

# **Health Insurance Overview I**

HealthInsuranceCE

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## **Preface**

I wrote this book as a text version of various lectures I gave to health insurance brokers over the past decade. It provides an overview of our healthcare system then digs deeper into various components and problems.

Each chapter addresses a stand alone issue or set of issues but these often overlap. I apologize for redundancy but, in health insurance, similar problems appear in different guises.

I take the healthcare issues discussed here personally and seriously. One of my clients once called me 'the conscience of the health insurance education business', not a particularly pithy label but one I'm enormously proud of. As a child of the 1960s who, among other things, worked for CARE in Chad, Africa building primary schools and planting orchards - the latter in a leaper colony outside N'Djamena - I believe that our healthcare system should benefit patients first, premium payers second and providers last. Some might disagree. Please let me know!

Whatever your particular orientation to healthcare, I hope you find reading this book a worthwhile experience.

Gary Fradin

August 2024

## **Two Types of Health Insurance** **and the associated problems of turning our high cost / low quality healthcare system** **into the opposite**

About half of Americans get their health insurance from the government, mainly Medicare and Medicaid, and about half get health insurance from their employer, aka commercial health insurance. Both forms of health insurance have their benefits and weaknesses, and both have their proponents. In this Introduction, we'll discuss both types of health insurance and explore their advantages and disadvantages.

Today's point of departure: our current healthcare system is soundly criticized for being **high cost / low quality**. In brief, Americans spend far more on healthcare than any other country in the world – double or even triple the western European countries, Canada and Australia – but we live about 5% less long than these folks. I use life expectancy as a measure of healthcare system quality, figuring that the #1 job of a healthcare system is to keep people alive.

In 2023 for example, the OECD average longevity at birth was 80.1 years; America's was 76.4.<sup>i</sup> Spending double but generating mediocre outcomes qualifies as high cost / low quality.

Solutions to this problem generally fall into two categories. Some say the fundamental problem with our healthcare system is the amount of regulation. 'Let doctors practice medicine without all these rules and regulations' these guys say. They want to deregulate our healthcare system and let 'market forces' rule. We'll explore that idea below.

Others say 'no, deregulating would make our healthcare system worse' and propose more government intervention or, indeed, an entirely government funded healthcare system, sometimes called Medicare-for-all. These folks argue that healthcare is a human right and only the government can protect human rights. We'll explore these ideas below also.

### **Where We Are Today**

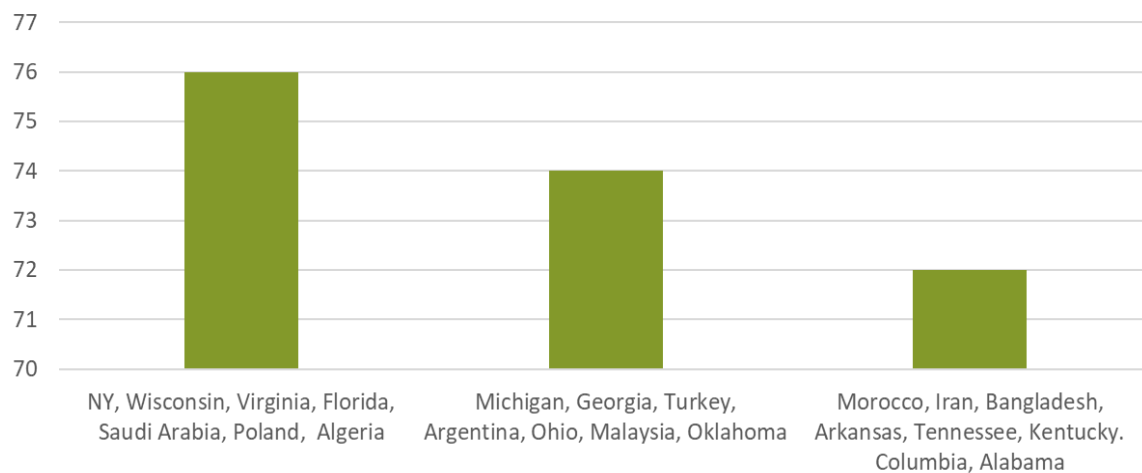
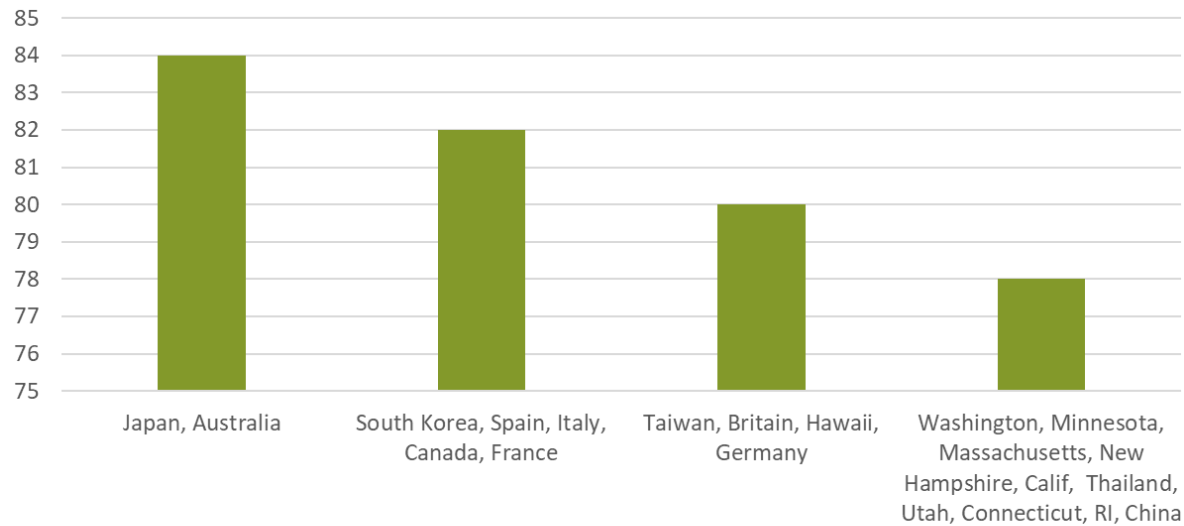
At \$4.5 trillion – our 2023 healthcare spending, the latest available as I wrote this text - our *healthcare* economy was larger than France's total gdp (about \$3 trillion) or Britain's (\$3.1 trillion) and about twice as big as Russia's (\$2.2 trillion).<sup>ii</sup> US healthcare spending equaled about \$13,493 per person or 17.3% of GDP.

That's the highest healthcare expenditure per capita or as a percentage of our GDP in the world. See below, a list of per capita healthcare spending in countries that live longer than the US national average or any individual US state average.<sup>iii</sup>

| Country        | 2023 per capita health spending |
|----------------|---------------------------------|
| US             | \$13,493                        |
| Australia      | \$ 5,376                        |
| France         | \$ 5,251                        |
| Canada         | \$ 5,915                        |
| Japan          | \$ 4,313                        |
| United Kingdom | \$ 4,485                        |
| Spain          | \$ 3,617                        |
| Italy          | \$ 3,615                        |

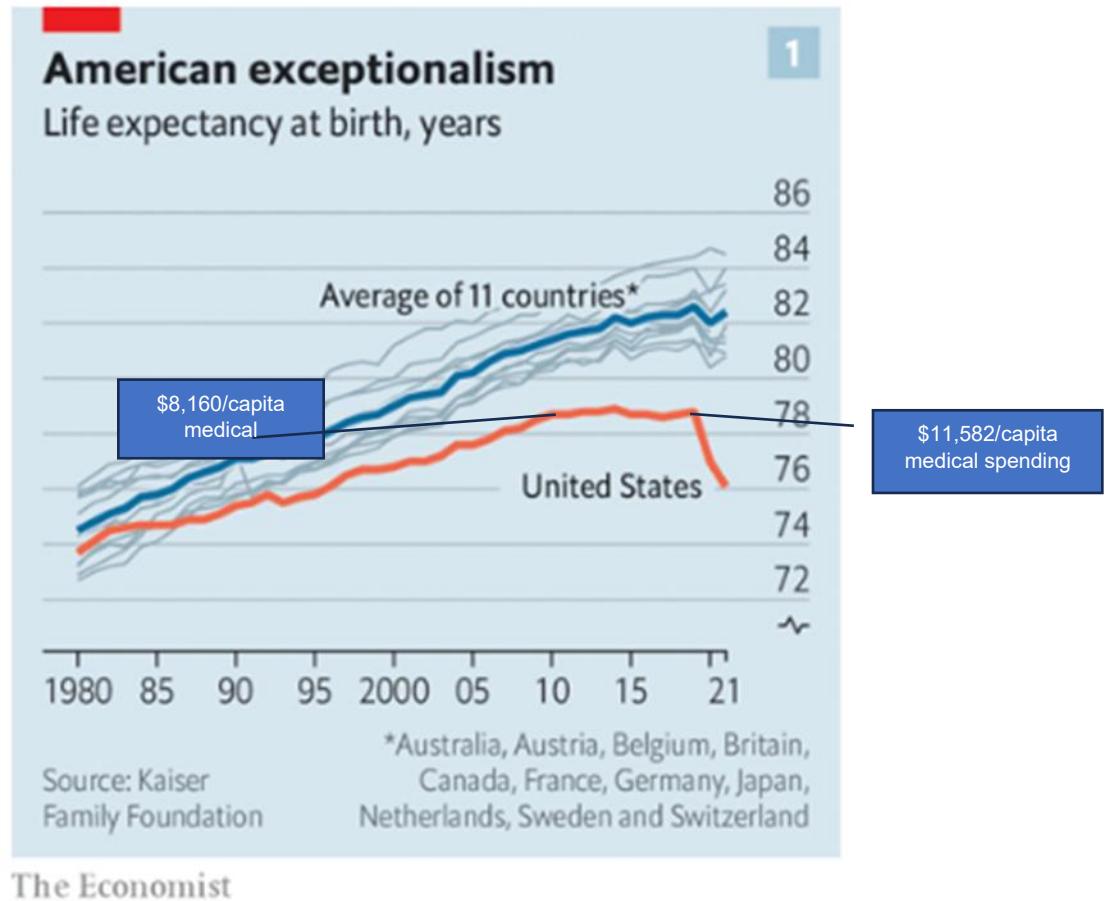
One way to see the magnitude of our healthcare system inefficiency is to see how those various countries compare to US *state* longevity at birth averages. These data were originally developed by the National Center for Health Statistics at the United Nations and presented by Nicholas Kristof in the New York Times, August 17, 2023.

Average Longevity at Birth  
 Various countries compared to US States  
 Life expectancy in 2 year age bands on the left  
 '82' means '82 – 84 years'; '78' means '78 – 80 years'



Equally or perhaps more upsettingly, we have experienced **no** national life expectancy gains since about 2009, despite a 40% increase of medical spending per capita from 2009 – 2020.<sup>iv</sup> This differs from other advanced, industrialized countries. See the chart below published in The Economist, July 13, 2023.

- Note first that Americans, while spending more on medical care than the others, had shorter life expectancies.
- Then, more upsettingly (personal opinion), see the 2009 – 2020 period, when our life expectancy was flat – despite spending more on medical care each year.
- Finally, note the relative impact of Covid on American and other life expectancies.



How do we get out of this mess?

### The commercial health insurance imperative

Ronald Reagan, patron saint of the ‘deregulate healthcare’ folks famously said ‘government isn’t the solution to our problems; government is the cause of our problems’. Applying Reagan’s philosophy to healthcare, commercial, deregulated health insurance would be his desired solution to the healthcare mess described above.

Articulating Reagan’s deregulation philosophy this more specifically to healthcare reforms, Paul Ryan, Speaker of the House between 2015 – 2019, claimed:

“Healthcare reforms should address government-imposed barriers to true choice and competition”<sup>v</sup> with market-based competition apparently the system goal.

Our high cost / low quality healthcare system is, in Reagan’s and Ryan’s view, largely-to-entirely caused by government programs, regulations and interventions. The 2017 Trump administration policy paper ‘Reforming America’s Healthcare System Through Choice and Competition’ by the US Department of Health and Human Services and endorsed by then HHS Secretary Alex Azar II, Treasury Secretary Steven Mnuchin and

Labor Secretary Alexander Acosta goes into more detail.<sup>vi</sup> Here are some short, salient quotes:

- The United States healthcare system increasingly imposes a bewildering array of complexity and inefficiency throughout the commercial insurance markets.
- These inefficiencies, mandates and regulations contribute to higher costs
- The federal regulation of healthcare has risen sharply
- This report finds many cases where government regulation and rules prevent healthcare markets from working efficiently.
- (This) report identifies numerous government policies that inhibit choice and competition in healthcare markets, dampen productivity gains among providers, lead to increased consolidation and market concentration, and prevent the introduction of more efficient or innovative ways of delivering and paying for care.
- Healthcare markets, like all other markets, benefit from vigorous competition.

‘Get the government out of the system’, in other words, and let the various players function unencumbered by regulations so doctors practice medicine, hospitals host patients and insurers pay. That, the Reagan, Ryan and Trump administration approach suggests, will simultaneously reduce healthcare costs and improve healthcare outcomes. Many other scholars, researchers and policy makers agree.<sup>vii</sup>

Maybe they’re right but color me skeptical.

Eliminating government regulations would leave in place our current healthcare structure: independent providers – doctors and hospitals - who treat patients, and the numerous, independent insurance companies who pay for those treatments.

Providers typically bill insurers fee-for-service, or a specific amount of money for each service. Providers and payers fight over payments: doctors *a/ways* want to receive more, and insurance companies *a/ways* want to pay less. They fight over codes, and they fight over amounts per code. Atul Gawande, NY Times bestselling author, Harvard professor and surgeon in Boston, described their relationship as ‘war, every step of the way.’<sup>viii</sup>

True choice and competition, in other words according to those involved, leads to war. Perhaps not the best foundation on which to build a high functioning healthcare system.

These two groups – providers and financiers – have generally agreed on a combat formula. Providers bill for each service and insurance companies pay according to a price list, sometimes for bundles of services, sometimes piecemeal per service. Non-capitated, unlimited fee-for-service in other words. It has existed in medicine since approximately the dawn of time.

### **Fee for Service Payments**



We have tried for years to develop a more efficient and effective payment system but have consistently failed. I'll demonstrate that failure shortly. But first, let's understand the fundamental problems using fee-for-service billing as our healthcare system's preferred field of battle.

Fee-for-service has, according to Alain Enthoven, Stanford Professor of Medicine and Business in his 2004 book *Toward a 21<sup>st</sup> Century Healthcare System*, 10 major flaws. <sup>ix</sup>

1. Fee-for-service creates an adversarial relationship between doctors and payers (That's Gawande's 'war'.);
2. Fee-for-service has little accountability – poor data collection and provider motivations for economy;
3. Fee-for-service 'free choice of provider' leaves patients to make remarkably poorly informed choices;
4. Fee-for-service generates excess hospital capacity, high tech equipment and open-heart surgeries;
5. Fee-for-service generated an excess supply of specialists;
6. Fee-for-service misallocates resources, as no incentive to use the least costly settings for treatment;
7. Fee-for-service has no capacity to plan care processes from diagnosis to treatment to rehabilitation;
8. Fee-for-service has led to a dangerous proliferation of facilities for complex and costly procedures without the volumes necessary to maintain good outcomes;
9. Fee-for-service cannot practice total quality management due to lack of service integration;
10. Fee-for-service cannot organize the rational use of technology.

Enthoven wrote this damning list in 2004. As a well-known healthcare researcher and Stanford professor, he commanded attention from healthcare system planners, workers and regulators, many of whom read his articles and books, and heard his lectures.

How well did his message impact healthcare? Not well at all. As evidence, here's an updated list of fee-for-service flaws published in 2024, 20 years later by Dave Chase. Well known in health insurance circles, Chase founded Health Rosetta and wrote numerous books including *The CEO's Guide to Restoring the American Dream*. He calls these problems 'tricks'.<sup>x</sup> In many ways, Chase's 'tricks' are Enthoven's 'fee-for-service problems':

- Trick #1: Pushing for Expensive Treatments: Patients often receive recommendations for costly and invasive treatments, even when less expensive and equally effective options are available. For example, physical therapy can be more effective than surgery for back pain, yet patients are often steered towards surgery. This is largely due to financial incentives for hospital-employed doctors to refer patients to high-margin specialty practices.

- Trick #2: Undermining Primary Care: Primary care appointments are often limited to 10 minutes, leaving little time for thorough diagnosis. This drives physicians to order tests or prescribe drugs, contributing to the opioid crisis. This bias against primary care favors higher-cost specialty care and undermines valuable resources.
- Trick #3: Confusing Drug Pricing: Drug pricing is confusing by design, allowing exorbitant prices to go unchecked. Pharmacy benefit managers (PBMs) are notorious for hidden fees and promoting expensive drugs. For instance, drugs such as Duexis and Vimovo, which are combinations of cheap generic drugs, cost thousands of dollars despite their generic counterparts being significantly cheaper.
- Trick #4: Managing High-Cost Claims Poorly: Outlier claims, where a small percentage of employees account for a large majority of medical costs, drive healthcare costs significantly. Programs like Walmart's Centers of Excellence have shown that many high-cost procedures, such as organ transplants, are often unnecessary. Seeking out high-quality, lower-cost services, in these cases can lead to substantial savings.
- Trick #5: Surprise Out-of-Network Bills: Patients often face surprise bills from out-of-network specialists involved in their care without their knowledge, even when their primary physician is in-network. This practice can lead to significant unexpected costs and potential legal issues for employers.
- Trick #6: Delivering Inappropriate Oncology Treatment: Many cancer treatments are unproven and don't follow evidence-based guidelines, often disregarding the severe side effects for patients. Financial conflicts at cancer centers can result in patients and families not being fully informed about treatment costs.
- Trick #7: Hiding Quality and Safety Information: The healthcare industry uses its significant lobbying power to hide quality and safety information from the public. Despite this, organizations like Leapfrog, Medicare's Hospital Compare, and various online physician rating sites can provide some transparency by offering accessible data on hospital performance. However, not all hospitals participate in these initiatives. Employers should proactively seek out this information to ensure the best care for their employees.

See the overlap of system problems from 2004 and 2024. Brokers and other healthcare professionals can probably enhance either or both lists based on their own experiences.

This juxtaposition of Enthoven's and Chase's list makes one point painfully clearly: none of the new-and-improved healthcare financing tools developed since 2004 – actually, since way before that – have worked!

The endless list includes diagnosed related groups, first dollar coverage, high deductibles, Pay 4 Performance, tiered networks, reference pricing, global payments, Health Savings Accounts, Health Reimbursement Accounts, patient-centered medical homes, price transparency and more, all designed to fix the fundamental fee-for-service problems and all utter failures.

Apologies for the pessimism but the progression from Enthoven in 2004 to Chase in 2024 leads to no other conclusion.

Let's switch gears slightly to hear a different point of view, this time from Michael Porter and Elizabeth Teisberg. Porter is Harvard Business School's great business strategy professor. He and his colleague Elizabeth Teisberg explain why these problems persist in their 2006 big book about healthcare reform, *Redefining Healthcare*. They conceptualized our ongoing failure to develop a high quality / low cost system as a failure of competition in healthcare. We'll discuss their analysis in more detail later in this book, in the chapter entitled 'Why Private Sector Healthcare Reforms Always Fail'.

In brief now though, since this is just the introduction to the book, they suggest that we have **dysfunctional healthcare competition** in

- The wrong geographic markets, i.e. a state or even local focus, not national;
- The wrong time horizon, i.e. annual, not disease cycle;
- The wrong unit of measure, i.e. individual doctors or hospitals, not the medical condition itself;
- The wrong goals, i.e. competition among providers to amass wealth not to generate outstanding patient outcomes;
- The wrong information, i.e. patients too often choose a treatment or provider based on price, personality, availability or reputation rather than likely outcomes. One depressing reason for this: our outcome data are generally quite poor;
- The wrong provider structures, i.e. broadline, general hospitals, not specialty ones. General hospitals, like general department stores suggest Porter and Teisberg, generally fail, compared to specialty hospitals, to generate consistently outstanding patient outcomes. A general hospital might be great at nephrology but poorer at obstetrics due to patient volumes or internal resource allocations; general hospitals, by their nature and structure, allocate resources based on criteria other than patient outcomes.
- Read the chapter below **Why Private Sector Healthcare Reforms Always Fail** for more on these points.

