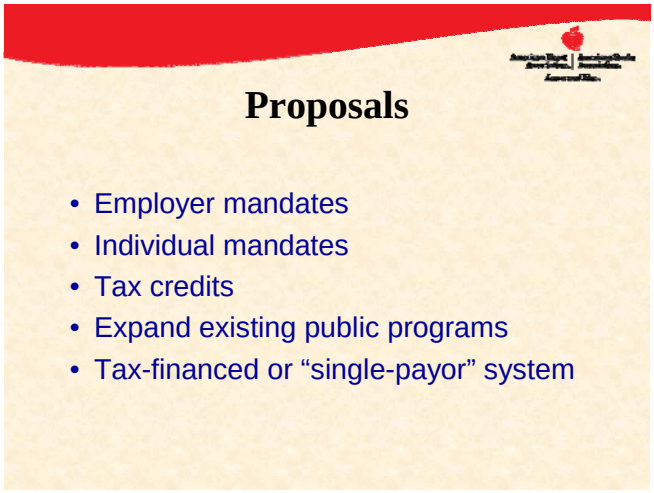
The potential cost advantage of public health insurance seems to arise from two main sources. The first is lower administrative costs. That's because private insurers spend large sums trying to identify and insure the healthiest people and avoiding those with diseases. In 2003 Medicare spent less than 2% of its resources on administration, while private insurance companies spent more than 13%. Fragmentation leads both to administrative complexity and zero-sum struggle.

The second source of savings is the ability to bargain with suppliers. With standardized, universal coverage, the savings could be substantial.

The Alliance for Health Reform, in their report "Health Care Coverage in America,"[45] compiled a representative list of general proposals for extending insurance coverage to more Americans.

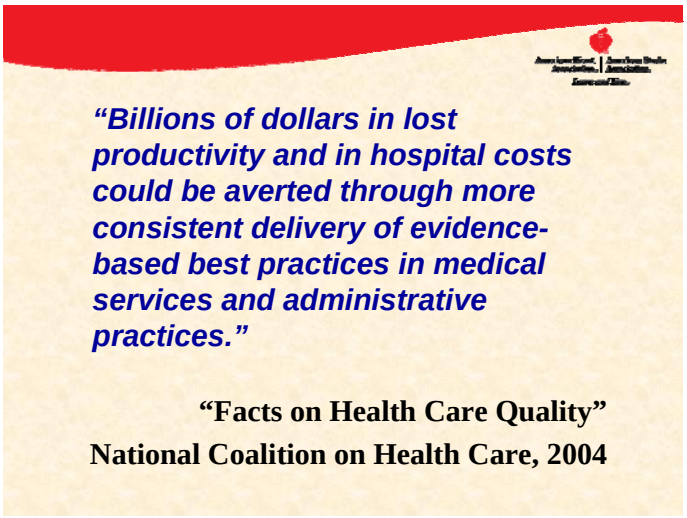
These include:

- **Employer mandates** to require employers to either provide insurance to their workers or pay a payroll tax that covers all or most of the cost of enrolling workers under a newly created public plan.
- Another option is **individual mandates** to require everyone to have some basic form of health insurance. (Massachusetts is the model for this type of plan.)
- **Tax credits** can be used to make private health insurance more affordable by allowing individuals and/or employers to deduct the cost of their health insurance premiums directly from their income tax.
- We could also **expand existing public programs** like Medicaid.
- And finally, we could **create a tax-financed or "single-payer" healthcare system.**



A growing number of experts argue that making progress on the coverage, access and cost of health care depends on improving organization and making healthcare delivery more quality-focused and efficient.

Lack of quality is a big and costly problem. Thirty percent of healthcare spending is for care that is ineffective and redundant. To fix that, we must begin to create incentives for delivering the best possible care instead of rewarding volume. We also need increased accountability and greater use of performance measurement and financial incentives that reward high performance.



Both consumers and providers need better tools to make informed healthcare decisions, so we need more information technology. Electronic health records might have an impact on health comparable to that of Quicken on tax preparation and home bookkeeping. Widespread use of information technology, allowing better and faster exchange of EHR data electronically, might result in fewer errors and fewer unnecessary (and potentially dangerous) procedures.

Reforms for slowing the growth in healthcare spending and increasing the value of care have largely focused on insurance-based solutions. Consumer-driven health care represents the most recent example of this approach. However, nearly two-thirds of the rise in healthcare spending is due to the rise in the prevalence of treated chronic diseases like diabetes and innovations in medical treatment. Over-eating, lack of exercise, smoking and stress account for about 40 to 50 percent of morbidity and mortality.