We have not, in the past several healthcare reforms, addressed most of Porter and Teisberg's issues at all, even unsatisfactorily. We still function in the wrong geographic markets, using the wrong time horizon, decide treatments based on the wrong unit of measure, fight for the wrong goals between providers and payers, choose providers based on the wrong information and use the wrong form of hospitals far too often.

That's the strategic reason why Enthoven's and Chase's criticisms resonate and continue today.

### Occam's Razor

Finally, I'd like to offer my own summary about how to understand healthcare reform failures and what to do about them. I'll adopt the Occam's Razor approach, named after the 14<sup>th</sup> century friar William of Ockham. Occam's Razor suggests that when you have multiple competing hypotheses or solutions to a problem, the one with the least assumptions, i.e. the simplest, is probably the best.

Friar William put it this way: "Entities should not be multiplied beyond necessity" (in Latin for those of you so inclined: *Entia non sunt multiplicanda praeter necessitate*).

In the healthcare reform arena, we have lots of explanations for our high cost / low quality system, including the lack of choice among patients, lack of critical information available to patients, inappropriate competition in healthcare, impact of lobbying on healthcare regulations and prices, impact of advertising on patient assumptions and desires and many more. All may enjoy some validity, but Occam's Razor asks for the fundamental cause of our healthcare problems. Where, in other words, should we focus our efforts to turn our healthcare system from high cost / low quality to the opposite? What problem need we fix first?

I suggest that fee for service billing in our multi-payer environment is the simplest, most fundamental cause of our high cost / low quality system.<sup>xi</sup> Dramatically alter or eliminate that problem and lots of good things start to happen system wide.

Today about half of financing comes from private, commercial insurers and about half from the government through Medicare, Medicaid or other, smaller programs. Those include the Veteran's Administration Healthcare system, the Federal Employees Health Benefits Program (FEHB), the Massachusetts Commonwealth Group Insurance Commission and many more. Each pays different prices to the same physicians and hospitals for the same treatments, though for different patients. This leads to tremendous administrative overhead expense, some \$600 billion annually,<sup>xii</sup> or about 14% of all healthcare spending.

Let's continue with Occam. Membership in any of the organizations listed above or others depends on factors unrelated to health, health status or medicine and includes things like

- You age ... for Medicare
- Your income ... for Medicaid
- Your employer ... for the FEHB

- Your former employer ... for the Massachusetts Teachers Retirement Association that gets its health insurance from the Massachusetts Group Insurance Commission
- Your employer when you were severely injured ... for the VA, and more.

None of this makes economic or medical sense. Why, a foreigner might ask, does a 55-year-old needing a knee replacement face higher prices if he or she is self-employed than if he or she works for a large company? Or is unemployed and on Medicaid?

Why do doctors bill more for a W-2 employee's annual physical than a retiree?

Why does a severely injured former soldier have access to the VA for specific treatments, but perhaps not Massachusetts General Hospital, while someone who served alongside and wasn't injured have access to Mass General but not the VA?

One result of this byzantine administrative chaos: American hospitals need to maintain and track multiple prices, including:

- Medicare's fee schedule, largely stipulated by Medicare nationally with some regional variations
- Medicaid's fee schedule, negotiated by each state and generally lower than Medicare's fee schedule
- Negotiated rates with private/commercial insurance plans, potentially a different rate for each insurance carrier. Commercial rates are generally higher than Medicare or Medicaid
- Chargemaster rates for uninsured/self-pay patients, usually the highest rate
- Financial assistance/discounted rates for low-income uninsured, at each hospital's discretion, often a sliding scale based on the patient's income
- Potentially also rates for automobile insurance cases, worker's compensation cases, out-of-state or international patients, and more.

Billing and administrative issues, caused by our multi-payer, fee-for-service system is the simplest, most obvious explanation for our high healthcare costs, the Occam Razor. Fee-for-service leads, almost inevitably, to the dysfunctional competition noted by Porter and Teisberg and the flaws and tricks listed by Enthoven and Chase.

This logic suggests that if we fix our multi-payer, fee-for-service problem, we can turn our healthcare system toward lower cost with, hopefully, higher quality.

Do such solutions exist?

### **Medicare-for-all to the Rescue *maybe***

Some who study our healthcare miasma call for a national single payer system. The Physicians for a National Health Program, for example, proposes a publicly financed

non-profit, single payer national health program that would fully cover medical care for all Americans.<sup>xiii</sup> This might address some of Porter and Teisberg's competition issues and, by extension, my Occam's Razor diagnosis. We'll see.

The PNHP proposal in brief:

Even after full implementation of the Affordable Care Act (ACA), tens of millions of Americans will remain uninsured or only partially insured, and costs will continue to rise faster than the background inflation rate.

We propose to replace the ACA with a publicly financed National Health Program (NHP) that would fully cover medical care for all Americans, while lowering costs by eliminating the profit-driven private insurance industry with its massive overhead. Hospitals, nursing homes, and other provider facilities would be nonprofit, and paid global operating budgets rather than fees for each service.

Physicians could opt to be paid on a fee-for-service basis, but with fees adjusted to better reward primary care providers, or by salaries in facilities paid by global budgets. The initial increase in government costs would be offset by savings in premiums and out-of-pocket costs, and the rate of medical inflation would slow, freeing up resources for unmet medical and public health needs.

Dr. Brian O'Malley summarized a version of this for Massachusetts, proposed in 2023 as Mass Senate Bill S.744 and Mass House Bill H.1239, endorsed by 13 Senators and 40 Representatives:<sup>xiv</sup>

The Medicare-for-all bills proposed in the Legislature would cover all residents for a much more comprehensive set of benefits than any private insurance with no deductibles or copayments, no networks to navigate, and free choice of providers.

Financing would be through a predictable 2.5 percent employee health tax and a 7.5 to 8 percent employer tax.

No more annual renegotiation of benefits and no budgeting uncertainties.

Note that the 'single payer' verbiage used by the Physicians for a National Health Program (PNHP) and the 'Medicare-for-all' verbiage used by Dr. O'Malley, mean about the same thing: government funded healthcare. In other words, 'Medicare-for-all' doesn't necessarily mean 'use the existing Medicare program and simply extend it to all Americans' but instead 'provide all Americans with full coverage for all medical care'. The system base could, in fact, be 'Medicaid for all'. 'Medicare-for-all' here becomes a slogan, not a specific policy proposal as best I can decipher its meaning.

Apologies for the confusion but, in this rare case, it's not my fault.

The PHNP estimated an administrative system savings of \$500 billion annually in 2018 by switching from our current multi-payer to their proposed single payer system. That

was about 14% of that year's \$3.6 trillion total healthcare spending. Today's equivalent savings would run about \$600 billion (14%) of our 2024 estimated \$4.5 trillion healthcare bill.

In addition, the PNHP approach addresses virtually all the fee-for-service flaws noted by Alain Enthoven above, the 'tricks' articulated by Dave Chase above and the failures of competition identified by Porter and Teisberg. It fixes our Occam's Razor problem. Seems like a no-brainer.

### **What could go wrong?**

I'll answer that question by exploring two fundamental problems that all single payer healthcare systems face: (1) how to develop a treatment rejection process that seems fair enough that the population will accept it, and (2) how to maintain the system's hospitals, workforce and technology financially. Failure of either or both can destroy a single payer healthcare system. That's fundamentally why we hesitate to move in this direction. (OK, healthcare lobbyists play a big role too. But we'll focus on the system structure in this chapter rather than politics and lobbying power.)

We'll discuss the treatment rejection problem first, the system maintenance issues second and learn from other countries' experiences third.

#### **Fundamental Problem #1: The problem of 'No'**

Free, universal, comprehensive medical care for all Americans runs into the problem of **moral hazard** and creates the need for a healthcare system to reject certain patients, for certain treatments, under certain conditions. This section will introduce these issues.

Moral hazard describes why and how, when someone else pays, people use more resources than otherwise, than necessary or than their allotted share. The term moral hazard developed when home fire insurance was initially developed in Britain centuries ago. Insurers worried that homeowners with 'poor moral character' would purchase insurance, burn down their houses, then collect the insurance proceeds and, theoretically at least, rebuild a cheaper house, thus profiting at the insurance company's expense. 'Poor moral character' became known as 'moral hazard'.

A modern day variation, for illustration purposes, is the all-you-can-eat buffet restaurant. Customers tend to eat more in these establishments per meal than in other restaurants.<sup>xv</sup> They figure 'I've already paid the entry fee, so the additional food is free to me. It doesn't cost me more if I waste it so I'll take more'.

The restaurant entry fee functions economically like a health insurance premium.

Moral hazard is a particular problem in healthcare since health is sometimes called a 'super good' in two senses. First, you can always feel better or improve your healthcare test results; no one is completely and paradigmatically healthy on all metrics.

You might have an occasional poor night's sleep, a sore shoulder after playing tennis, indigestion after eating certain foods or mild headaches when the barometric pressure falls. Or one of your annual physical test results for cholesterol, blood sugar, triglycerides, blood pressure or something else might be in the 'low normal' category instead of perfectly normal. You can always improve something about your health.

'Doing something' consumes system resources. If *everyone* wanted unlimited access to medical care each time they felt a shoulder twinge or received a slightly below average result from a lab test, the system would get overwhelmed.

We need somehow to constrain utilization.

Second, 'super goods' are things that people desire increasingly as they become wealthier. What would a wealthy person want once they have a summer and winter vacation home, season tickets to the local sports teams and art programs, unlimited choice of restaurant every day, and a multitude of friends or sycophants? Better health and longer lives suggest some. In other words, as people get richer, the relative value of additional material purchases declines while the relative value of an additional year of life increases. Two researchers in this arena, Robert Hall of Stanford and Charles Jones of Berkley, suggest that 'the value of life grows roughly twice as fast as income.' <sup>xvi</sup>

According to this line of thinking, as our society gets wealthier, people will want to access more and more medical care. This becomes increasingly problematic under a single payer financing system where the financier needs to balance access, tax rates and medical care quality. The system needs to stay on budget, making the problem of 'no' increasingly difficult as we become richer and medical care more expensive.

We face two issues here. First, what criteria should we adopt to reject unnecessary treatments or patients, or restrict easy access to minor, low quality care? Second, how can the proposed single payer system generate widespread popular support for those criteria? Let's address each in turn.

### **Excess Demand and High Value Care**

Our current healthcare system deals with excess demand in opaque and complicated ways. Plans have deductibles, copayments, and/or referral requirements that inhibit demand. Some limit access by time, say 3 prescription refills per month.<sup>xvii</sup> Hospitals have bed capacity, workforce constraints or other resource limits. Physicians have time capacity limits with only so many appointments per day. All these keep system utilization rates under control more or less.

Unfortunately, none are terribly efficient. Systemic efficiency means getting the highest value or best outcomes per dollar spent. By simply constraining supply, they may reduce access to the most valuable services while allowing easy access to the least.

Supply constraints may, in other words, be systemically inefficient.



**Time limitations**, the 3 prescription refills per month idea above, may prohibit some people from accessing excessive amounts of low-quality medications. But they equally might prohibit other folks from accessing necessary meds, including long term longevity promoting ones. Time access limitations don't differentiate low quality / unnecessary medications from high quality / necessary ones.

**Cost sharing** is more difficult for middle- and lower-income folks than high income ones. That creates equity issues. In addition, patients often confuse 'cheap' with 'low value' medical care. Cost sharing can certainly constrain healthcare utilization, but it likely does so at the cost of people's health and lives.

**Time limitations** plus **cost sharing** can have a particularly strong negative health impact on lower income people, sometimes forcing them to choose between medicine and food.

**Supply limitations** can substitute 'made appointment earlier' for 'needs treatment more today' especially in relatively inflexible scheduling systems. These limitations again fail to differentiate low- from high-quality care.

I once ran into this problem with an extremely painful tooth abscess. My dentist's scheduler said 'no, you can't come in today. All our dentists are fully booked' generally with non-emergency, routine care. When I spoke directly to my dentist, he said 'you need to come in immediately when you're in severe pain. The quicker we treat it, the less invasive our treatments, the lower your cost and the better your outcomes.' Note the tradeoff here between 'appointment scheduling ease' and 'high value care'.

Or consider wait times in Emergency Rooms. Though ERs try to triage patients, wait times of 2 – 4 hours were frequently reported in 2023, with some 5 – 10% of patients waiting 6 hours or more to see a doctor.

We'll discuss waiting lists in more detail below.

Ad hoc, company specific, and idiosyncratic restrictions can work, more-or-less, to control demand in our current system, artistically described by Ezekiel Emanuel, a chief architect of the Affordable Care Act, as "terribly complex, blatantly unjust, outrageously expensive, grossly inefficient".<sup>xviii</sup> In our current system, however, patients can switch carrier or medical provider when sufficiently annoyed.

A universal, single payer system needs a clearer demand control mechanism to ensure fairness, improve efficiency and reduce cost prudently, a system that everyone understands and abides by.

## **Waiting Lists**

Waiting lists are commonly used, imprudent and inefficient control mechanisms. Those reserving their spots first get treatment first, those reserving their spots later need to wait longer. While perhaps useful to keep spending down, waiting lists suffer from 2 main problems. First, they **fail to differentiate sicker from less sick patients**, those needing care immediately from those who can wait longer without harming their health. Some waiting platforms, of course, attempt to differentiate.

The National Health Service in Britain, for example, utilizes a triage system to prioritize patients based on the severity and urgency of their medical needs. This helps ensure that those with life-threatening or serious conditions receive immediate care, while those with less urgent issues may have to wait longer for treatment. I don't know how well the system works in real life but here's a general overview of how prioritization works:<sup>xix</sup>

1. Emergency cases: Patients with acute, life-threatening conditions such as severe trauma, heart attacks, strokes, or severe bleeding are given the highest priority and seen immediately in the emergency department.
2. Urgent cases: Patients with serious but not immediately life-threatening conditions, such as acute infections, severe pain, or worsening chronic conditions, are seen on the same day or within a few days, depending on the specific situation.
3. Semi-urgent cases: Patients with conditions that require treatment within a few weeks, such as suspected cancers, hernias, or certain chronic disease flare-ups, are placed on a more urgent waiting list.
4. Routine cases: Patients with non-urgent conditions, such as mild to moderate chronic conditions or elective procedures like joint replacements or cataract surgeries, are placed on a routine waiting list and may have to wait several months or longer for treatment.

The prioritization is typically done through a combination of factors, including the patient's reported symptoms, medical history, and the results of any initial tests or examinations. Healthcare professionals, such as triage nurses or doctors, use standardized guidelines and their clinical judgment to assess the urgency of each case.

Patients participate in this prioritization process. See the sign below, posted outside the Royal Lancaster Hospital in Lancaster, England. 'A & E' stands for Accidents and Emergencies, the British equivalent of our Emergency Room. I hope you can read it; I took the photo and am a significantly poorer photographer than author, if that's even possible!



Additionally, the NHS has maximum waiting time targets for different types of treatments. For example, patients with suspected cancer should receive their first treatment within 62 days of referral, and most patients should receive non-urgent treatment within 18 weeks of referral.

This system is not perfect – far from it - and patients may experience delays or prioritization issues, especially during times of high demand or resource constraints within the NHS.

One 2010 study found that waiting times target remained piecemeal and did not necessarily reflect patients' individual experience of waiting.<sup>xx</sup> This report labelled as 'successful' in June 2010 that around 90 per cent of admitted patients and 98 per cent of non-admitted patients were seen within 18 weeks. I shudder to think how Americans would react to that!

This raises the second issue: **popular acceptance**. Would Americans tolerate long waits for medical care in return for, hopefully, lower costs? I doubt it and equally doubt that our politicians would endorse this as our cost control mechanism in a single payer / Medicare-for-all type system. Already some 26% of us wait 2 or more months for treatment according to research by the American Association of Nurse Practitioners.<sup>xxi</sup>

Sorry but as a moderately well-informed non-political scientist, I just don't see Americans accepting waiting longer for medical care as a solution to our existing healthcare cost problems.

## QALYs

### Quality Adjusted Life Years

Instead of inefficient, poorly targeted cost sharing or waiting lists to control healthcare demand and thus reduce spending, some suggest an alternative methodology. The Brits, for example, ration medical care through the National Institutes for Health and Care Excellence or NICE. We'll discuss their rationing experience in this section, then try to extrapolate lessons from it for the US.

'Ration' isn't a dirty word. It simply means restricting access to certain treatments, generally to keep costs down or maybe to promote fairness. We in the US currently ration medical care in many ways - waiting lists (see the Nurse Practitioner study above), state regulations (abortion access for example), hospital capacity or insurance coverage among others. These are often hidden, private and subjective methods. The British National Health Service through NICE simply rations care openly, objectively and publicly.

Rationing can make our healthcare system simultaneously less expensive, higher quality and fairer. Consider a hypothetical \$1,000,000 treatment for a specific patient. Would we, as a society, be healthier, live longer and be better off overall, if that one patient got the million-dollar treatment, or if 100 people got \$10,000 treatments instead? (Review the British cost and life expectancy data above before you answer.)

Rational rationing criteria can help us make those uncomfortable trade-offs.

NICE in the UK employs a rigorous system to assess the clinical and cost-effectiveness of healthcare interventions.<sup>xxii</sup> It aims to ensure that NHS resources are allocated efficiently and that patients have access to effective, evidence-based healthcare interventions that represent value for money. NICE's transparent, objective, evidence-based approach seeks to balance clinical need, patient benefit, and affordability.

By many accounts, it does a pretty good job as evidenced by the high public satisfaction levels with the National Health Service among Brits.

NICE uses **Quality-Adjusted Life Years (QALYs)** as a measure of health outcomes to determine medical care cost-effectiveness. QALYs integrate both the quantity and quality of life gained from a healthcare intervention into a single measure.

1. **Definition of QALY:** A QALY is a measure of health outcome that combines both the length of life (quantity) and the quality of life (utility or health-related quality of life) experienced during that time. One QALY is equivalent to one year of life lived in perfect health. Health states considered less desirable than perfect health have QALY values less than 1.

2. **Utility Values:** Utility values represent the quality of life associated with different health states. These values range from 0 (representing death) to 1 (representing perfect health). We'll discuss at least 1 way to determine these values below.
3. **Assessment of Health Benefits:** When evaluating a healthcare intervention, NICE considers the impact of the intervention on patients' health-related quality of life over time. This is done by estimating the number of QALYs gained or lost as a result of the intervention.
4. **Cost per QALY:** NICE calculates the incremental cost per QALY gained. This involves comparing the costs of the intervention (e.g., drug costs, administration costs, monitoring costs) with the additional QALYs gained. Interventions with lower incremental cost per QALY gained are generally considered more cost-effective.
5. **Cost-Effectiveness Threshold:** NICE uses a cost-effectiveness threshold to determine whether an intervention represents value for money. It typically sets the value of each QALY at between \$25,000 to \$40,000. They determine this amount in various ways that lie outside the scope of this particular chapter; QALY determination methodology is incredibly complicated. I'll discuss one relatively easy-to-understand method below.
6. **Decision Making:** Based on its assessment of cost-effectiveness, NICE provides recommendations on whether the intervention should be funded. Interventions generating more QALY value than cost are generally recommended for adoption, while those showing higher costs than QALY calculated benefits are generally not.

Thus, as a simple example, assume that a \$100,000 treatment would increase someone's life expectancy by 5 years of excellent health or 5 QALYs. Here, we know the cost (\$100,000) and can estimate the value of those additional life years at about \$150,000. (5 year at approximately \$30,000 per year.) NICE would probably approve the treatment.

But change things slightly. Now the same \$100,000 treatment would only increase someone's life expectancy by 3 years of excellent health, thus generating about a \$90,000 benefit. (3 years at \$30,000) NICE would probably not approve the treatment. Or 4 years of moderate health (4 years at \$20,000 = \$80,000). NICE, again, would probably deny that treatment.

These calculations get very complicated very quickly. Imagine explaining this to Congress!

### **Determining QALY values**

Now for the wrench in the works (*the* wrench? I can think of several.) Let's determine an American value of each QALY. We'll use a **willingness to pay** methodology as articulated by Harvard's David Cutler in his 2004 book *Your Money or Your Life*.

The willingness to pay idea suggests that we can determine the value of a life year based on calculations of our expenditures for various lifesaving products. Cutler used car airbag purchases as the basis of his calculations, as car airbags were once optional purchases. How much, based on aggregate spending for this lifesaving device, do we value 1 life year?

Cutler estimated \$300 / airbag in 2004, and saved on average, 1 life in 10,000. Thus, based on airbag purchases, our willingness to pay methodology suggests that we, on a society wide basis, spend \$3 million to save 1 life.

Cutler further assumed that the average person whose life was saved would subsequently live an additional 30 years. Probably a reasonable ball-park assumption.

Based on these lifesaving purchases and some rather unsavory calculations, Cutler estimated that Americans would value each additional life year at about \$100,000. (How has that number inflated over time? No idea!)

Cutler and others then performed similar willingness to pay studies on other lifesaving purchases such as fire alarms, and salary premiums for dangerous jobs. By running multiple calculations using the same methodology on multiple products, US economists have arrived at \$100,000 per QALY, far higher than the UK.

### **Would Americans Accept QALYs or almost any other way of saying 'no'?**

I provided this introductory discussion of waiting lists, QALYs and Willingness to Pay ideas to show the richness, complexity and confusion involved in making these difficult healthcare treatment acceptance / rejection decisions. At the end of all this, I wonder how well readers understand it and if they, themselves, are comfortable explaining this to colleagues and deciding their own positions on these various issues. I know that I'm not.

Now try expanding this discussion into our political sphere or asking politicians in our sound-bite laden national discussions to articulate universal, national criteria for treatment acceptance or rejection. Too heavy a lift in my opinion.

### **How Does Medicare Handle This?**

Medicare, our national single payer system for the elderly, is, of course, widely popular. It rations some treatments like cosmetic and dental, and doesn't cover weight loss drugs like Ozampic except for specific medical conditions like Type II diabetes. These

restrictions have not provoked a national outcry against rationing. Beneficiaries can get around some restrictions by purchasing supplements or Advantage plans at different costs for different benefits. A good, though expensive safety valve.

In other words, by practicing minimal rationing, Medicare gains widespread popular acceptance at the cost of potentially breaking the US government's budget. (More on that below.) Many economists and some politicians, generally from the party not in control of the White House, argue that we need to reform Medicare. 'Reform' means 'cut spending', a polite way of saying either 'pay doctors less' (good luck with that one) or 'ration care'. Relatively easy for the out-of-power party to support but, as we have seen above, relatively difficult to implement.

I'd summarize our chance of developing a widely accepted treatment rejection criteria for a Medicare-for-all system as falling somewhere between zero and 'extremely unlikely'.

Let's review. As society gets wealthier, people demand increasing amounts of medical care. That's from the 'healthcare as a super good' discussion above. We expanded on that issue to discuss how to control the moral hazard aspect of universal coverage via waiting lists or treatment rejection, and we introduced QALYs as a treatment acceptance / rejection criterion. We needed to find some national, objective, acceptable mechanism for rejecting certain medical treatments. I don't think we have. We're still left, quite unsatisfyingly, with our Problem #1: How to Say No.

With that failure in mind, let's now turn to Fundamental Problem #2 with Medicare-for-all: the need to maintain and increase funding over time.

### **Fundamental Problem #2: Funding Maintenance**

If we adopt a Medicare-for-all, single payer type healthcare system, we will need to maintain an adequate level of funding to keep the workforce sharp and technologies current. Plus we need to increase funding over time as both inflation and medical advances add costs to the system. The failure to maintain adequate funding can destroy the system, as our case study of the British National Health Service at the end of this section below, will demonstrate.

My concern is that a federally funded, single payer healthcare system that fails to maintain appropriate funding will destroy itself 'little by little at first, then all of a sudden', to paraphrase Ernest Hemingway's description of the bankruptcy process. Would the PNHP proposed 2.5% employee health tax and 7.5 to 8% employer tax cover all expenses? What happens if that's insufficient, or if Congress approves a lower tax-and-funding level? Would / could the government step in to cover the shortfall?

Let's first discuss the US federal budget.

### **Federal budgetary constraints**

The federal budget shows how we, as a society, allocate our public resources. Our current budget makes us look like a healthcare system with an army financed by foreigners.<sup>xxiii</sup> See the breakdown below.<sup>xxiv</sup> In round numbers, we allocate

- 8% of our federal budget to Medicaid
- 12% to Medicare
- 21% to Social Security
- 13% to Defense, and
- 11% to interest on the national debt.

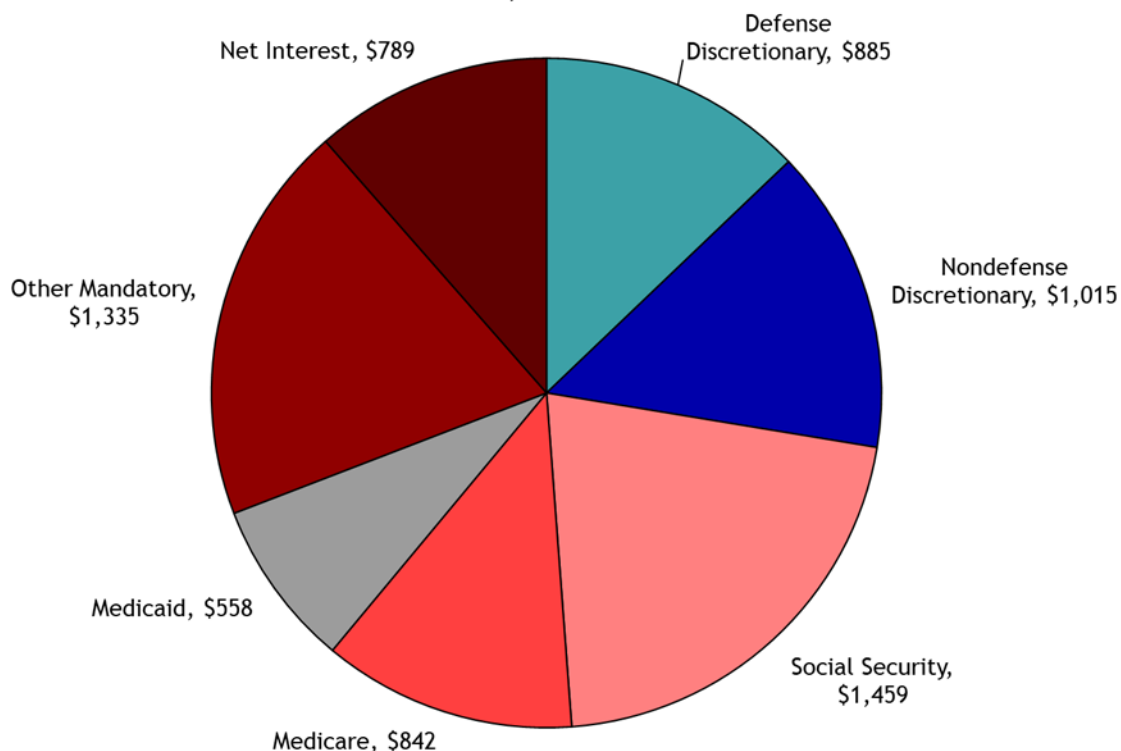
That's almost 2/3 of our budget! A healthcare system with an army indeed!

The last 1/3 gets more complicated to discuss, with various discretionary, mandatory and non-discretionary categories. I'll sidestep a broader, more detailed discussion of our federal budget here to focus instead on the healthcare funding implications. Apologies to any budget nerds but this is an insurance continuing education text, not a macro-economic academic exercise!

## Composition of the Proposed FY 2024 Budget

### Total Outlays = \$6.9 trillion

Below: outlays in billions of dollars



Source: Budget of the United States Government FY 2024. | 2023 AAAS

Developers of our annual national federal budget, or any budget for that matter, always balance at least 3 competing needs:



- The inflation and new technology-based needs to spend more money on virtually everything,
- The lobbying pressure from various groups to gain more resources for their own favored special interests, and
- The ongoing political pressure not to raise taxes.

Consider our Medicare budget growth over the past 30+ years in light of these issues.

xxv

| Year | Expenditure   | % Increase Over Previous Year |
|------|---------------|-------------------------------|
| 1990 | \$98 billion  |                               |
| 2000 | \$197 billion | 101%                          |
| 2010 | \$451 billion | 129%                          |
| 2020 | \$776 billion | 72%                           |

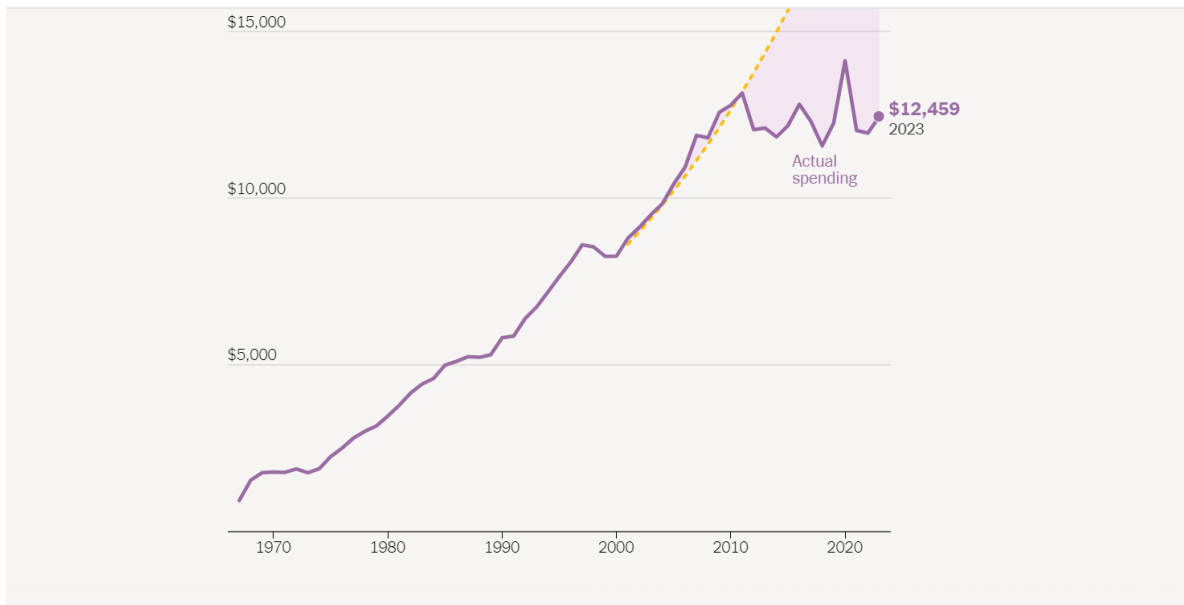
During the same years, the number of Medicare beneficiaries grew:

| Year | Number Medicare Beneficiaries | % Increase Over Previous Year |
|------|-------------------------------|-------------------------------|
| 1990 | 34 million                    |                               |
| 2000 | 40 million                    | 18%                           |
| 2010 | 48 million                    | 20%                           |
| 2020 | 63 million                    | 31%                           |

Interestingly, however, Medicare's spending per capita has flattened in the past few years.<sup>xxvi</sup> Might this suggest that Medicare has learned how to control its expenditures so can act as a viable, national healthcare system?

| Year | Medicare spending per beneficiary |
|------|-----------------------------------|
| 2010 | \$11,000                          |
| 2020 | \$13,200                          |
| 2024 | \$13,092                          |

The chart below from the NY Times shows actual spending (the purple line) vs. projected spending (the dotted yellow line with purple shaded area).<sup>xxvii</sup> The cumulative savings was about \$3.9 trillion, an enormous sum.



Unfortunately for Medicare-for-all proponents, this rosy financial picture doesn't necessarily result from brilliant system management.

Certainly some of the savings comes from various payment reforms, things like bundled payments, the Affordable Care Act that reduced Medicare's payments to hospitals and to health insurers that offered private Medicare Advantage plans, and the budget deal of 2011 that reduced Medicare's payments.<sup>xxviii</sup> If those reasons explained most of the spending reduction, then we might feel more enthusiastic about our government's ability to control single payer healthcare spending.

According to the Times analysis, though, that is not the case; most of the Medicare savings are attributable to other things including

- Preventive medical practices and inexpensive medications that have reduced the number of elderly Americans having heart attacks and strokes.
- Doctors being more cautious about adopting new treatment protocols absent solid evidence of effectiveness.
- Increasing amounts of medical care being performed outside of expensive hospital settings, and, perhaps most disconcertingly,
- Fewer expensive new treatments entering the healthcare system over the past 10 years.

Instead of expecting these cost controlling factors to continue long into the future, some suggest that we will shortly revert to our historical norm of Medicare's cost growth far exceeding overall inflation. Those traditional cost drivers include

- The increasing cost burden of various chronic diseases like obesity, diabetes, Alzheimer's, cancer, chronic obstructive pulmonary disease (COPD), chronic kidney disease and arthritis,

- Expensive, newly available new drugs to treat these and other diseases like
  - Ozampic for diabetes and weight management at \$10,000 per person per year
  - Leqembi for Alzheimer's at \$26,000 per person per year,
  - Keytruda and Obdivo for cancer at \$150,000 per person per year,
  - Trelegy for COPD at \$7,000 per person per year
  - Farxiga for chronic kidney disease at \$6,000 per person per year, and others.<sup>xxix</sup>
- The impact of long covid or some other pandemic.

In addition, our political or cultural focus might migrate from simple cost cutting toward, perhaps, increased longevity as Medicare's criteria for success. I don't know if this will happen, but perhaps.

Bottom line: Medicare's expenditures per capita will likely revert to about their historical rate i.e. much faster than overall inflation. Will the PNHP's proposed 2.5 percent employee health tax and 7.5 to 8 percent employer tax cover costs? I don't know. What happens if Medicare falls short? Again no idea. But if and when Medicare-for-all falls short on funding, I expect an increasingly intense fight among **deficit hawks** who want to control or reduce the federal government's deficit, **tax cut enthusiasts** who want to stimulate overall economic growth via tax cuts, and **Medicare supporters** who seek more money for the system.

I can't guess who will win.

### Lessons from Other Countries

None of these funding problems are uniquely American; other countries have faced them, often for years. What lessons can we learn from their successes or failures?

We'll focus on the British National Health System experience over the past couple of decades. I chose this because (a) the data are easily accessible, (b) publications are in English, a big deal for me, and (c) I used to live there and liked it. Consider this a cautionary tale for Medicare-for-all proponents. Why and how might the US experience in a hypothetical single payer system differ from the UKs, if it differs at all?

The UK's National Health Service was in acute crisis by 2023. Four quick datapoints:

- 300 – 500 people died *per week* while waiting for emergency care, estimate from the Royal College of Emergency Medicine,
- Emergency department wait times regularly exceeded 12 hours.
- Ambulance drivers, nurses and junior physicians held their first strikes in decades, leading to thousands - perhaps hundreds of thousands - of canceled surgeries and appointments,
- Over 10% of the British population was on a waiting list for some sort of medical care in 2023,

**A key factor** causing these problems was a long-term *capital* underinvestment in the system's infrastructure. Government funding hovered around 10% of GDP since about 2009 under the Conservative government's austerity program designed to keep taxes low. Essentially the government increased NHS contributions annually only by about 0.1% in real terms from 2010 – 2015, essentially a funding freeze and far below the 4% it had averaged since establishment. The funding shortfall continued, so by 2021 the NHS was underfunded by about \$50 billion.

One impact: the number of inpatient hospital beds declined by about 8% from 2010 to 2019. This resulted in insufficient system capacity to handle a public health crisis when Covid struck.

Compounding the hospital bed supply problem, the NHS also had an insufficient number of nursing home or long-term treatment beds. This led to 'bed blocking'; acute care hospitals could not discharge patients for longer term care as there were no facilities to house them. About 14% of hospital beds were blocked / unnecessarily occupied in early 2023 because the dischargeable patients had no place to go. This in turn led to hospital admission delays and the waiting lists referenced above.

In addition, and also largely due to the annual underfunding, some hospitals reserved beds or floors for 'private pay' patients, folks who didn't rely on public funding for their medical care. This generated more income for the hospital but put an additional crimp on the bed supply available to most Brits.

An insufficient number of hospital beds + an insufficient number of nursing home beds = inadequate hospital bed supply system wide = lengthy waits for care.

A contributing reason for the bed insufficiency is the low reimbursement per patient in nursing homes, meaning they couldn't compete with local businesses for employees. (This sounds like the Medicaid situation in some areas of the US.)

**A second key factor** in the NHS's crisis was their long-term *workforce* underinvestment, again due to that \$50 billion funding shortfall. Three data points here:

- Nurses' salaries fell by 10% in real terms over the decade, leading to resignations and early retirements,
- The number of General Practitioners (Primary Care Physicians in American terminology) fell by about 15% per 1000 of population while caseloads increased by 17% per GP.
- By late 2023, the NHS was 150,000+ employees short of its staffing requirement.

Compound this with immigration restrictions, especially since Brexit 2020. The NHS had previously imported nurses from poorer European countries including Italy, Poland and Romania, folks willing to work for lower wages than acceptable by Brits. Post-Brexit, the movement of Europeans to Britain became much more difficult.

An insufficient healthcare workforce investment + immigration restrictions = inadequate healthcare labor force = long waits for care = poorer medical outcomes.

Britain underfunded its National Health Service bit-by-bit, year after year, until it no longer provided the high-quality care the population expected. Simultaneously, politicians and some lobbyists campaigned to privatize parts of it.

### **How closely do these conditions resemble the US?**

In the US, we face a long-term hospital bed decrease from 4.5 beds per 1000 population in 1975 to 2.8 beds per 1000 population today.

- Some of this is positive and due to system improvements, things like better outpatient care and improved technologies leading to shorter inpatient stays.
- Some, though, is due to economic pressure to keep bed occupancy rates high; empty beds are expensive.
- Overall, the reduced number of inpatient beds led to system stress during Covid and other high demand periods like flu season, and longer waits for some elective surgeries.
- This resembles the NHS during the early days of its system decline. (Remember Hemingway's comment about going bankrupt: 'Little by little then all at once.')

We have an insufficient number of Primary Care Physicians, with some 80 – 85% of medical students going into specialties, largely because specialists earn more money.

- The number of PCPs has declined slightly from 68.4 per 100,000 patients in 2012 to 67.2 per 100,000 in 2021.
- This contributes to a higher cost, poorer longevity healthcare system. Many studies show a stronger correlation between primary care and increased life expectancy than specialty care and longevity on a population wide basis.<sup>xxx</sup> Try to find a PCP open to new patients to understand the impact in your own specific region.
- Again, this resembles the NHS early in their system decline.

We face a nursing shortage, needing 200,000 new nurses per year until 2026 according to the Bureau of Labor Statistics to maintain adequate staffing. This is caused both by increased demand (population aging, moral hazard) and burnout / job dissatisfaction in the existing nurse workforce.

- Currently about 16% of RNs are foreign born.
- Immigration restrictions could exacerbate this problem, plus reduce our system's ability to manage increasingly culturally and linguistically diverse patients.
- Again, similarities to the NHS early in their system decline.

Various political and lobbying forces seek to privatize more of our own healthcare system.

- Medicare Part C / Advantage is one attempt to privatize parts of Medicare,
- Part D is entirely managed by private insurers.
- We have a history of groups trying to privatize public social services. President George W. Bush, for example, attempted to partially privatize Social Security in 2005. I would expect these efforts to continue in a Medicare-for-all system just like in Britain.

### **Medicare-for-all wrap up**

I could go on, but I hope readers understand the major points about Medicare-for-all by now:

- A national, public healthcare system needs a clear treatment rejection program that's acceptable to the population. We don't currently have that. I don't see any chance that we will develop it,
- A national, publicly funded healthcare system needs ongoing investment to maintain its capacity, technologies and workforce. I see a future of budgetary fights rather than secure ongoing funding for an expensive Medicare-for-all system. Specifically, I fear that deficit and budgetary hawks will underfund the system bit-by-bit until Hemingway's observation becomes reality.

### **Which Type of Health Insurance Is Best?**

I don't know!

Proponents of healthcare deregulation tend to focus on and exaggerate flaws in the single payer / Medicare-for-all approach, while proponents of Medicare-for-all tend to focus on and exaggerate flaws in commercial insurance. Both sides have strengths and weaknesses. I don't know which is better or even what 'better' means exactly.

Fortunately for this exercise, I'm just a teacher, not an advocate. My job is to introduce and summarize the issues and help brokers better understand them, not convince you that one side is right and the other wrong.

My expectation is that you'll end this chapter supporting the same side as you did at the beginning. My hope, though, is that you'll do so with a stronger command of the issues, a better understanding of the system context and a greater ability to articulate your position.

Please let me know if I've succeeded.