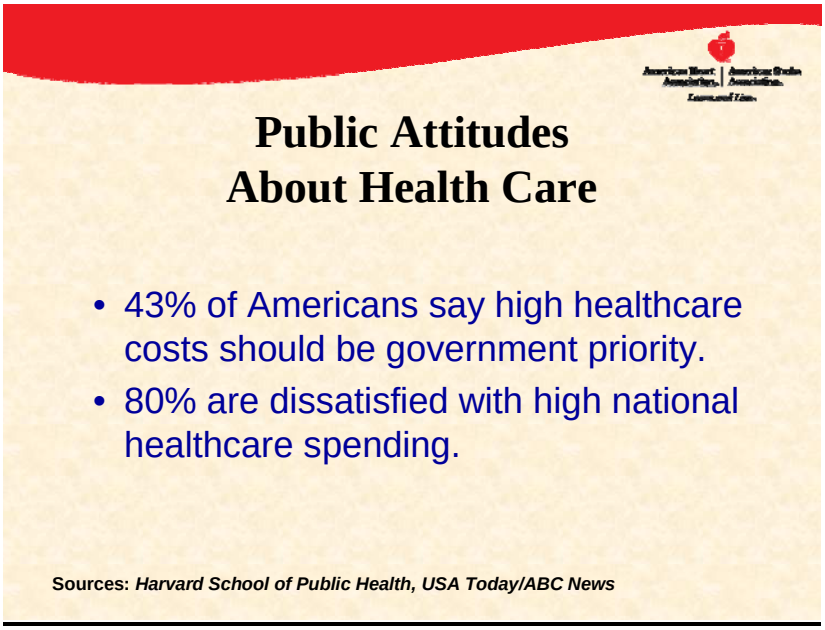
To be effective, reforms must focus on promoting health, public health interventions, and the cost-effective use of medical care, particularly for managing chronic diseases.

One of the biggest prevention pay offs might be to grant the FDA the authority to regulate tobacco products. Tobacco use is the single greatest cause of preventable deaths in the US, causing 440,000 deaths annually resulting in $96 billion in medical costs each year. [46]

The Role of Healthcare in the 2008 Presidential Primary Elections

Now let's turn to politics. For the first time since 1928, neither the Democratic nor the Republican party has an incumbent president or vice president among the candidates in its field.[47]

That makes it a great time to be debating healthcare reform. And Americans care about this issue. In a poll conducted by the Harvard School of Public Health, 43% of respondents named high costs as one of the two most important healthcare issues for government to address.[48]



In fact, in a *USA Today/ABC News* survey, 80% of Americans said that they were dissatisfied with high national healthcare spending — and 60% said they were VERY dissatisfied.[49]

Members of both parties are generally dissatisfied with many aspects of health care in America, but Democrats are significantly more likely to give the system poor reviews.

A plurality of Democrats say that government should have primary responsibility for making sure that Americans have health care, and the majority say they are willing to pay higher taxes for increased coverage. The plurality of Republicans say healthcare coverage should be an individual responsibility. Republicans are also more likely than Democrats to view the private health insurance industry as being more effective than government in providing coverage and controlling costs. [50, 51]

In addition, Democrats are considerably more likely than Republicans to favor requiring that everyone have health insurance, with the government helping to pay for insurance for those who cannot afford it. [52]

Voters' Concerns

What are voters concerned about? The vast majority of voters — 94% — are insured, and their top concern is rising costs. In a Harris Interactive Poll conducted for the Mayo Clinic Health Policy Center last December, 91 percent of respondents said healthcare costs are too high. They feel they are paying more and getting less.[53]

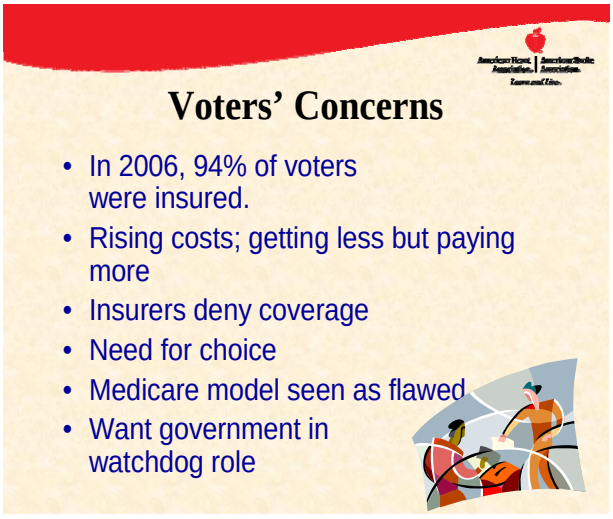
Voters also resent that insurance companies deny coverage.