## Review Questions

correct answers on next page

1. Which below best describes our current healthcare system according to this text?
  - a. High cost / low quality
  - b. Low cost
  - c. High quality
  - d. About average life expectancy among developed countries
2. About what percentage of Americans get their health insurance from private companies?
  - a. 4%
  - b. 6%
  - c. 50%
  - d. 98%
3. About how long do Americans live, on average, as compared to other advanced, industrialized countries?
  - a. Americans live about 5% less long than the others
  - b. Americans live about 10% longer than the others
  - c. Americans live about 20% longer than the others
  - d. Americans live about 50% longer than the others
4. Which statement below is correct?
  - a. Americans spend about twice as much per capita on healthcare as other advanced, industrialized countries like Britain, France, Germany, Spain and Italy
  - b. American spend about the same per capita on healthcare as countries like China, India and Chad
  - c. Americans spend about half as much on healthcare as countries like Britain, France, Morocco and India
  - d. Americans spend less than 10% as much on healthcare as countries like Russia, Iran, Iraq and Gabon
5. Roughly how much did our life expectancy increase between passage of the Affordable Care Act and the Covid pandemic?
  - a. Our overall life expectancy did not increase at all during this period
  - b. Our overall life expectancy fell by 15%
  - c. Our overall life expectancy increased by 20%
  - d. Our overall life expectancy roughly doubled
6. Roughly how much did American's average annual spending on healthcare per capita change between passage of the Affordable Care Act in 2010 and Covid's arrival in 2020?
  - a. Spending increased per capita by about 40%
  - b. Spending decreased per capita by about 40%
  - c. Spending doubled per capita
  - d. Spending fell by about half
7. What is the most common relationship platform between healthcare providers like doctors and healthcare payers like insurance carriers?
  - a. Fee for service billing
  - b. Family interconnectedness
  - c. Telephone communications
  - d. Fax communications

8. Which word or phrase below best describes the relationship in a fee for service environment between medical providers payers according to Atul Gawande in this text?
  - a. War, every step of the way
  - b. Collegial
  - c. Friendly
  - d. Sympatico
9. According to this text, which financing platform works extremely well and has turned our healthcare system into a low cost / high quality one?
  - a. Pay 4 Performance
  - b. Tiered networks
  - c. Health Savings Accounts
  - d. None of the above. Our system remains a high cost / low quality one
10. This text discusses 'super goods'. What is a super good?
  - a. Something that you can never get enough of like good health; you can always be healthier on some scale or other. Thus, you can always justify spending more on healthcare
  - b. Large items like houses and cars
  - c. A larger and larger investment portfolio; a large portfolio is 'good' but a larger one is 'super good'
  - d. Something that saves you time like office automation. Working efficiently is 'good' but working faster and more efficiently is 'super good'
11. Which below is a fundamental problem with a national single payer healthcare system?
  - a. The need for an understandable and broadly acceptable criteria for rejecting certain treatments to certain people under certain conditions.
  - b. It would be too simple to use
  - c. It would have too many beneficiaries
  - d. It would be too productive
12. What is one reason why a national single payer healthcare system needs to have a treatment rejection criteria?
  - a. Healthcare is sometimes called a 'super good'; you can always feel better or score better on a medical test. As such, demand for healthcare can easily outstrip the supply
  - b. Doctors might be confused about what is covered and what is not
  - c. Nurses might be confused about what is covered and what is not
  - d. Benefits brokers might be confused

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### **How our healthcare system developed**

Our healthcare financing system evolved from a vertically integrated 'financing + care provision' system to a non-vertically integrated one. This theme runs throughout today's course.

- Vertical integration means that medical care and medical financing are the same entity, with physicians on salary. Both the financing arm and medical care arm work together to generate the best patient outcomes at the lowest cost. This is the basic concept of a Managed Care Organization or a Health Maintenance Organization (HMO).

'Managed competition' is competition among vertically integrated healthcare providers. Those generating the best outcomes at the lowest costs will gain customers; those operating at higher costs and generating poorer outcomes will lose.<sup>1</sup>

Vertically integrated healthcare entities compete with each other on value: outcomes per dollar spent. This incentivizes Managed Care Organizations to improve patient outcomes (life expectancy, diabetes control, post-surgical functionality and similar) without unduly raising prices. It disincentivizes Managed Care Organizations from providing excessive, unnecessary or low quality care, or raising prices too aggressively. Vertically integrated entities are, therefore, more ethically structured than the alternatives.

The better a Managed Care Organization improves patient outcomes without raising prices, the more value it creates, the greater the company's market share and the bigger its business. This fits the Utilitarian view of an ethical healthcare system; it provides the greatest good for the greatest number. Good ethics, from this point of view, equals good business. So goes the theory at least.

- A 'non-vertically integrated system' has separate companies handling financing and medical care. Today we call financing companies 'insurance carriers' and medical care provision companies like hospitals and physician groups 'providers.'

In this non-vertically integrated system, financiers want to pay service providers less and service providers want to bill more. The relationship between the two is 'war' according to Atul Gawande, professor at Harvard Medical School and staff writer for the New Yorker, 'every step of the way'.<sup>2</sup>

In a non-vertically integrated system, carriers and hospitals argue over payment amounts and formulas. A very different focus from the vertically integrated model above where the entity's singular goal is outstanding patient outcomes at a reasonable price.

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<sup>1</sup> Alain Enthoven of Stanford University, perhaps our greatest managed care theorist and proponent, has written widely about this which is somewhat outside the scope of this particular chapter. See his seminal article The History and Principles of Managed Competition for more.  
[http://elsa.berkeley.edu/pub/users/webfac/held/157\\_VC2.pdf](http://elsa.berkeley.edu/pub/users/webfac/held/157_VC2.pdf)

<sup>2</sup> See Gawande's second book 'Better', chapter entitled Piecework

Non-vertically integrated systems, as I suggested above, are designed to generate jobs, incomes, and benefits for participants in it, like doctors, financiers and all the rest.

The more our healthcare system resembles a vertically integrated one, the more ethical it is because it serves the medical needs of patients, creating the greatest health good for the greatest number of patients. The less vertically integrated it is, the less ethical it is because it is designed to serve the needs of relatively few participants.

Ethical brokers, according to the Utilitarians, should help clients emulate the benefits of a vertically integrated system despite the current structure of our healthcare system. This is a heavy lift. We'll address some ways to do this in Chapter 3.

But first, we'll discuss how our healthcare system developed around this vertically / non-vertically integrated idea below. Then, in Chapter 2, we'll discuss various problems that arise from our systemic development.

### **How Commercial Healthcare Started**

As commonly accepted among health insurance historians, commercial health insurance started in Dallas around 1929 as a reaction to the stock market crash and financial meltdown.<sup>3</sup> Baylor University Hospital in Dallas faced a cash crunch and designed a creative solution to pay its bills.

Prior to the stock market crash, hospitals raised funds in two ways. First, they had customers who paid for services rendered - a fairly modest percentage of the population because most people didn't have a lot of money. Second, the community chest, the charitable organizations - the wealthy would donate to the hospital because it was a good place to donate your extra money. Charity made you feel good and was good for the community.

But after the 1929 stock market crash, unemployment reduced the number of patients able to pay, the wealthy didn't have as much money to donate, and the hospital faced a difficult financial landscape. So, Baylor University Hospital made a deal with the Dallas School System. They said, "School system, you always have money; you raise money from taxes. Pay us \$.50 per employee per month and when they get sick, they can come to us and we'll take care of them." Commercial health insurance arrived.

A few comments about this.

First, it's a nice deal. It's a nice deal for the hospital because they stay in business. They don't have to worry about going out of business. They didn't have to worry about turning people away as long as they got the numbers right, which apparently they did at \$.50 per employee per month. The school system payments protected the hospital's cash flow so the hospital stayed in business.

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<sup>3</sup> This suggestion comes from Richmond and Fein, *The Healthcare Mess*, page 30.

Second, this was very efficient. The hospital signed one contract with one employer group and received back enough money to stay in business. That was a pretty good incentive to look for other large employer groups.

Third, there was no prevention or provider choice, but theoretically the teachers and other employees of the school system were happy because they got medical care essentially for free.

Fourth, this was for hospitalization only; no outpatient or physician office coverage.

Fifth, community rating. The Dallas School System paid \$.50 per person per month, regardless of individual medical status. No medical underwriting.

Sixth, there were no quality controls, no outcome-based incentives, no holdbacks for poor hospital performance. Health insurance began simply to save the financial health of the hospital.

This was a vertically integrated system, almost textbook variety. And it exhibited the classic flaw of vertically integrated healthcare systems: lack of consumer choice. As initially developed with Baylor University Hospital, the Dallas school system employees could only go to one hospital. This has advantages and disadvantages.

Advantages:

1. Lower Costs
2. Reasonable medical care from a small number of in-network providers

Disadvantage:

1. Little provider choice as few hospitals are 'in-network'

The Baylor Hospital / Dallas School System deal worked so well that other hospitals copied it. Different hospitals looked for different large employers, offering the same kind of deal. Large manufacturers, the Dallas Morning News, and others. What problem begins to arise?

### **The Choice Problem**

Consumers - school system employees or manufacturing workers, for example - wanted to choose among various hospitals. 'What do I know about Baylor University Hospital? I only know one thing. I know someone who went there and didn't get good care (whatever 'didn't get good care' means), so I want to go somewhere else.' Someone always knows of someone else who had a negative experience there. So you want to go somewhere else - consumers want choice.

A different way to understand our demand for choice in healthcare: we don't *really* trust our own doctor or, indeed, the overall medical system. We somehow think that we –

patients – have better medical care insights than the various trained professionals in our network. This uninformed demand for choice has plagued our system since inception.

The way out of this problem, according to Michael Porter and Elizabeth Olmsted Teisberg in their massive tome *Redefining Health Care*, is for the government to require results reporting, things like 30-day readmission rates for coronary procedures, 3-6-and-9 month follow-up data on orthopedic patient range of motion and pain, infant and maternal mortality rates and similar. As Porter and Teisberg put it back in 2006: *Mandatory measurement and reporting of results is perhaps the single most important step in reforming the healthcare system.*<sup>4</sup>

We still haven't made sufficient progress along these lines. That, it seems to me, is a fertile arena for ethical broker interventions. Indeed, that will be our focus in Chapter 3, below.

Remember vertical integration, where finance and service provision are the same company? Once you introduce choice, then you have one group handling finance and another handling service provision. You have a split and you lose vertical integration.

That split happened shortly after the Baylor – Dallas School System deal. A clever entrepreneurial company offered to provide financing for lots of Dallas hospitals. 'Dallas teachers' they might have said, 'you can sign up with Baylor University Hospital only, or, for just a little more money, sign up with us and we'll give you the choice of many hospitals in Dallas. We contract with lots of hospitals. We have a large network.'

These new companies competed with vertically integrated hospitals, like Baylor University Hospital and the Dallas School System.

The insurance entrepreneurs developed a couple of clever ideas in the 1930s. First, from a marketing point of view, they offered this very attractive provider choice option.

Second, they began searching for the healthiest subscribers. If they could find the healthiest people, they could offer lower priced policies and gain a competitive edge vs. their vertically integrated competitors signing up large employers at a fixed price per person.

### **Underwriting vs. Community Rating**

The entrepreneurs – we'll call them 'insurance carriers' - figured that they would underwrite better than the competition so people would join them because their premiums would be a little bit lower. The community rating folks faced higher premiums because they took all employees. In a very real sense, underwriting is a form of rationing: people unable to pass the underwriting standard don't get covered. Or they pay a lot more.

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<sup>4</sup> Porter and Teisberg, *Redefining Health Care* page 7

Underwriting serves the economic interests of the carriers. It doesn't improve healthcare outcomes. It doesn't improve the healthcare system. It doesn't differentiate medical quality. It doesn't create patient value. It only makes one carrier lower cost than another carrier by having sick people pay more. It's a zero-sum exercise – healthy pay less, sick pay more - since total community medical costs remain the same.

Our private healthcare financing system had little to do with getting people healthy or creating value. That was not its intention. It was designed to protect physician and hospital income, the original Baylor idea. Then carriers came along to make a profit from consumer demand for choice. The demand for choice led to the Split.

### **The Split and the Provider Payment Problem**

Once you split finance from service provision, you have a wider consumer choice and you have to figure out how to pay doctors and hospitals. We're still, today, trying to get this one right.

The original and still most popular payment mechanism is fee-for-service. The doctor gets paid \$100 for treating each broken arm and \$350 for each rotator cuff surgery, or whatever.

As soon as you split finance and service provision, service providers have an incentive to do more. The more they do, the more they earn.

The insurance carrier, on the other hand, wants to limit the number of treatments only to those necessary to control costs. They ask service providers if they absolutely need to do that procedure. Insurers and providers fight all the time. It's a fight between

- provider clinical judgment, influenced, perhaps, at least psychologically, by the fee-for-service payment formula, and
- carrier financial judgment, influenced, perhaps, at least psychologically, by the same fee-for-service formula. Insurers don't *really* trust provider clinical judgment, at least not without discussion and justification.

That's the conflict between healthcare payers and medical service providers.

Fee-for-service / component financing is inflationary and expensive and not designed to improve patient health. It's designed to reward providers, which it did quite well historically. We, in the US, have traditionally performed more procedures / 1000 of population than similar developed countries around the world. Things today like spinal fusion surgery, hip replacements, knee replacements, coronary bypass surgeries. The Split between finance and service provision led us down this road. It continues to this day.

### **The Impact of World War II**

World War II plays an important role in our story for three main reasons.

First, the soldiers who received health coverage while in the military wanted to continue with it afterward. They saw the advantages of having health coverage. They married and wanted their families to receive coverage also. This created demand for health insurance.

Second, our wartime economy devoted significant resources to medical technology improvements. Perhaps most significant was the introduction of sulfa drugs to combat infections and ultrasound, originally used to determine tank structural integrity after battles. Sulfa drugs helped turn hospitals from infection breeding institutions into patient treatment and improvement centers. Ultrasound ultimately became a routine pregnancy evaluation tool. These and other new technologies improved the quality of medical care, or the supply.

Third, the Federal wartime wage and price freezes fostered the development of 'fringe benefits' and the entire benefits industry. That's the financing arm and it's a pretty interesting story.

The government implemented wage and price freezes during the War to avoid domestic economic difficulties and help focus our economy on war production. Employers, in other words, could not raise wages to attract new workers or to reward their best employees. But they could offer 'fringe benefits' such as health insurance. This allowed employers to attract new talent and retain their current employees without raising wages. The concept of 'fringe' meant 'outside the normal compensation' and 'benefits' meant 'advantages of working here'. Employers couldn't simply raise wages, the traditional way of attracting labor, since that was illegal during the war. Fringe benefits were a mechanism to get around the wartime wage freeze.

These 3 factors – increased demand, improved supply, and creative financing - led to a tremendous increase in our insured population. Some coverage data points:

1942: 10 million hospital insurance / health insurance subscribers

1946: 32 million

1951: 77 million<sup>5</sup> out of a total US population of 150 million.

The health insurance industry arrived, grew and gained political power.

### **The Hill Burton Act and an IRS decision strengthens hospitals**

Congress, just after World War II, passed the Hill Burton Act to fund hospital expansion. This increased the number of hospital beds in this country by about 40%, from 3.2 per 1000 people to 4.5. It also made hospitals the centerpiece of our medical care system; the travelling doctor who made house calls began to disappear.

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<sup>5</sup> Richmond and Fein, The Health Care Mess pages 30 - 38



Shortly thereafter, in 1953, the IRS decided that fringe benefits were exempt from federal income tax: those became *tax deductible to the employer* but *not income taxable to the employee*. This was essentially a government subsidy for hospital care since that's where most medical care took place. The government stimulated sales of commercial health insurance by subsidizing the price through the tax exemption.

This subsidy for health insurance was so effective that by 1963, 77% of us had hospital coverage, and about 50% had some form of physician coverage.<sup>6</sup>

- Employees liked the system because it appeared free to them.
- Carriers liked the system because the government subsidized their product, tax deductible health insurance policies.
- Hospitals loved the system because they received patients and insurance payments – a wonderful recipe for making money.
- Employers objected somewhat to this system, but not terribly strenuously. After all, the government subsidized their health insurance payments, so they felt the pain only partially.

Through this period, roughly 1930 – 1965, healthcare discussions generally focused on insurance coverage, medical technology, hospital capacity and access. Indeed, access issues took center stage in the mid-1960s because of the potential political power of the elderly and the poor, both of which were left out of the employer based financing system.

### **Medicare and Medicaid Remove Potential Political Threats to Employer Based Insurance**

One potential political threat to our employer based health insurance system could have come from the unemployed – that significant percent of the population that was too old to work or unable to find full time work with benefits. This was potentially a very potent political force that could have lobbied in favor of single payer healthcare, universal coverage or similar, like in other countries.

By introducing Medicare and Medicaid in the 1960s, this political force went away. Elderly folks were happy. They didn't demand or need universal coverage because they had Medicare. Ditto the poor with Medicaid. No large, identifiable voting block favored a single payer, universal healthcare system post-Medicare and Medicaid. M & M took that potential voting block off the table.

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<sup>6</sup> Enthoven and Fuchs, 'Employment Based Health Insurance: Past, Present and Future' Health Affairs, Nov/Dec 2006

Here is an estimate of the population size that these two entitlement programs satisfied. I'll use Medicare, because this covers the elderly who vote in particularly high numbers and in particularly important electoral states like Florida.

#### Medicare Enrollment 1970 – 2020

| <u>Year</u> | <u>Number Medicare Enrollees</u> | <u>% of US population</u> |
|-------------|----------------------------------|---------------------------|
| 1970        | 20 million                       | 10%                       |
| 1980        | 28 million                       | 12%                       |
| 1990        | 34 million                       | 13.5%                     |
| 2000        | 39 million                       | 13.8%                     |
| 2010        | 47 million                       | 15%                       |
| 2020        | 58 million                       | 18%                       |

Medicaid covers about the same population size.

The argument is that Medicare and Medicaid are key supporters of our employer based, commercial health insurance system. They allowed the system to grow and become entrenched nationally in the second half of the last century.

Post passage of Medicare and Medicaid, i.e. by the late 1960s, healthcare costs and cost increases became an issue. Indeed, in 1969 Robert Finch, then Secretary of Health, Education and Welfare warned Congress that “the nation is faced with a breakdown in the delivery of health care unless immediate concerted action is taken by government and the private sector”. Both costs and the very structure of our healthcare delivery system became a topic of national debate, leading to a reconsideration of vertical integration.

#### **Nixon's HMO Act of 1973**

Nixon had to do something to address the rising costs of healthcare, but felt politically wedged-in. He couldn't support a Democratic healthcare plan sponsored by one of his chief rivals, Ted Kennedy. Nor could support a Republican plan sponsored by another political rival, Nelson Rockefeller – especially a plan that potentially harmed the physicians, hospitals and insurance carriers that supported Nixon politically.

He chose, instead, to pursue Health Maintenance Organizations, then conceived as a prepaid healthcare system that would motivate doctors and hospitals to control costs and keep patients healthy. Many conservative politicians and organizations agreed with the HMO idea because it was flexible, inexpensive, encouraged private investment in profit-making organizations and imposed few mandates or regulations. It sorta, kinda, almost resembled Baylor's original plan with the Dallas School System.

Nixon's plan faced opposition from both the left and right between 1970 – 1973. Kennedy and the Left consistently fought for higher levels of guaranteed benefits, community rating, open enrollment periods and significant Federal grants and loans to help HMOs proliferate. The American Medical Association and the Right wanted only basic levels of guaranteed benefits, less government funding and individual underwriting.

As a result of these competing pressures and Nixon's determination to implement his own plan (i.e. not Kennedy's or Rockefeller's), the HMO Act of 1973 deviated from our ideal vertically integrated model in three main ways:

**First**, under Nixon's law, HMO meant simply 'prepayment'. Healthcare delivery and healthcare finance were separate functions handled by separate companies. This satisfied independent insurance carriers, physician groups and general hospitals - all parts of Nixon's political base. But it lacked the key integration feature that made real managed care organizations like Kaiser-Permanente so successful.

Why did carriers, physician groups and general hospitals dislike vertical integration? The short answer: they wanted to compete for revenues with each other.

Carriers hoped to dominate the marketplace and dictate economic terms to providers. The American Medical Association wanted its members to remain free from carrier or hospital meddling so they could protect their incomes. Hospitals wanted to determine patient lengths of stay to protect their own cash flow.

None of these groups trusted the others or the government to protect their interests.

**Second**, Nixon's law called for a loose physician structure, in which practitioners could opt in or out of any HMO. Again, this satisfied the insurance, physician and hospital groups. But it was the opposite of vertical integration's tight structure in which physicians were fully integrated into both the hospital and financial system. The loose physician structure meant that providers lacked loyalty to any specific HMO.

**Third**, Nixon's law allowed providers to bill insurance carriers on a fee-for-service basis, not on a capitation basis.

In a capitated system, the vertically integrated HMO only received a specified amount of money per patient per year. The old Baylor – Dallas school system model charged \$6 per employee per year. As long as Baylor University Hospital kept its costs below \$6 per employee, it made money. But if Baylor's costs exceeded \$6, it lost money and potentially went out of business.

Capitation, in other words, forced HMOs to control costs and use their resources efficiently. Absent capitation as in Nixon's Act, much of the underlying financial discipline disappeared.

These three factors – separate companies for finance and service provision, loose relationships between physicians and HMO entities and little-to-no capitation - drastically altered the original vertical integration model. Stanford Medical School Professor Alain Enthoven, for example, a key managed care theorist, argued in 1993, ‘Some say that managed care has failed. I say that managed care has not yet been tried’ since Nixon’s HMO Act so perverted the vertical integration model.<sup>7</sup>

By the early 2000s, American healthcare had given up on the vertical integration / managed care approach in fact, if not in name, in favor of the fee-for-service based billing platform. Stanford’s Enthoven articulated the fee-for-service flaws in his 2004 book ‘Toward a 21st Century Health System’ page xxix.

11. Fee-for-service creates an adversarial relationship between doctors and payers;
12. Fee-for-service has little accountability – poor data collection and provider motivations for economy;
13. Fee-for-service ‘free choice of provider’ leaves patients to make remarkably poorly informed choices;
14. Fee-for-service generates excess hospital capacity, high tech equipment and open-heart surgeries;
15. Fee-for-service generated an excess supply of specialists;
16. Fee-for-service misallocates resources, as no incentive to use the least costly settings for treatment;
17. Fee-for-service has no capacity to plan care processes from diagnosis to treatment to rehabilitation;
18. Fee-for-service has led to a dangerous proliferation of facilities for complex and costly procedures without the volumes necessary to maintain good outcomes;
19. Fee-for-service cannot practice total quality management due to lack of service integration;
20. Fee-for-service cannot organize the rational use of technology.

We created, in other words, a healthcare structural mess in our quest for patient choice, profits and jobs.<sup>8</sup>

### **Consumer Driven Healthcare to the rescue (or not)**

With the failure of the HMO movement, our commercial healthcare industry needed a new paradigm. One attempt was CDHC or Consumer Driven Health Care. The term

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<sup>7</sup> Enthoven, Why Managed Care Has Failed to Contain Health Costs, Health Affairs, 1993, paraphrased for context here.

<sup>8</sup> ‘Mess’ comes from the title of Richmond and Fein’s 2005 book, The Healthcare Mess, op cit.

'consumer driven health care' arose from the Medicare Modernization Act of 2003 which established Health Savings Accounts.

'Consumer driven products' are high deductible health insurance policies with certain tax benefits. Each consumer spends the deductible as he/she sees fit, for physician visits, medications, tests, therapies etc. Only after satisfying the deductible does insurance pay. Then, depending on the specific plan design, insurance pays all or part of additional medical expenses.

CDHC policies embrace the notion of consumer sovereignty. Consumer sovereignty means each individual consumer makes decisions in ways he or she deems best for themselves; individual patient decision making for themselves, not physician decision making for patients would now drive our healthcare system.

Consumer driven healthcare implicitly accepts The Split between healthcare finance and service delivery as a given. Effectively, HSAs and the entire CDHC movement says 'The Split exists and we can't figure out how to fix the problems it causes, so we'll turf the whole thing onto patients. Maybe they can rationalize our otherwise irrational system'. Maybe, in other words, they can make the system operate more ethically.

It didn't go well.

### **Problems equating high deductibles with consumerism in healthcare**

Consumer driven healthcare as practiced using Health Savings Accounts, similar tax-deductible programs, and medical care price lists fail in healthcare for two main reasons.

**First**, an annual \$1000 deductible (or even \$3000) is too small to act as a real medical spending brake. Once satisfied, and depending on the specific plan design, all other medical care is free.

A patient might satisfy that deductible hurdle in January and then enjoy lots of excessive and unnecessary medical care for free during the next 12 months. Patients could even 'play' the system by scheduling all their expensive medical treatments during the same calendar year.

Or the deductible has little impact on a patient facing an expensive procedure. What's the difference to the patient if the procedure costs \$45,000 .... \$50,000....\$60,000 or \$100,000? Once the deductible is satisfied, the rest is free. 'Consumerism' fails to affect patient behavior in these expensive cases.

This fundamental flaw in the 'high deductible = consumer driven healthcare' thesis exists because the vast majority of healthcare spending goes to a very small group of high cost patients. Here's spending by percentage of the population. These numbers have remained remarkably constant for years.

### Healthcare Consumption by % of Our Population <sup>9</sup>

1% of our population accounts for about 24% of medical spending

5% of our population accounts for about 49% of medical spending

10% of our population accounts for about 64% of medical spending

50% of our population accounts for about 97% of medical spending

50% of our population also accounts for 3% of medical spending.

The healthiest half of our population costs very little medically. These are typically the folks who purchase CDHC products and who often spend less than \$1000 annually. Cutting their spending by 20 or 30% would have virtually no impact on *overall* medical spending or trend.

Here's the same chart using 2022 spending amounts, not percentages. In 2022, total US healthcare costs reached about \$4.4 trillion for the approximately 333 million of us. Though the average annual healthcare spending per person that year was about \$13,400,

The 1% heaviest users (3.3 million people) averaged about \$320,000 each;

The 5% heaviest users (16.7 million people) averaged about \$129,000 each;

The 10% heaviest users (33 million people) averaged about \$85,000 each;

The 50% lightest users (167 million people) averaged about \$790 each.

Very few of the 10% of users who account for about 2/3 of all medical spending will change their medical choices based on a \$1000 (or even \$2500 or \$5000) deductible. *Whatever* the deductible, their medical care needs far exceed it.

**Second**, medical consumers have little meaningful quality information, and even if they have it, they rarely know how to use it. This makes medical decisions different from, say, car purchasing decisions. The car buyer can compare the quality of various cars before deciding which to purchase. Large or small, good gas mileage or poor, lots of luxuries or few, high resale value or low, etc.

But the medical purchaser generally has very little similar information. Which doctor has the best outcomes? Which hospital? How effective is this medication compared to that one? We generally lack detailed answers to these questions.

For these two reasons – unequal healthcare spending and lack of medical quality information / well educated medical consumers - so-called Consumer Driven Health Care had only a small impact on medical trend which has run at our gdp growth rate

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<sup>9</sup> Yu, et al, 'Medical Expenditure Panel Survey Statistical Brief #81', May 2005, Agency for Healthcare Research and Quality

plus 3 – 5% annually for years. CDH policies became the vogue in the early 2000s. They pretty much ran their course within about a dozen years.

Americans continue to spend about twice as much on healthcare as other developed countries without getting any value for the excess spending, just as we did prior to CDHC policy introduction. Here are estimates for 2019, the last year before Covid hit and altered these statistics with a unique set of circumstances. (I don't know if or how Covid is representative of 'normal' healthcare trends, so I'll leave that out of this analysis.) <sup>10</sup> I could have included more countries but you get the idea from this limited comparison.

| 2019   | Annual spending / capita | Life expectancy at birth |
|--------|--------------------------|--------------------------|
| US     | \$10,855                 | 78.8                     |
| Canada | \$6,730                  | 82.3                     |
| France | \$4,014                  | 83                       |
| Spain  | \$2,412                  | 84                       |
| UK     | \$3,334                  | 81.4                     |

These other countries live 4 – 5% longer than us while spending about half as much on healthcare. We clearly haven't figured out how to generate good value for our healthcare system investment. We haven't figured out how to generate the greatest good for the greatest number.

### **The Affordable Care Act gives up on vertical integration in favor of wider coverage**

The 2010 Affordable Care Act, a massive piece of legislation, is more-or-less a business plan for our entire healthcare economy.

Vast in scope and complexity, it's far too big to summarize quickly here. Instead, I'll focus only on 2 components: coverage expansion and patient decision-making assistance.

### **Why healthcare reform in 2009**

President Obama decided to move aggressively on healthcare because of several disturbing trends. From 2000 - 2006

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<sup>10</sup> OECD Health Data statistic updated annually <https://stats.oecd.org/Index.aspx?ThemeTreeId=9>

- Health insurance premiums rose by about 80% while
- Overall inflation only rose by 20%, but
- Median household income was actually down 3% in real (after inflation) terms.

Obama and his aides worried about two different health insurance death spirals especially affecting the individual and small group markets.

The **first** would occur when healthy people decide not to purchase health insurance, thus leaving only sick people in the insurance pool. Premiums would rise quickly forcing 'healthier' sick people opt out, leaving only the sickest of the sick still in. Health insurance then would become a payment program for sick people. It wouldn't, under these conditions, play its traditional role of protection against catastrophic financial calamity due to an unexpected illness for the vast majority of Americans.

The **second**, separate though somewhat related death spiral would occur when young people decide that health insurance is too expensive to purchase. Young 'Invincibles' – so called because they don't think they'll get sick – exit the market, leaving only older and more expensive participants in the pool. Again premiums rise, causing more and more young, healthy people to leave the pool and thus depriving the insurance pool of this healthy, inexpensive population.

Obama worried that continued economic stagnation - as began with the stock market crash in 2007 - would exacerbate both situations. Indeed, the number of uninsured had risen by about a million people per year from under 44 million in 2002 to over 50 million in 2009.

Among the reasons for this huge uninsured problem was our change in national economic circumstances. Our post-World War II economic dominance had lessened and along with it, businesses' ability to generate sufficient margin to cover all employee benefits. Employers responded to the changed economy by shifting benefit costs to their employees and outsourcing. That's why the percent of Americans covered by commercial / employer based health insurance shrunk from 59% to 48% between 2000 and 2020. Meanwhile, the number of Medicaid recipients and uninsured Americans grew.<sup>11</sup> (I included the 2020 numbers to show trend and the ACA impact.)

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<sup>11</sup> Medicaid data from stasta.com <https://www.statista.com/statistics/245347/total-medicaid-enrollment-since-1966/>. Uninsured data from the CDC including [https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201106.htm#:~:text=Results-.Lack%20of%20health%20insurance%20coverage,\(Tables%201%20and%202\)](https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201106.htm#:~:text=Results-.Lack%20of%20health%20insurance%20coverage,(Tables%201%20and%202) and https://www.google.com/search?q=number+uninsured+americans+2020&rlz=1C1ONGR_enUS1065US1066&oq=number+uninsured+americans+2020&gs_lcrp=EgZjaHJvbWUyBggAEEUYOdIBCDYwMzdqMG o3qAlAsAIA&sourceid=chrome&ie=UTF-8) and [https://www.google.com/search?q=number+uninsured+americans+2020&rlz=1C1ONGR\\_enUS1065US1066&oq=number+uninsured+americans+2020&gs\\_lcrp=EgZjaHJvbWUyBggAEEUYOdIBCDYwMzdqMG o3qAlAsAIA&sourceid=chrome&ie=UTF-8](https://www.google.com/search?q=number+uninsured+americans+2020&rlz=1C1ONGR_enUS1065US1066&oq=number+uninsured+americans+2020&gs_lcrp=EgZjaHJvbWUyBggAEEUYOdIBCDYwMzdqMG o3qAlAsAIA&sourceid=chrome&ie=UTF-8)



| Year | Number of Medicaid Beneficiaries |
|------|----------------------------------|
| 2000 | 34 million                       |
| 2010 | 54 million                       |
| 2020 | 76 million                       |

| Year | Number Uninsured Americans |
|------|----------------------------|
| 2000 | 39 million                 |
| 2010 | 49 million                 |
| 2020 | 32 million                 |

Thus, the prime focus and effect of the Affordable Care Act was coverage expansion, perhaps somewhat ethical in that it provided a greater good – health insurance – to a greater number of Americans. I’m underwhelmed by the ethical achievement of giving more people financial access to our otherwise unethical system. Our overall life expectancy numbers – flat since 2010 - support this skepticism. See below pages 25 – 26.

### **One way the ACA addresses vertical integration and The Split**

The ACA also, in a relatively hidden and small way, addressed problems cause by The Split between healthcare finance and service delivery. We have already discussed how this grew out of the Baylor – Dallas School System’s initial commercial insurance venture, how Nixon attempted to put this genie back into the bottle, and how the introduction of Health Savings Accounts and similar products cemented The Split into our healthcare system architecture.

Section 3506 of the Affordable Care Act discusses Shared Decision Making. Here is the legislative summary:

The purpose of this section is to facilitate collaborative processes between patients, caregivers or authorized representatives, and clinicians that engages the patient, caregiver or authorized representative in decision making, provides patients, caregivers or authorized representatives with information about trade-offs among treatment options, and facilitates the incorporation of patient preferences and values into the medical plan.

We can read this as an attempt to circumvent The Split by helping patients make wise decisions in conjunction with but not entirely based on, their physician’s recommendations. It harkens back to Porter and Teisberg’s position on the importance

of publicly available outcome measurement and results reporting. The ACA in this section recommends that patients not rely blindly on their physician's advice for two main reasons:

First, the ACA recognizes the economic reality of physicians providing excessive care – sometimes – in response to the economic incentives they face.

Second, the ACA understands that preference-sensitive care exists.

Preference-sensitive simply means that various treatment alternatives often exist. Some patients might reasonably prefer orthopedic surgery while others, equally reasonably, might prefer physical therapy. Or medication vs. surgery. Or other options.

Section 3506 implicitly accepts The Split as reality and legislates a mechanism to ameliorate its most negative consequences.

### **Where We Are Today Post HMO, post ACA, post Split**

Managed care as vertical integration has disappeared from our healthcare landscape. Today, post-Consumer Driven Healthcare and post-ACA, we live in a fee-for-service based medical billing environment. Each individual actor in our healthcare system faces various economic incentives either to provide or control care severity; each individual patient is supposed to make wise healthcare decisions while relying on the advice of financially compromised actors.

We don't do this very well. At \$4.4 trillion – our 2022 healthcare spending - our *healthcare* economy was larger than France's total gdp (about \$2.8 trillion) or Britain's (\$3.0 trillion) and about twice as big as Russia's (\$2.2 trillion).<sup>12</sup>

We have the highest healthcare expenditures per capita or as a percentage of our GDP in the world. See below, a list of per capita healthcare spending in countries that live longer than the US national average or any individual US state average:<sup>13</sup>

| <b>Country</b> | <b>2022 per capita health spending</b> |
|----------------|----------------------------------------|
| US             | \$12,555                               |
| Australia      | \$ 6,569                               |
| France         | \$ 6,516                               |

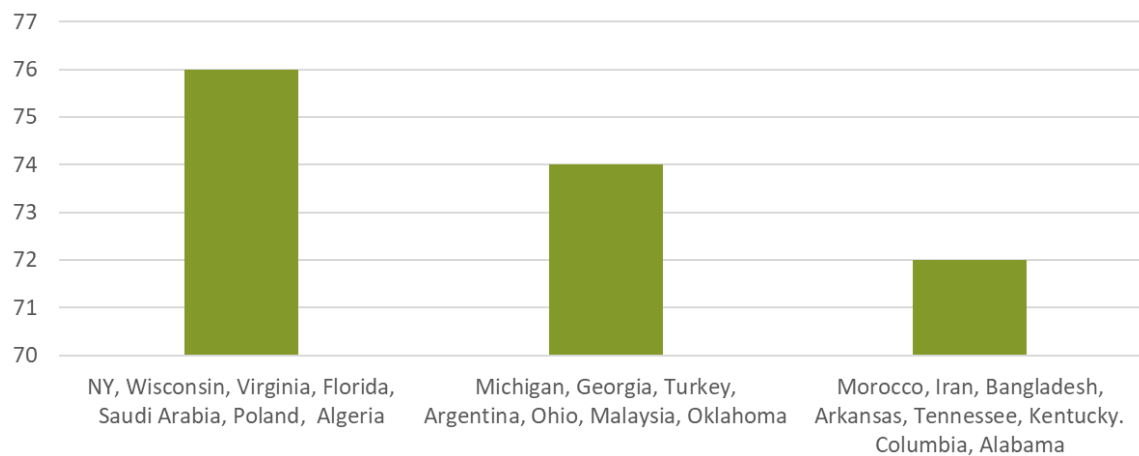
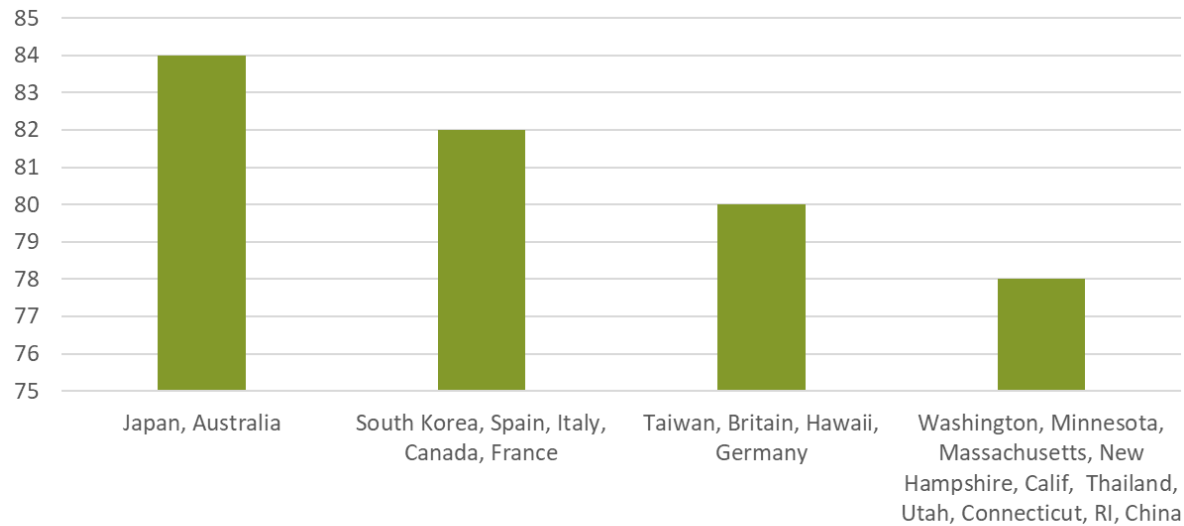
<sup>12</sup> World Bank, Gross Domestic Products 2022 <https://data.worldbank.org/indicator/NY.GDP.MKTP.CD>

<sup>13</sup> Data from Statista <https://www.statista.com/statistics/236541/per-capita-health-expenditure-by-country/#:~:text=In%202022%2C%20the%20United%20States,highest%20per%20capita%20health%20expenditure.>

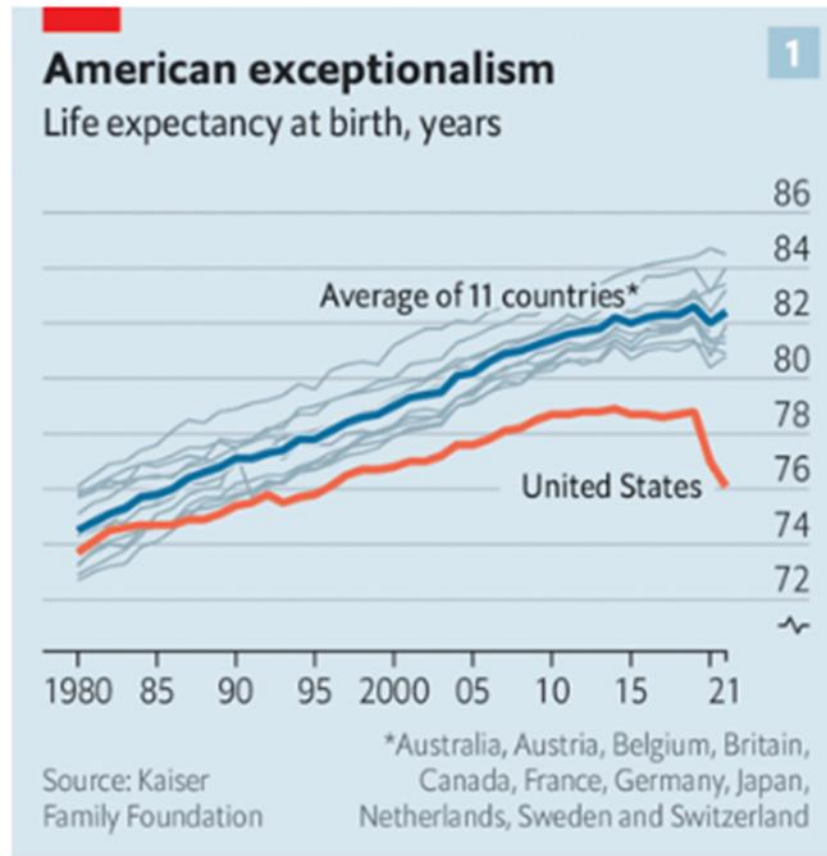
|             |          |
|-------------|----------|
| Canada      | \$ 6,319 |
| Japan       | \$ 5,250 |
| South Korea | \$ 4,569 |
| Spain       | \$ 4,461 |
| Italy       | \$ 4,290 |

One way to see the magnitude of our healthcare system inefficiency is to see how those various countries compare to US state longevity at birth averages. These data were originally developed by the National Center for Health Statistics at the United Nations and presented by Nicholas Kristof in the New York Times, August 17, 2023. As you review these charts, consider this question: if private, commercial health insurance is as beneficial a system as its proponents claim, then why do we see such mediocre outcomes?