Voters often support reform proposals in principle but pull away from policy specifics because they fear higher costs or lower quality *for them personally*. This means choice is key to reassuring them.

Voters find the idea of "quality, affordable health care" more appealing than "universal coverage."

Voters strongly support Medicare but believe it has problems. For that reason, people are wary of using it as a model.

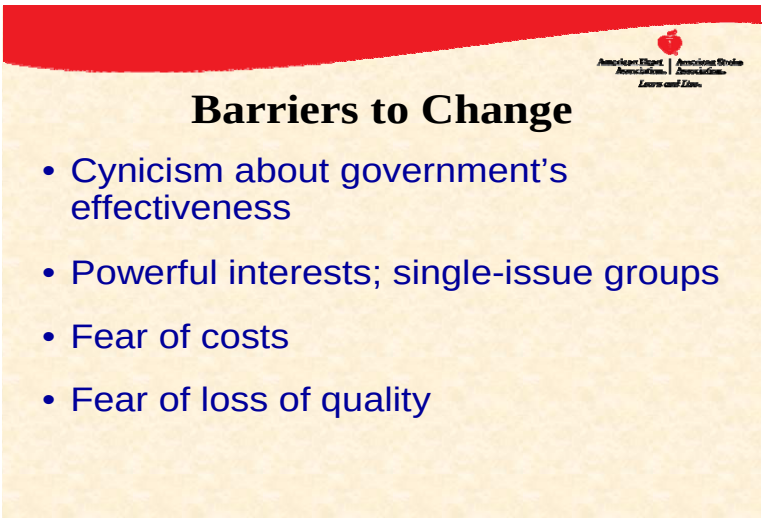
In general, voters are skeptical of a "government-run" program, but they see a clear role for government as a watchdog.



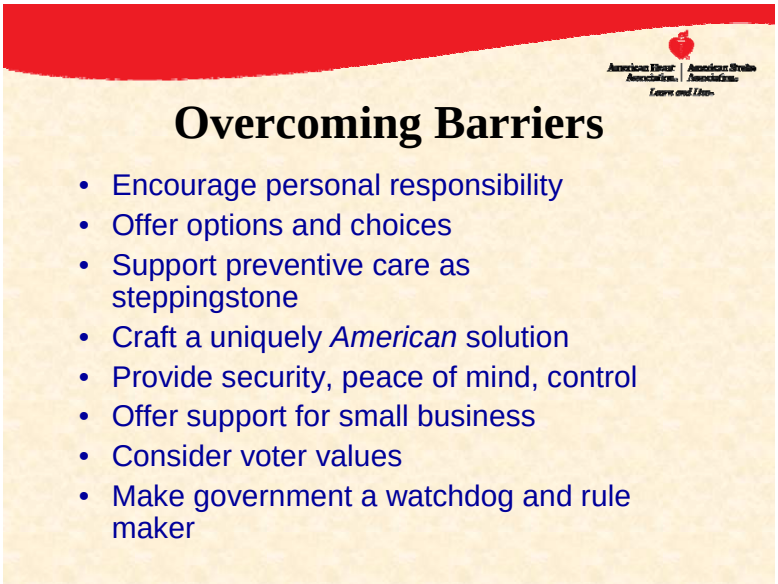
Barriers to Change

There are many barriers to changing health care in this country. One of them is cynicism about government and concerns about government bureaucracy, red tape and high costs. Another is perceived loss, which will motivate the prospective losers to try to thwart reform. Powerful interests and single-issue groups will have to be dealt with.

People also have concerns about who is going to pay, fear of higher costs and higher taxes, and perceived impact on small business. Scarcity is a final barrier, because voters worry about what they will lose in quality.



The barriers I've just mentioned aren't insurmountable. They can be accounted for in the new or revised system. For example, to address concerns, we can incorporate an element of personal responsibility and include options and choices in proposals – to make sure it's employee choice, not just employer choice. We can emphasize security, peace of mind and control. We can also use preventive care as a steppingstone and find a uniquely *American* solution, including choice.