Average Longevity at Birth  
Various countries compared to US States  
Life expectancy in 2 year age bands on the left  
'82' means '82 – 84 years'; '78' means '78 – 80 years'



Equally or perhaps more upsettingly, we have experienced **no** national life expectancy gains since about 2009, despite spending more each year on medical care. This differs from other advanced, industrialized countries. See the chart below published in The Economist, July 13, 2023. Note first that Americans, while spending more on medical care than the others, enjoyed shorter life expectancies. Equally interesting (upsetting), see the 2009 – 2020 period, before Covid, when our life expectancy was flat – despite spending more on medical care each year - while the others improved. Finally, note the relative impact of Covid on American and other life expectancies.



The Economist

All this looks to me like a living, working, breathing definition of an ineffective, inefficient healthcare system. It always rewards the relatively few participants in it but only sometimes benefits the huge number of patients who need it.

Why do we have this spending-to-outcome discrepancy? Why does our largely private sector, commercial healthcare system perform so poorly?

## **Some Problems in the commercial health insurance arena**

Brokers know many of the specific problems that afflict our healthcare system. These range from complicated insurance rules that differ by carrier to complicated billing rules that differ by provider to complicated access rules that differ by policy, to many others. Additional system problems also include high overheads caused by having so many different insurance carriers, providers, treatments, medications and options. I originally thought about simply listing a bunch of problems that brokers face regularly and discussing some ethical issues that arise from dealing with them.

But let's go in a different direction. Instead of simply listing a bunch of problems, let's try to identify a core structural issue caused by The Split that underlies many – maybe even most – of these specific issues. This helps us address our ethical problem and understand why our commercial healthcare system fails to produce the greatest good for the greatest number.

We'll do all this by introducing an economic concept alternately called The Tyranny of Small Decisions or The Tragedy of the Commons. The first – the Tyranny of Small Decisions – often leads to the second, the Tragedy of the Commons.

Consider the visual image of a paradigm old English village to introduce these ideas. In this little village, a bunch of farmers lived in small houses around a central public open space called 'the Common' in which cows grazed. Each farmer had a cow or two and the Common provided sufficient room and grass for them all to graze and grow.<sup>14</sup>

Now imagine that our old English village prospered and grew. Families bought a second, third, fourth or fifth cow. New families moved in, each with a few cows. After a while the Commons became too small to support all these cows. Each individual cow lost weight and produced less milk. Villagers' incomes fell. The Commons became overgrazed. Its topsoil began to erode after each rain and eventually the grass disappeared. It ultimately became useless for grazing. We might call this the Tragedy of the Commons v1, in which everyone uses too many resources so there are not enough for all.<sup>15</sup>

In v1, each individual's small decision, made in each individual's own interest, diminished the overall good. The Tyranny of Small Decisions led to overgrazing and, in turn, to the Tragedy of the Commons in which everyone ended up worse off.

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<sup>14</sup> Many New England towns have a Common today. Think of Boston Common or Cambridge Common in Massachusetts, places where cows grazed in colonial times but today are nice public parks.

<sup>15</sup> Apparently this happened to the Mayans in Central American centuries ago and the environmental degradation led to their civilization's destruction, though I'm not a Mayan historian. I did, however, enjoy a fascinating trip to Belize and Guatemala in 2020.

As an alternate version of this story, instead of each villager buying an extra cow, a new person moves to town with 30 cows. The Commons couldn't support this increase and the tragedy unfolded. In the Tragedy of the Commons v2, one person consuming too much destroys the benefit that everyone enjoyed from their shared resource.

In either case, the Tyranny of Small Decisions, in which people individually made decisions to maximize their own welfare, led to overgrazing and, in turn, to the Tragedy of the Commons.

Another way to phrase this: the Tragedy of the Commons decreases the amount of good for the great number of people.

Let's update this to a real situation in Pomfret Vermont, 2023. Pomfret, a small town, apparently enjoys spectacular foliage each fall. <sup>16</sup> A relative handful of tourists annually enjoyed it. In 2021 or 2022 though, a Tic Tok influencer, apparently one of those tourists, broadcast descriptions of Pomfret's beauty to his or her audience. A few local inns also advertised the town's beauty. Thousands of tourists arrived. The town became overwhelmed. Among the problems:

- Tourists blocked Margarete Pierce's driveway, parked illegally on her land, and used her garden house as a toilet,
- Cathy Emmons watched tourists stroll onto her farm and steal tomatoes from her vine,
- Mike Doten got tired of pulling tourists out of ditches with his tractor.

According to the Boston Globe's description, 'The town's selectboard ... voted to block the road to anyone except residents for three weeks at the height of the foliage season, from Sept. 23 to Oct. 15...Windsor County deputy sheriffs will staff checkpoints at the bottom of Cloudland Road in neighboring Woodstock and at the top of the road here in Pomfret.' (I don't know how this is legal but that's a separate issue.)

The Tyranny of Small Decisions – individual publicity for individual interests - led to the Tragedy of the Commons, so now no tourists can enjoy Pomfret's beauty during foliage season.

The Tyranny of Small Decisions and the Tragedy of the Commons can provide a framework to understand many of our healthcare system problems. Let's explore some of them.

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<sup>16</sup> This story comes from the Boston Globe, Sept 18, 2023  
[https://edition.pagesuite.com/popovers/dynamic\\_article\\_popover.aspx?artguid=04b5fe08-f5ff-489d-acbe-ae0c5035891e](https://edition.pagesuite.com/popovers/dynamic_article_popover.aspx?artguid=04b5fe08-f5ff-489d-acbe-ae0c5035891e)

**Medical Care Rationing.** Rationing or ‘the limiting of goods or services that are in high demand and short supply’ per Investopedia, is a classic unintended, indirect consequence of the Tyranny of Small Decisions. We’ll consider two case studies.

First, pediatric bed rationing in Boston. Tufts Medical Center, Boston, closed its 41 bed inpatient pediatric unit in July 2022, then repurposed them as adult inpatient beds.<sup>17</sup> The justification, according to Dr. Daniel Rauch, Tufts Chief of Pediatric Medicine: “Should we take care of kids we don’t make any money off of, or use the bed for an adult who needs a bunch of expensive tests?...If you’re a hospital, that’s a no-brainer.”<sup>18</sup> Tufts could bill more for adults than kids. A small decision that clearly benefited Tufts’ bottom line. Pretty simple to understand.

But a local Tragedy of the Commons followed, documented with Boston Globe headlines like:

October 21, 2022:

## Hospitals scramble to find beds as pediatric admissions rise

By [Jessica Bartlett](#) Globe Staff, Updated October 21, 2022, 8:08 p.m.



November 10, 2022

## Hospitals postpone pediatric surgeries as capacity crunch escalates

By [Jessica Bartlett](#) Globe Staff, Updated November 10, 2022, 5:37 a.m.



Hospital executives said pediatric intensive care unit beds at Massachusetts General for Children were operating at 150 percent capacity, and there were few signs the surge was nearing an end.

December 11, 2022

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<sup>17</sup> Boston Globe ‘Who will care for our sickest children’, Oct 26, 2022

<sup>18</sup> NY Times As Hospitals Close Children’s Units..., Baumgaetner, Oct 11, 2022



## **Hospital finances play a major role in the critical shortage of pediatric beds for RSV patients**

Health Dec 11, 2022 10:33 AM EDT

This Commons Tragedy continued with higher prices. According to the Massachusetts Health Policy Commission report in September 2023, Children's Hospital and Mass General Brigham, representing about 73% of pediatric discharges in Massachusetts, have the highest commercial prices in Massachusetts. Among the data points in that report, the average commercial price per pediatric discharge at Boston Children's was 47 percent higher than at other state hospitals with significant inpatient volume, even after adjusting for the illness of the patient.<sup>19</sup>

Here, the few service providers benefit financially while the rest of us pay higher prices for the same care ... if we can find it. Our national total number of inpatient pediatric beds fell by 19% from 2008 to 2018. The Tufts closing followed this trend. Pediatric hospitals have recently closed or partially closed in Richmond Virginia, Colorado Springs Colorado, Raleigh North Carolina, Doylestown Pennsylvania and Shriners New England because 'kids are not lucrative'.<sup>20</sup>

The Tyranny of Small Decisions – each hospital followed its own economic self-interest and closed less profitable beds in favor of more profitable ones to earn more money – led to a tragedy for the rest of us. A few service providers and investors made more money while many sick kids and their families suffered longer waits for care, longer ambulance or med flights to hospitals, higher prices and perhaps ended up medically much worse as a result.

Greatest good for the greatest number? I think not.

Second, maternity ward rationing in central Massachusetts and nationally. Leominster Hospital closed its maternity ward in 2023. Their justification: "reimbursement rates paid to hospitals for treating maternity unit patients on Medicaid are far lower than what private insurance plans pay" particularly harming Gateway cities like Leominster according to the Boston Globe's June 25, 2023 analysis.

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<sup>19</sup> Jessica Bartlett, Boston Globe, Sept 10, 2023

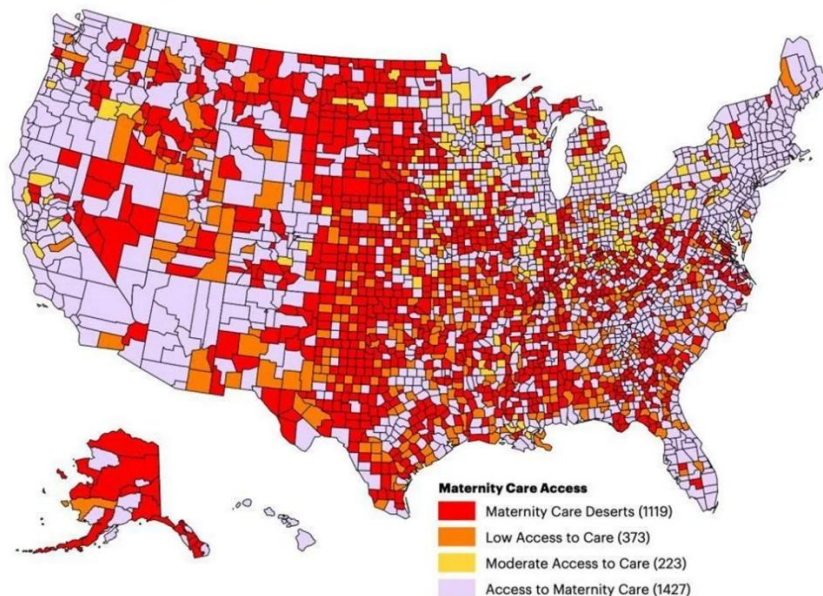
<sup>20</sup> Boston Globe 'Who will care for our sickest children', Oct 26, 2022

Maternity beds in Gateway Cities were, in other words, unprofitable or at least less profitable than other types of hospital wards or other types of patients.

Leominster's closure also followed a state trend. Holyoke Medical Center closed its maternity center in 2020. Harrington Hospital in Southbridge closed its center in 2017.

And all this follows a national trend. According to the March of Dimes, the number of maternity deserts in this country – counties with no hospital providing maternity care, no birth center, OB/GYN, and no certified nurse midwife – has increased over time, mainly in rural areas.<sup>21</sup> Here's their 2020 map

Figure 1: Maternity Care Deserts, 2020



Pregnant women had to drive farther for their appointments and to give birth. This negatively affects them. Health Affairs reported that, after controlling for socioeconomic factors and clinical conditions, “rural residents had a 9 percent greater probability of severe maternal morbidity and mortality, compared with urban residents.”<sup>22</sup>

Hospitals made more money – Tyranny of Small Decisions. Patients ended up worse off – Tragedy of the Commons. The same story unfolds time and time again, in specialty after specialty and treatment arena after treatment arena.

Let's switch focus now away from rationing and explore other clinical and ethical implications of the Tyranny and Tragedy.

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<sup>21</sup> March of Dimes maternity desert report <https://www.marchofdimes.org/maternity-care-deserts-report>

<sup>22</sup> Rural-Urban Differences In Severe Maternal Morbidity And Mortality In The US, 2007–15, Health Affairs, December 2019

**Excessive care.** Excessive care incentives so permeate our post-Split, commercially based healthcare system that Andrew Dreyfus, former CEO of Blue Cross Blue Shield of Massachusetts, claims healthcare today ‘is designed around the needs of institutions and health professionals and not around the needs of patients’. <sup>23</sup>

**Excessive care through disease mongering.** Disease mongering means hyping treatments for little known diseases, more or less advertising diseases for which your company has a treatment. This instills fear among patients, expands markets and positions your product as a solution. Pfizer appears to engage in disease mongering about RSV with this ad, published in the Boston Globe, August 24, 2023, page 5.



We know this is disease mongering and not a public service announcement because Pfizer is not a public education organization; it's a private sector pharmaceutical that makes money by selling medications. This ad helps that process.

Other disease mongering examples exist too – look for them on TV and in your local newspapers - but I want to move on and discuss two other, related concepts: *overdiagnosis* and *overtreatment*. Overdiagnosis means broadening disease definitions so more people qualify for medical care. Overtreatment means providing more care than necessary to patients. Both overdiagnosis and overtreatment can cause patients to

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<sup>23</sup> Boston Globe, June 22, 2018

experience higher care treatment risks and side effects without also enjoying higher chances of treatment benefit.

**Excessive care through overdiagnosis.** Overdiagnosis means broadening disease definitions so more people qualify for medical care. According to H. Gilbert Welch, the overdiagnosis guru, it occurs “when individuals are diagnosed with conditions that will never cause symptoms or death.”<sup>24</sup> Overdiagnosed patients, in other words, *can’t* benefit from care because they weren’t sick to begin with. But medical care providers, testers, drug manufacturers and similar *can* benefit financially by treating these patients. We’ll consider just one example, overdiagnosis of hypertension.<sup>25</sup>

In 1997, the definition of hypertension (high blood pressure) changed from diastolic blood pressure of 160 over systolic blood pressure of 100 to 140 / 90. That immediately switched about 13 million people from having normal blood pressure to having high blood pressure, or, in our terms, increased the market for blood pressure lowering medications by 13 million people.

The definition of hypertension changed more times, always increasing the number of people so-diagnosed. In 2017, for example, the American College of Cardiology and American Heart Association redefined hypertension as greater than 130 / 80, again increasing the number of hypertension patients and the market for hypertensive medications. I don’t know how many people this affected.

During this time period, sales of ACE inhibitors, medications to treat hypertension, grew at an annual compound growth rate of 5%, hitting \$6.9 billion in 2023. Ditto for various other anti-hypertensive medications. The hypertension redefinition appears to have stimulated these medication’s sales (or, at least, didn’t hurt) and again, benefited a few participants in our healthcare system.

Did the redefinition help the Commons? First, some data. The age adjusted heart disease mortality rate fell in this country from 170.5 per 100,000 in 2012 to 161.5 in 2019 or, using my back-of-the envelope calculation, by about 30,000 people annually nationally.<sup>26</sup> 30,000 fewer deaths divided by 13 million new patients = about 0.2% benefit. That’s two tenths of one percent. About 99.8% of the newly diagnosed patients did not benefit from the new hypertension definition while 0.2% did. Maybe. That’s the most optimistic reading of these data.

This interpretation assumes the redefinition itself led directly to the 30,000 fewer deaths. We don’t know that to be the case. The entire mortality decrease could have been caused by other factors – less smoking, better diets, better overall physician advice or

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<sup>24</sup> H. Gilbert Welch, *Overdiagnosed*, page xiv

<sup>25</sup> This case study comes largely from Welch, *Overdiagnosis* pages 20 - 23

<sup>26</sup> Mortality rate data from the National Center for Health Statics, part of the US Centers for Disease Control and Prevention <https://www.cdc.gov/nchs/has/topics/heart-disease-deaths.htm>

something else. We just don't know. At best 0.2% of the newly redefined-as-sick folks benefited from the redefinition. Perhaps none did.

All this raises some troubling questions, including

- How impactful were the redefinitions in preventing heart disease deaths?
- How impactful were ACE inhibitors in reducing heart disease mortality?
- How important were other medications?
- How many people were harmed either physically, emotionally, or financially by taking these medications after they were redefined as 'sick', not 'normal'?
- Could we have reduced heart disease mortality by a similar amount in less expensive ways than redefining at-risk folks and prescribing medications for them?
- Did the increase in hypertension medication sales and associated corporate profits affect the new hypertension definition?

A disturbing consideration of this last point comes from Otis Brawley, former Chief Medical and Scientific Officer of the American Cancer Society in his book *How We Do Harm*. He suggests that of our 555 guidelines (555!) for treating hypertension, "some are self-interested and harmful. Many are commercial documents"<sup>27</sup> meaning they're designed to sell products, more-or-less a form of disease mongering. No one, according to Brawley, promulgates good practices for guideline composition or hypertension redefinitions. Might the 1997 and other redefinitions reflect commercial pressures? Might this simply be the Tyranny of Small, Self-Interested Decisions on the part of hypertension treaters?

All we know for sure is that more Americans are now diagnosed with hypertension and that a very small percent of them benefit from redefinition as measured by age adjusted mortality rates per year. Medical statisticians could parse this analysis far better than I – this is simply an introductory overview – but at first cut, a 2/10s of 1% benefit rate appears underwhelming or, in our terms, like overdiagnosis.

But the drug makers, labs and related folks made more money.

We could expand this analysis, as Welch did in *Overdiagnosed*, to include hyperlipidemia (high cholesterol), diabetes, osteoporosis in women and many more. I hope, though, this one example can suggest what overdiagnosis is, why it's a systemic problem and, more directly for our purposes today, why it's an ethical one for brokers.

**Excessive Care Through Overtreatment.** Overtreatment means providing more care than necessary to patients. Patients can't benefit from overtreatment by definition; overtreatment is care that does not provide benefit. But patients can be harmed by it because all medical treatments involve some element of risk. The more care someone

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<sup>27</sup> Brawley, *How We Do Harm*, page 243



receives, the higher the chance of risk. An overtreated patient gets all the risks without the possibility of benefit.

But the overtreatment *providers* still get paid.

Consider coronary stents as one overtreatment example. According to research from the Lown Institute, between 2019 – 2021, US hospitals performed over 229,000 unnecessary coronary stent procedures, or about 1 every 7 minutes.<sup>28</sup> That's about 22% of all coronary stents and the unnecessary care cost Medicare alone up to \$2.4 million. Rates of overuse varied widely by hospital: at some, more than 50 percent of all stents met criteria for overuse, while at others, fewer than 5 percent were unnecessary.

In all cases, the providers got paid – an economic incentive-based Tyranny of Small Decisions. But 229,000 people undertook the procedure risks without much or any likelihood of benefit because the stent was unnecessary, and everyone's health insurance premiums increased. An economic cost and tragedy for the rest of us.

Let's move from a specific to the general case and estimate the size of the overtreatment problem from a 2017 physician survey published by PLOS, an online medical journal.<sup>29</sup> According to physicians themselves, 20% of all medical care is unnecessary, including 22% of prescription drugs, 25% of tests and 11% of procedures. Among the most common excuses for this by the physicians were fear of malpractice and patient pressure or demands. In other words, in our post-Split healthcare system, no one pushes back sufficiently aggressively when patients want unnecessary treatment. That opens the door to our Tyranny and Tragedy.

By contrast, in a vertically integrated system where healthcare finance and service delivery are the same company, there is a brake on overtreatment; the finance arm, in its desire to keep premiums competitive, won't allow it. Unfortunately, though, today in much of America, one large hospital system typically controls 50-75% of the beds in a region, while the largest insurance carriers in a region – organizations potentially able to push back on overtreatment – typically only have about a 15 – 30% market share. This unequal playing field contributes to our unnecessary care problem; organizations incentivized to provide more care dominate.

**One personal experience with overtreatment.** I had a sore ankle in September 2023 that felt tight early in the morning, then loosened up during the day. I felt under time

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<sup>28</sup> Lown Institute Hospital Index 2023, Avoiding Overuse: Coronary Stents.

<https://lownhospitalsindex.org/avoiding-coronary-stent-overuse/> Lown defines overuse as inserting stents in patients with a diagnosis of ischemic heart disease at least six months prior to the procedure, excluding patients with a diagnosis of unstable angina or heart attack within the past two weeks, and excluding patients who visited the emergency department over the past two weeks.

<sup>29</sup> <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0181970>

pressure to resolve the issue as I was going hiking with my kids in November, about 6 weeks in the future. I first tried rest but that didn't work. I then considered my treatment options:

- Option 1, see an orthopedist. That would take a couple months as orthopedists typically book weeks or months in advance. I suspected there was insufficient time to pursue this option. The orthopedist would probably (my uninformed guess here) want to run some tests, then have me return for a second visit and maybe prescribe therapy or medications (my guess again). I expected that the orthopedist would resolve my ankle pain problem but, most likely, after I returned from my hiking vacation.
- Option 2, see a physical therapist. My limited experience with PT suggested that I would visit once or twice a week for a few weeks. My experience also suggested that the therapy would work. I decided to keep this option on hold.
- Option 3, see my local chiropractor. Note here that I am not a shill for the chiropractic industry and do not understand anatomy; I'm just a commentator here. However, I like chiropractic primarily for one, virtually overwhelming reason: I can get an appointment in a day. Plus it's cheap. I had no idea if chiropractic would resolve my ankle pain problem, but I figured 'why not?'. Very low risk. I could learn quickly – in one afternoon since my chiropractor is about 15 minutes from my house – if chiropractic could help and it only cost \$8.80 for a copayment. I figured it was worth the time to find out.

My chiropractor felt my ankle, gave me a couple stretches, and sent me home with 'come back if you still feel pain next week'. I did the stretches a couple times and, astonishingly to me, the pain disappeared. Problem solved. In one day. For \$8.80.

Would the physical therapist or orthopedist have overtreated my problem? It certainly seems likely to me though I can't know for sure. But I feel like I maneuvered around the tyranny of their own small, incentive based decisions for my own benefit.

### **Excessive care through lack of high quality, randomize, comparative studies.**

We'll first discuss Vitamin D supplements to prevent bone fractures or extend life. Millions of Americans take vitamin D supplements and labs run 10 million vitamin D level in patients tests every year.<sup>30</sup> Vitamin D sales and testing has become a billion dollar industry with about 25% of Americans over age 60 taking vitamin D supplements.<sup>31</sup>

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<sup>30</sup> Gina Kolata, Study Finds Another Condition that Vitamin D Pills Do Not Help, New York Times, July 27, 2022

<sup>31</sup> Szabo, Selling American on Vitamin D, Kaiser Health News, August 20, 2018, <https://www.nbcnews.com/health/health-news/selling-america-vitamin-d-reaping-profits-n902276>

Though use of vitamin D supplements may make biochemical sense – the body needs vitamin D to help it absorb calcium, a mineral necessary for strong bones – a 2022 comparative study of 25,000 people with half taking the supplements and half taking a placebo found little-to-no benefit to the vitamin D supplements.<sup>32</sup> Indeed and perhaps more interesting from our perspective, that 2022 study found that ‘no large randomized, controlled trials had previously tested the effects of daily supplemental vitamin D alone (without coadministered calcium) in preventing fractures in the U.S. population.’

Why were there no studies on such a widely prescribed vitamin? One answer may be that the American Clinical Laboratory Association, the trade association for the laboratory and diagnostic health industry, spent around \$1 million on political lobbying annually since 2014<sup>33</sup> though I don’t know exactly where all this money went.

Another answer may be that the Endocrine Society – the leading organization in the fields of endocrinology and metabolism according to Wikipedia, that ‘influences a wide range of policies’ according to its website<sup>34</sup> – argues that “vitamin D deficiency is very common in all age groups” and advocated a huge expansion of vitamin D level testing in patients in the 2010s.<sup>35</sup> Though the Endocrine Society’s financial lobbying is relatively small, only about \$120,000 in 2020 for example, it plays a large role in ‘helping to shape healthcare and research policy in the US and around the world’ according to its website.<sup>36</sup>

A third answer maybe be that ‘it’s obvious’ that vitamin D helps people, based on a simplistic, linear, biochemical analysis. ‘Bones need calcium, vitamin D helps bones absorb calcium so vitamin D supplements will help bones remain strong’. If only the human body was so simple! We have an extensive history of *medical reversal* in this country; medical reversal means ‘high quality comparative studies show that something that makes sense in theory does not provide patient benefit in real life’. See Ending Medical Reversal by Adam Cifu and Vinay Prasad for more on this.

I’ll go out on a limb now and suggest that the financial lobbying impact of the American Clinical Laboratory Association, plus the intellectual clout of the Endocrine Society, combined with the ‘obviousness’ of vitamin D’s benefit, supported an environment for continued vitamin D level testing in patients and supplement prescriptions, *always* to the economic benefit of the industry but *only sometimes*, if ever, to the medical benefit of

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<sup>32</sup> LeBoff et al, Supplemental Vitamin D and Incident Fractures in Midlife and Older Adults, NEJM, July 28, 2022.

<sup>33</sup> Open Secrets <https://www.opensecrets.org/federal-lobbying/clients/summary?cycle=2022&id=D000023934>

<sup>34</sup> <https://www.endocrine.org/advocacy>

<sup>35</sup> Szabo op cit

<sup>36</sup> <https://www.endocrine.org/advocacy>



patients. That's one impact of our profit motivated, private sector based medical industry post-Split.

We'll switch focus now to discuss excess care and medical spending on over-the-counter-decongestants. The US over-the-counter decongestant market was worth about \$1.8 billion in 2023,<sup>37</sup> including common, over-the-counter medications such as Sudafed PE, Vicks Nyquil Sinex Nighttime Sinus Relief and Benadryl Allergy Plus Congestion. The problem with these and similar phenylephrine-based medications: they don't work. That's the unanimous conclusion of an FDA panel that reviewed several existing studies of phenylephrine-based medications in September 2023.

From our point of view, though – the impact of private sector medicine's lobbying for its own financial gain and not necessarily for patient benefit - the back story of how ineffective medications came to market and remained on the market so long is more compelling than the scientific analytics.

We begin in 1976 when the (then new) Food and Drug Administration adopted a 'safe and effective' standard for medications.<sup>38</sup> After an initial purge of unsafe or ineffective drugs in the 1970s, the agency's approval criterion morphed, in real life, from 'safe and effective' to 'safe' with few if any drugs were removed from the market during the ensuing 50 years due to their lack of effectiveness. The agency apparently lacked the resources to police medications as rigorously as, perhaps, it would have liked, and so focused more on product safety.

We'll jump ahead 30 years, bypassing drug reformulations and FDA oversight issues, to 2007 when two University of Florida researchers, Leslie Hendeles and Randy Hatton, filed a citizen's petition for the FDA to review various phenylephrine-based medicine studies. Hendeles and Hatton had themselves reviewed dozens of original studies and determined that over-the-counter, phenylephrine-based oral decongestants performed no better than a placebo. In other words, these medications were safe but ineffective. The FDA, in response, assembled the Non-Prescription Drug Advisory Committee (NDAC), composed of petitioners, manufacturers and the Consumer Healthcare Products Association, the industry trade group. The NDAC decided that the evidence on phenylephrine was "suggestive of efficacy" so left these drugs on the market. (I'm not sure what 'suggestive of efficacy' means, especially after years of patient utilization. 'Suggestive of efficacy' is not a standard statistical, regulatory or legal concept.)

Fast forward 8 more years and several new studies, and Hendeles and Hatton again filed a citizen's petition, this time to remove phenylephrine-based oral decongestants from the market. The FDA reviewed the newest information, this time with enhanced

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<sup>37</sup> Berkeley Lovelace Jr, FDA Panel Says Common Over-The-Counter Decongestant Doesn't Work, NBC News, September 12, 2023

<sup>38</sup> Much of this section comes from Haley Weiss, With the Decongestant Snafu, the FDA Tries Something New, Time, September 14, 2023

powers granted to it by the Coronavirus Aid, Relief, and Economic Security Act, passed in 2020. Post-2020, the agency could more easily revise over-the-counter approvals and recommendations.

That brings us to September 2023 when an advisory panel to the FDA concluded that phenylephrine-based oral decongestants are ineffective, more-or-less returning to the 1976 'safe and effective' standard. During those 50 years, Americans took a safe but ineffective medication thanks, in part, to weak FDA oversight (lobbying impact?) and weak regulations (lobbying impact?).

I left out the history of Schering-Plough, since bought out by Merck and the maker of Claritin D. Their internal studies showed that phenylephrine-based oral decongestants were, in fact, ineffective. That's why they continued making Claritin D, a prescription medication, and didn't switch to a phenylephrine-based over the counter formulation. The Schering-Plough story suggests that the pharmaceutical industry knew of phenylephrine-based oral decongestant ineffectiveness but still promoted the medications to patients.

The net result of that 50 year lag, according to Hendeles and Hatton:

Americans spend billions on drugs that contain ingredients that will not help them. That's not just a waste of money — it could mean they are delaying appropriate treatment, which can lead to more severe illnesses.

But the OTC drug provision industry made billions thanks, in large part, to their industry lobbyists.

**Excess billing.** Somewhat like the excess care problems, our post-Split healthcare system allows for excess billing. In this excess billing case, patients don't gain additional benefits – they (or their insurance carrier, which ultimately means their premiums) just pay more for the same care...at best. The excess billing problem may ultimately lead to overtreatment.

In our non-vertically integrated, post-Dallas healthcare system, providers typically bill by code. We have, in this country, thousands of codes, many subject to interpretation. The Physicians for a National Health Plan offers one example, below, showing the difference in potential billing for the same patient.

| Original Coding             |                | Enhanced Coding        |                 |
|-----------------------------|----------------|------------------------|-----------------|
| Base rate                   | \$3,950        | Base rate              | \$3,950         |
| DM 2, uncomplicated         | \$1,040        | DM 2 with Diabetic CKD | \$3,180         |
| Chronic Kidney Disease      | \$0            | CKD Stage 4            | \$2,370         |
| Obesity                     | \$0            | Morbid Obesity         | \$2,730         |
| Depression                  | \$0            | Major Depression       | \$3,950         |
| Coronary Art. Dis., Chronic | \$0            | CAD with Angina        | \$1,400         |
| <b>Total</b>                | <b>\$4,990</b> | <b>Total</b>           | <b>\$17,580</b> |

SGIM Forum, 2017

**PNHP** PHYSICIANS FOR A NATIONAL HEALTH PROGRAM

The players in our health insurance melodrama understand this, as do investors like private equity firms. Private equity firms purchased 355 physician practices between 2013 and 2016 and 578 between 2017 – 2021. Individual physician practices can have dozens or hundreds of doctors.<sup>39</sup>

Private equity investors seek high returns from their investments, up to 20% annually according to some estimates. Our post-Split healthcare system offers only 3 ways to accomplish this: see more patients, provide more treatments and/or bill at higher rates. PE owned firms apparently do all three, according to research published the Journal of the American Medical Association in 2022.<sup>40</sup> That study noted “Following a private equity acquisition, physician practices saw a 20.2 percent increase in charges per claim...and a 37.9 percent increase in new patient visits.” Additionally, PE owned firms generated a 16% increase in the total number of encounters. (Encounters = lab tests, imaging, procedures).<sup>41</sup>

Little to none of this helps patients get healthier (personal opinion and probably an overstatement) while all benefit system participants – physicians, nurses, private equity investors, drug companies, etc - just like Andrew Dreyfus observed. This helps explain why we enjoy more healthcare spending year over year, while failing to enjoy improved outcomes as measured by increased longevity.

**Medical procedure approvals.** Let’s turn now to a case study of spinal fusion surgery research and information dissemination to see how the Tyranny of the few can affect the well being of the Common. This comes from research published in Scientific

<sup>39</sup> Robert Pearl, Private Equity And The Monopolization Of Medical Care, Forbes, Feb 20, 2023

<sup>40</sup> Association of Private Equity Acquisition of Physician Practices With Changes in Health Care Spending and Utilization, JAMA, Sept 2, 2022.

<sup>41</sup> Discussion with Jane Zhu, co-author of the JAMA study and assistant professor of medicine at Oregon Health & Safety University <https://www.opb.org/article/2022/09/16/what-happens-to-healthcare-spending-and-use-under-private-equity-ownership/>

American<sup>42</sup> by two researchers, Sanjaya Kumar, Chief Medical Officer at Quantros, a healthcare analytics company, and David Nash, dean of the Jefferson School of Population Health at Thomas Jefferson University.

We'll start in the 1990s when the Federal Agency for Health Care Policy and Research (now the Agency for Healthcare Research and Quality) released findings from a five-year investigation of the effectiveness of various treatments for low back pain. Here's Kumar and Nash's summary from their Scientific American article:

Between 1989 and 1994, an interdisciplinary Back Pain Patient Outcomes Assessment Team (BOAT) at the University of Washington Medical School in Seattle set out to determine what treatment strategies work best and for whom. Led by back expert Richard A. Deyo, MD, MPH, the team included orthopedic surgeons, primary-care physicians, physical therapists, epidemiologists and economists. Together, they examined the relative value of various diagnostic tests and surgical procedures.

They conducted a comprehensive review of clinical literature on back pain. They exhaustively examined variations in the rates at which different procedures were being used to diagnose and treat back pain. Their chief finding was deeply disturbing: what physicians thought worked well for treating low back pain doesn't. The implication was that a great many standard interventions for low back pain may not be justified. And that was immensely threatening to physicians, especially surgeons who perform back operations for a living.

Among the researchers' specific findings: no evidence shows that spinal-fusion surgery is superior to other surgical procedures for common spine problems, and such surgery leads to more complications, longer hospital stays and higher hospital charges than other types of back surgery.

Disgruntled orthopedic surgeons and neurosurgeons reacted vigorously to the researchers' conclusion that not enough scientific evidence exists to support commonly performed back operations. The surgeons joined with Congressional critics of the Clinton health plan to attack federal funding for such research and for the agency that sponsored it. Consequently, the Agency for Healthcare Policy and Research had its budget for evaluative research slashed drastically.

The back panel's guidelines were published in 1994. Since then, even though there are still no rigorous, independently funded clinical trials showing that back

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<sup>42</sup> Kumar and Nash, 'Myth: There is a high degree of scientific certainty in modern medicine', Scientific American, March 25, 2011.

surgery is superior to less invasive treatments, surgeons continue to perform a great many spinal fusions. The number increased from about 100,000 in 1997 to 303,000 in 2006.

In 2023, twelve years after Kumar and Nash's Scientific American article, I searched for rigorous, independently funded clinical studies on back surgery. The most recent available was a 2018 summary of the evidence about spinal fusion surgery. Those researchers concluded "We found no high-quality systematic reviews and the risk of bias of the randomized controlled trials in the reviews was generally high."<sup>43</sup>

I also googled 'number of spinal fusion surgeries per year' and learned from various sources, that we in the US experienced 500,000 in 2011 and 1.3 million in 2021, though that later number may include a wider definition.<sup>44</sup> These procedures cost about \$50,000 each for an annual national total of perhaps \$68 billion.<sup>45</sup>

Since the Baylor – Dallas School System initial foray into health insurance, medical providers, suppliers, financiers and others have made Small Decisions for their own financial benefit. Many have harmed The Commons. That's the tragedy of commercial health insurance today.

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<sup>43</sup> Harris, et al, Lumbar spine fusion, what is the evidence? Internal Medicine Journal, Dec 5, 2018

<sup>44</sup> iData Research 8/16/23

<sup>45</sup> Cost of spinal fusion surgery in the 30 biggest US cities, Becker's Spine Review, Carly Behm, Feb 21, 2022 <https://www.beckersspine.com/spine/53684-cost-of-lumbar-spinal-fusion-in-the-30-biggest-us-cities.html> . Boston's cost was \$50,150

## Understanding Employer Based Health Insurance

The US is the only advanced industrialized country to finance medical care primarily through employment. Most other countries use employer based financing either to supplement a national healthcare system (e.g. the United Kingdom) or ban it from competing with the national system (Canada).

About 160 million Americans receive health insurance from work. That's about half of our population. The other half either receives health insurance through a government program – Medicare, Medicaid for example – from a state exchange or is uninsured. About 30 million Americans are medically uninsured.

Employers who offer health insurance worry about the costs. They need to balance their firm's financial health with their employee's medical health so provide plans that are good enough to comply with the various state and federal regulations and provide satisfactory employee coverage without costing too much. It's a delicate and confusing balance.

Employees should also worry about their employer's health insurance costs but too few actually do. Most employees think health insurance is a 'benefit' – a freebie that the employers offer. Labor economists virtually universally reject this assumption. They claim that the actual cost of each employee is the total of salary plus benefits, so if the employer pays less in benefits, the employee will receive more in salary.

In other words, the employee actually pays for employer-based health insurance via foregone wages.

Employer based health insurance has set the paradigm of healthcare financing in this country. We rely on 1 year long insurance policies to finance medical care even though 70% of healthcare spending goes to chronic disease treatment, i.e. treatments that take longer than 1 year. This sets up a fundamental inefficiency, treating long term problems with short term financing, a mismatch resulting in higher costs and, apparently, poorer outcomes than optimal.

Other healthcare financing systems, most notably Medicare, follow this one year long policy format. I'll discuss this in more detail below.

### Three structural problems with employer based healthcare financing #1: Moral hazard

Our employer based system finances all medical care with **insurance** rather than **payment plans** probably for historical reasons that we'll discuss shortly.

This confuses *insurance* (protection against financial harm caused by random events) with financing normal, routine and expected medical events like flu shots and knee replacements.

Compare health insurance to auto insurance. Auto insurance pays for unexpected events, like crashes; it doesn't pay for expected events like oil changes, tire rotations or transmission rebuilds. Yet we expect health insurance to cover all medical events, from the most routine and predictable to the most random and unpredictable. This leads to enormous inefficiencies because, many argue, insurance is the wrong financing mechanism for routine medical events.

- Insurance pools risk inefficiently based on timing; those *not having* medical events this year pay for those having.
- This suppresses any market mechanisms from pooling more efficiently and developing better, more targeted, more actuarially based medical financing products - orthopedic payment plans for example, or pediatric immunization payment plans.

We can imagine lots of medical payment programs, underwritten and priced for individuals or banded for groups. Middle aged men might buy 5 or 10 year orthopedic and urologic plans but not birthing; younger women the opposite.

This kind of program pools need more efficiently than blanket insurance plans that cover every possible medical situation, for all people, that might occur this year. 'Insurance' then provides a safety net for the unexpected or random events not covered by specific payment plans.<sup>46</sup>

A fundamental problem using insurance to finance all medical activities is **moral hazard**. Insurance programs *always* face concerns about moral hazard. Moral hazard is the phenomenon in which people get more care than they need because it appears free to them. Insurance financing that includes this moral hazard component is a great foundation for a healthcare jobs program but a poor one for an efficient medical care financing system.

The moral hazard concept originated when home fire insurance was developed centuries ago. Underwriters were concerned that people with 'poor moral character' would burn their houses to collect the insurance proceeds then rebuild a less expensive house and pocket the difference. This translates in the health insurance arena to people having tests and treatments because –why not? It's free to me and may offer some benefits.

Medical care providers understand this issue and can generate income from it: 'let's send you for another test just to rule something out. Don't worry – it's covered by insurance' and medical testing and treatment industries develop. Dr. Sandeep Jauhar, Director of the Heart Failure Program at Long Island Jewish Medical Center, has written

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<sup>46</sup> Regina Herzlinger has written extensively and creatively about this type of program. See especially her book *Who Killed Healthcare*.

eloquently and painfully about this. Consider these various quotes from his 2014 book *Doctored*:

Bob and Joe and Dave have an unwritten agreement to call one another when patient issues arise outside their scope of expertise. If Bob, the nephrologist, sees a patient, he finds a cardiac and a gastrointestinal issue and consults the other two specialists and vice versa...a mutual scratching of backs...**Insurance companies can restrict medications, tests and payments. But they still cannot tell us who or when we can ask for help.** (page 97, emphasis added)

A large percentage of healthcare cost is a consequence of induced demand – that is, physicians persuading patients to consume services that they would not have chosen if they were better educated. (page 107)

[Describing one particular physician] ...he was doing a plethora of tests – eye exams, audiometry, pulmonary function tests, even Holter monitoring – to generate revenue ... he avoided the high-risk cases... ‘Those we would send to a cardiologist’ ...[and, quoting a gastroenterologist] ‘If a doctor doesn’t do excess testing, forget it, he isn’t going to be able to live.’ (page 167)

Dr. Jauhar’s unsettling conclusion about the impact of moral hazard:

In our healthcare system, if you have a slew of physicians and a willing patient, almost any sort of terrible excess can occur. (page 94)

Others have, of course, also written expansively about the impact of moral hazard on our healthcare system. My point in this discussion: by relying on insurance to finance all aspects of healthcare, the employer based model exacerbates, rather than ameliorates, this problem. By basing our entire healthcare financing system on and around the employer model, the moral hazard problems permeate all aspects of American healthcare financing, creating more healthcare jobs and less healthcare value.