Finally, it's important to focus on our support for small business, propose initiatives that reflect voter values about health care and define a role for government as watchdog and rule maker.

Let's wrap this up. I think that relief is possible. We can make decisions and take control. To do that, we need new ideas and strategies to craft a solution that makes sense and above all has bipartisan support.

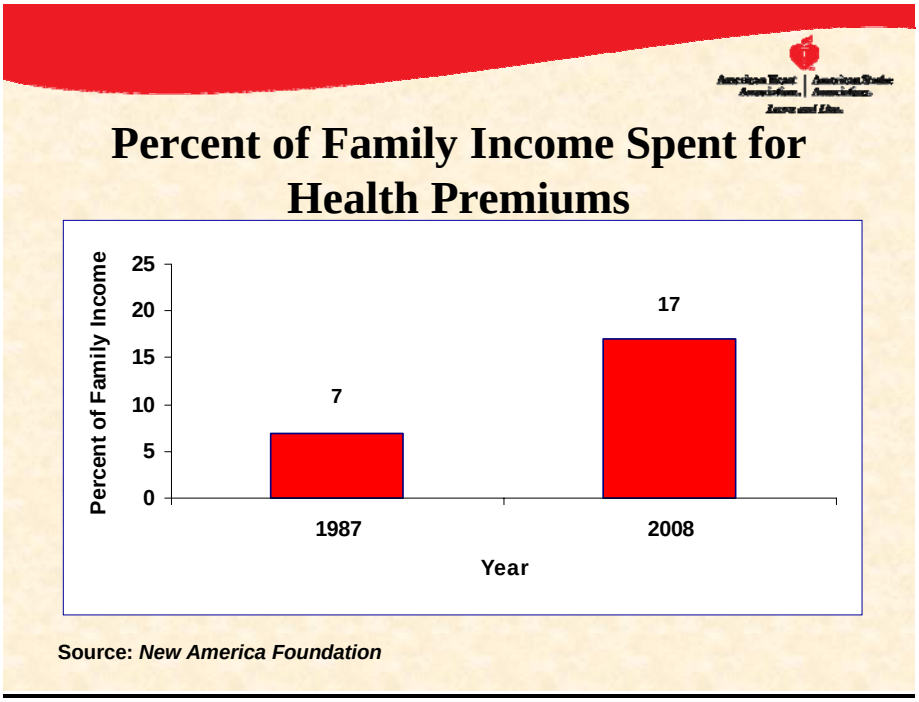
Clearly, there are some daunting political obstacles to reforming our healthcare system, but we cannot continue on our present path. The longer we wait, the more painful the change.

We need a system that's built to maximize health. To have reform, we have to do a better job of communicating that all of us have a stake when it comes to healthcare reform — not just the uninsured, the underinsured and the sick. If we don't have a healthcare system that works for all of us, we will soon have a system that works for none of us. We need to make it clear that we are building on what's best about our healthcare system while fixing what doesn't work.

The time is right for change. We need to focus on the big picture and look at the trend.

In 1987 healthcare premiums accounted for 7% of family income. Today it's 17%. And in future years it will only grow worse unless we act.

Because of our broken healthcare system, our taxes are higher, the products we buy have healthcare costs built in, our global corporate competitiveness is at risk, and we are being stuck with a $37 billion tab in free care provided by hospitals.



The American Heart Association, AARP, American Cancer Society and American Diabetes Association have been speaking out on behalf of four principles in the "Are You Covered?" campaign. Those principles are:

1. Quality health care for all…Because all Americans deserve effective prevention, treatment and care.

2. Health care that's affordable…Because getting the health care we need should not bankrupt individuals, families, businesses or society.

3. Health care without the "red tape"…Because all Americans deserve a healthcare system that provides clear, up-front explanations of costs and benefits, provides the best value for their dollar, and eliminates unnecessary paperwork.

And finally,

4. Health care when and where people need it…Because all Americans, regardless of their health, deserve adequate coverage that gives them the best available treatment and care in appropriate settings through all life stages and levels of disability.

We need a strong, healthy healthcare system just like the body needs a strong, healthy heart. That's not what we have now. Our system is like a failing heart that's working harder and harder, getting bigger and bigger, and becoming less and less efficient. We need to act now, before any more time passes. Americans are concerned about economy and if this isn't an economic issue, then I don't know what is. We need to make fixing our healthcare system a national priority.

Thank you.

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