While we can’t calculate an exact cost of moral hazard in our healthcare system, credible research suggests that 30% + of all medical spending is wasted on unnecessary care. That’s generally estimated at about \$700+ billion annually or \$2500+ per employer based policy. The Dartmouth researchers primarily responsible for that estimate, though, are quick to note that we ‘view these as an underestimate given the potential savings even in low cost regions’<sup>47</sup> meaning that even they have no real solid idea how much moral hazard exists in our system.

But they and others admit that it’s a lot.

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<sup>47</sup> Dartmouth Atlas of Healthcare, Reflections on Variation, answer to the question ‘The Atlas is often cited as a source for the estimate that 30% of the nation’s spending is unnecessary --- what is the evidence?’ <http://www.dartmouthatlas.org/keyissues/issue.aspx?con=1338>



A very lot.

## **Structural problem #2: Disconnecting payers from users**

Payers in the employer based model are employers, often acting through their benefits department. Payers decide what network size employees want, what deductible levels, what drugs to include in the formulary and what copayments to have. This is particularly true in small companies covering the bulk of American workers that may offer only 1 policy to all employees.

Consider the impact of payer's decisions. A company opting for a wide provider network decides that each employee would prefer *paying more for health insurance to having more disposable income available* (and using a smaller network).

Or a company opting for a smaller network decides that employees prefer *more disposable income to having the most expensive doctors and hospitals available in-network*.

Employees, though, are the consumers and each may seek different things from our healthcare financing system. One may want higher deductibles or lower, wider networks or smaller, bigger drug formularies or not. Each facing his or her own specific medical issues can reasonably have his or her own set of preferences.

We call this 'consumer sovereignty' meaning that the most efficient economic distribution system is one in which consumers express their desires through purchases. We have seen this work quite effectively in other markets for hundreds of years.

Take the grocery market for example. A typical supermarket has thousands of products available because some people like expensive cuts of meat while others are vegetarians. Some people like ice cream while others are lactose intolerant. Some people like rye bread, others white bread and still others prefer bagels. And so on, for canned foods, soups, fruit and many other food products.

Our food distribution system is 'efficient', or so goes the argument, because individual consumers, casting their own dollar-votes, decide which products should be available and how much shelf space stores should allocate to each product. As consumers demand more soup, the store supplies more soup. Ditto for apples, mangoes and bread.

Imagine the impact on our food choices if these decisions were made by your employer! 'Apples are good for my employees, so stock a lot. Cut down on cookies and fatty meats. And, since more and more people are lactose intolerant, switch to carrying more skim milk.' (As if your employer had any interest in making those decisions. Your employer wants to make and sell widgets, not decide what you should eat. Hmmm, sounds like healthcare, doesn't it?)

Restrictions on consumer sovereignty lead to higher prices, less choice and sometimes poorer quality. Would apple producers focus as much energy on their product quality if they knew that all stores had to buy more apples from them? Maybe – or maybe they'd focus more on quantity and price.

In the employer based health insurance model, consumers have far less sovereignty than many would like, since benefits administrators make many of their key consumption decisions. But remember the economic axiom: the more consumer sovereignty, the more efficiency. And vice versa.

### **Structural Problem #3: One year long policies**

Some 70% of healthcare expenditures go toward chronic, long term and on-going medical care as opposed to episodic, acute care. A chronic condition is, for example diabetes and an on-going care example might be post-operative cancer treatment. Dozens more examples exist. The best outcomes result from continuity of treatment from the same provider. Medically, thus, *long term financing programs* tend to generate the best outcomes, generally at the lowest costs since care discontinuities can lead to errors, which add treatment costs.

Employers, however, oppose funding multi-year health insurance policies. Business conditions may change they reason, their employee census may change, prices may fall – why encumber themselves with long term liabilities? Employers like 1 year long policies so they can change the program if business conditions warrant.

This creates a conflict between *employee medical needs* and the *employer's business considerations*. We have, nationally, adopted the employer's position as the basis of our healthcare financing system, not the medical need position. Financing medicine based on anything other than medical concerns adds inefficiencies (costs) to the system without any related benefits or value increases.

The employer financing model forces health insurance carriers to compete on short term medical cost controls rather than long term patient outcomes. I'll explain how all this works and some impacts later in this chapter.

These three structural problems – financing routine medical care through insurance, disconnecting payers from users and embracing 1 year health insurance plans - lead to an inefficient system with skewed incentives. Good for healthcare jobs growth but bad for system value creation.

But that's what we get with employer based financing as the core of our national healthcare financing system.

### **Three consequences of employer based health insurance**

Uwe Reinhardt, professor of healthcare economics at Princeton, suggests 3 consequences of placing employer based health insurance at the center of healthcare financing.<sup>48</sup>

**First**, it is tremendously expensive. In 2021, for example, the average family health insurance annual premium was \$22,221<sup>49</sup> up about \$17,000 from \$4,969 in 2011.<sup>50</sup> This compares to a median annual family income in 2021 of about \$79,900. That's 28% of the average annual family income going to health insurance. Under what definition of 'affordable' does this make any sense?

Reinhardt wonders how any employer who finances employee healthcare, carrier that designs plans or broker who implements benefit programs can take pride in his/her work product. So do I.

**Second**, having employment at the center of our healthcare financing system requires lots of 'fill in' programs for people unable to obtain employer based insurance. Each of those programs – Medicare and Medicaid, for example, or SCHIP – develops their own regulations, licensure requirement, codes and prices resulting in overlapping and confusing payment categories.

We have, as a result:

- One healthcare system for fulltime, employed people. This system has its own access rules, reporting rules, prices and payment rules.
- A second healthcare system for elderly people, with its own (different) access rules, reporting rules, prices and payment rules.
- A third healthcare system for very poor, unemployed people who (for lots of bureaucratic and political reasons but no medical ones) must *also* be either i children, ii blind or disabled, iii elderly, iv mentally ill, v pregnant or vi mothers.<sup>51</sup> This system, as the two previously mentioned, also has its own access rules, reporting rules, prices and payment rules
- A fourth healthcare system for slightly poor, partly employed people (we sometimes call this 'non-group', a financial distinction but not a medical one)
- A fifth system for children not otherwise accounted for

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<sup>48</sup> This section based on Reinhardt's lecture at the Pioneer Institute in Boston, 2014. I updated the premium numbers in this text but his core argument remains valid.

<sup>49</sup> KFF.org 2021 Employer Health Benefits Survey

<sup>50</sup> How much does health insurance cost, Nov 2, 2011, eHealth news release

<sup>51</sup> Ezekiel Emanuel makes this point in Redefining American Healthcare, page 47

- A sixth system for military veterans, but only if they're also either old or accessing medical care as a result of combat injuries, or both, and finally
- A seventh system for people with kidney disease, provided it's end-stage.<sup>52</sup>

Inefficient and irrational are two polite ways to summarize this chaos: nuts might be more appropriate. Having all these overlapping, irrational categories creates confusion and complexity that makes our system far less efficient and effective than we would like or hope for, leading to more jobs, higher costs and, unfortunately, poorer outcomes than patients would hope for.

I wonder if that's the system goal.

These different categories exist, again, because of the employer basis of healthcare financing. We needed to develop all these programs to address groups left out of the employer coverage model.

And **third**, having all these different categories has led to different prices for the same service.<sup>53</sup>

- The **List Price** exists though is rarely paid. It's reserved for rich foreigners and uninsured Americans. It's the highest price hospitals charge.
- The **Medicare rate**, completely transparent, is stipulated by Medicare. It's generally about 80% of hospital costs, meaning hospitals must overbill some other category of patients to remain financially solvent.
- The **Commercial Insurance rate**, higher than Medicare and lower than List Price, varies by carrier based on their market clout and negotiating skills. It tends to run about 135% of hospital costs though this can vary significantly.

One reason for the high price and variation: market clout. A carrier with 8% of the market generally negotiates relatively ineffectively with a hospital network that controls 60% of the beds.

- The **Usual and Customary rate** is the rate hospitals charge carriers with which they don't have a contract – a Colorado hospital that treats Florida insureds who injures themselves while skiing for example.
- The **Medicaid rate** is typically the hospital's lowest rate, often quoted as a percentage of Medicare's rate.

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<sup>52</sup> We also have the Indian Healthcare System which, you'll be pleased to read, is funded under the Indian Healthcare Improvement Act, signed by President Obama in 2010 and which is included in the Affordable Care Act. Probably others too, but that falls outside my area of expertise.

<sup>53</sup> This section comes from Ezekiel Emanuel's book *Reinventing American Healthcare*, pages 72 -76. It follows from Reinhardt's analysis.

- The **Actual Cost** of providing the service is generally unknown. Many medical professionals interact with each patient, requiring detailed time-and-motion studies which are expensive to produce.

Note that in other – efficient – parts of our economy, the service provider determines his/her price for the service and then sells it to anyone who will buy with, perhaps, some quantity discounts to account for scale. But in medical care, the same service varies in price by patient and the same patient can switch from category to category, thus inducing different prices from the same providers for the same care. See why I suggested this is nuts?

This huge, complex, irrational and inefficient system exists, again, because of the employer centric structure of our healthcare financing system.

### **Two problems that employer based health insurance fails to address** **#1: Unnecessary Care**

Unnecessary care, defined as care that does not improve patient health, is the largest single category of medical spending in this country. Credible estimates, as from the Dartmouth Atlas of Healthcare and Dartmouth Institute for Health Policy, suggest that up to about 1/3 of all healthcare spending or some \$700 billion annually is unnecessary. I think this a low estimate, but at 30% of medical spending, it trumps

- Heart disease, about 10% of medical spending
- Diabetes and cancer, about 5% of medical spending each.

In fact, according to Jonathan Bush, founder and CEO of Athenahealth, ‘unnecessary care is part of the hospital business model’. <sup>54</sup>

The interesting question for this section: who, in the employer financing model, tackles unnecessary care as a function of his/her job?

- **Does the benefits administrator care?**

Probably not. The benefits administrator generally wants to keep premium inflation around ‘trend’, the industry definition of healthcare inflation.

If his/her company’s premiums inflate at trend, then he or she can take a CYA approach: ‘I did my job. Our premiums reflect trend.’

If his/her company’s premiums inflate faster than trend, then alter plan designs, generally by increasing deductibles and copayments and shrinking the provider network.

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<sup>54</sup> Jonathan Bush, Where Does It Hurt?

Engaging with carriers and providers to reduce unnecessary care is time consuming, a task for which the benefits administrator probably doesn't get paid and is probably ill-equipped. It will likely be an unsuccessful effort anyway. That's why most benefits people tend to take the CYA approach and settle for the 'we're at trend' justification for mediocrity.

- **Does the CFO care?**

Again, probably not. The CFO is busy, responsible for the company's financial health and less interested in the internal operations of a hospital. As long as premiums inflate at an 'appropriate' rate, then the CFO will focus on his/her company's core business, making widgets for example, and generate profit on those.

CFO's lacks both the time and expertise to work with doctors and hospitals on reducing unnecessary care. A huge company CFO might have the time and interest to work with a select group of providers on this issue. But hospitals that engage with this particular large company may well then turn around and bill other, smaller companies more to make up the difference.

- **Does the employer care, especially the small and mid-sized ones?**

Again, probably not. Most economists argue that employers simply reduce wage increases to fund health premiums. (See below). If premiums rise quickly, wages rise more slowly.

The employer corporation doesn't care – economically – if it pays employees wages or premiums. It's only concerned with the total employee costs.

## **#2: Underfunded Social Programs**

Among developed countries, the US has the highest rates of diabetes, sexually transmitted diseases, teen pregnancy and auto mortality. We also have the second highest rates of heart and lung disease and lose more years of life before age 50 to drug and alcohol abuse.<sup>55</sup>

Are sexually transmitted disease and teen pregnancy the *employer's* problem? The patients typically don't work for the employer but the employer pays for treatments through 'trend'.

We know that social and behavioral factors affect more than

- 70% of colon cancer and strokes.
- 80% of coronary heart disease

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<sup>55</sup> For Americans Under 50, Stark Findings on Health, Tavernise, NY Times, Jan 9, 2013

- 90% of adult on-set diabetes, and
- Probably most leg amputations (we lead the developed world)

But the underlying social and behavioral factors exacerbating these problems are not addressed by employer based health insurance. These are 'social' problems, appropriate for some government agency or non-profit to address – or so believe many employers and benefits administrators.

Perhaps as a result, we spend far less on social determinants of health (housing and rent subsidies, training programs for poorly educated or unemployed folks, disability cash benefits and social services in general) and far more on medical treatments after someone gets sick than do most other developed countries.

In fact, though we're #1 in medical spending per capita in the world, we're #13 in 'medical and social spending' combined. We have the ratios reversed from most others. The OECD average is about 2/3 of combined 'medical and social spending' going to social and about 1/3 going to medical; we're the opposite, joining only Korea and Japan as spending the majority of 'medical and social' on medical.<sup>56</sup>

This situation developed largely because employers lobbied more successfully for health insurance premium tax breaks than did social service agencies for funding. (More on this below when we discuss the history of employer based health insurance.)

### **How well do employers negotiate for their employees?**

In 1964, the average wage in this country was \$2.53/hour and the average health expenditure \$197 per person per year, requiring the average person to work about 78 hours (2 weeks) to pay for healthcare.<sup>57</sup> Divide \$197 by \$2.53 to see this.

In 2019, the last year before Covid, the average wage had risen to \$22.98 / hour, healthcare cost to about \$11,500 per person, requiring the average person to work 500 hours (12.5 weeks) to pay for healthcare.<sup>58</sup>

This strikes many as a pretty poor track record. One wonders if individuals, negotiating for their own policies, might have done better than employers and brokers working together.<sup>59</sup>

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<sup>56</sup> See The American Healthcare Paradox by Bradley and Taylor for more on this. I only summarized their research here.

<sup>57</sup> This example comes from Philip Longman's excellent book on the Veteran's Administration Healthcare system, Best Care Anywhere

<sup>58</sup> Wage estimates from the Bureau of Labor Statistics 'Usual Weekly Earnings of Wage and Salary Workers, Third Quarter 2019'

<sup>59</sup> See in particular David Goldhill's Catastrophic Care. Philip Longman compares cost inflation in the Veteran's Healthcare Administration system to the employer based system in his book Best Care

### **‘But my employer pays 75% of my premiums’**

This misconception pervades the employer based health insurance model. Let me explain what most people believe first, and then show the real costs.<sup>60</sup>

Consider Mary, a single woman who earns \$35,000 a year. In this hypothetical example, the company’s single premium is \$649/month (\$7791 annually) of which Mary pays 27% or \$2112 per year. She also pays a \$250 annual deductible and has 4 office visits at \$25 each.

Mary thinks her healthcare costs about \$2462, or roughly 7% of salary. Not too bad.

There’s only one problem with this analysis: it’s completely wrong. Not even close to correct.

Here’s what Mary actually pays:

- The entire **\$7791** premium in foregone wages. Remember that her employer doesn’t care if Mary receives compensation as salary or benefits. The employer only cares about the total annual cost of employing Mary.
- \$1276 in state taxes at a 3.6% state tax rate. Since states average spending about 10% of their budgets on healthcare costs for employees and Medicaid, Mary pays about **\$128** in healthcare costs to the state.
- \$3827 in Federal taxes, about 11% of her income. Since 20% of the federal budget goes to healthcare, Mary pays another **\$765** here.
- Medicare taxes (1.45%) plus the employer match (foregone wages again), another **\$1015**.

Mary actually spends about **\$10,000** on healthcare annually, not \$2462. See why all the healthcare system inefficiencies we’ve been discussing really matter?

### **Part 2: How Employer Based Health Insurance Developed An historical accident**

Let’s consider two historical themes to understand both why we have an employer-centric healthcare financing model and why it works so poorly.

**First**, remember that healthcare and social services evolved independently and differently. Healthcare was a profitable industry, supported by powerful special interests;

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Anywhere. The VHA did a better job controlling costs while, according to Longman, generating better outcomes.

<sup>60</sup> This analysis comes from David Goldhill’s ‘Catastrophic Care’, chapter 2 ‘The Hidden Beast’. I’ve adjusted the numbers slightly and changed the woman’s name to Mary, though unclear exactly why.



social services were not but, but rather were disorganized, politically weak and stigmatized for helping the 'undeserving'.<sup>61</sup>

Consider this story from Bradley and Taylor's book *The American Healthcare Paradox* about Joe, a 28 year old, very low income diabetic:<sup>62</sup>

- His poor diet, including very little fresh food, exacerbates his condition
- He wears old, holey shoes that keep his feet constantly damp.
- His doctor admonishes him to eat better, take his insulin and keep his feet dry, but he can't afford to do these things often enough
- Last year he had 2 toes removed costing \$7000 and next year likely two more for \$14,000
- His doctor discussed the possibility of a foot amputation (\$18,000) plus rehab (total medical costs about \$30,000), plus a wheelchair (\$1000). This would make finding a job far more difficult, reducing Joe's chance of earning much income and consequently paying taxes (more or less paying for the social welfare of others). A leg amputation might permanently relegate him to surviving on government benefits, not a job.

Perhaps the most ironic or depressing part of this story: new shoes cost \$75 and an apple costs \$1 per day. Our (underfunded, disorganized) social services can't manage these minimal costs while our (well funded, powerful) medical system racks up tens of thousands in fees by implementing medical solutions to social problems.

**Second**, our healthcare financing system evolved inefficiently, from a vertically integrated 'financing + care provision' system to a non-vertically integrated one.

- Vertical integration means medical care and medical financing are the same entity with salaried physicians. Both the financing arm and medical care arm work together to generate the best patient outcomes at the lowest cost, at least in theory.

'Managed competition' is competition among vertically integrated healthcare providers. Those generating the best outcomes at the lowest costs will gain customers; those operating at higher costs and generating poorer outcomes will lose.<sup>63</sup>

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<sup>61</sup> See Bradley and Taylor, *The American Healthcare Paradox* for a longer explanation of this point.

<sup>62</sup> Ibid. page 1

<sup>63</sup> Alain Enthoven of Stanford University, perhaps our greatest managed care theorists and proponent, has written widely about this which is somewhat outside the scope of this particular chapter. See his

Vertically integrated healthcare entities compete with each other on value: outcomes per dollar spent, since they control their own income (i.e. the premiums they charge customers.)

- A 'non-vertically integrated system' has separate companies handling financing and medical care. Today we call financing companies 'insurance carriers' and medical care provision companies 'providers', generally hospitals and physician groups.

In this system, financiers always want to pay service providers less and service providers always want to bill more. The relationship between the two is 'war' - according to Atul Gawande, professor at Harvard Medical School and staff writer for the New Yorker – 'every step of the way'.<sup>64</sup>

In a non-vertically integrated system, carriers and hospitals argue over payment formulas since hospitals do not control premiums. A very different focus from the vertically integrated model above.

### **How Employer Based Healthcare Started**

(A version of this section appeared previously in this text. Readers may wish to skim the next 10 pages. GF)

The myth – or perhaps truth - is that it started in Dallas around 1929 as a reaction to the stock market crash and financial meltdown.<sup>65</sup> The business problem for Baylor University Hospital in Dallas was that it didn't have enough money to pay its bills.

Prior to the stock market cash, hospitals raised funds in two ways. First they had paying customers who were billed for services rendered - a fairly modest percentage of the population because most people didn't have a lot of money. Second, the community chest, the charitable organizations - the wealthy would donate to the hospital because it was a good place to donate your extra money. Charity made you feel good and was good for the community.

But with the stock market crash, the wealthy didn't have as much money to donate, unemployment increased (reducing the number of patients able to pay), and the hospital faced a difficult financial landscape. So Baylor University Hospital made a deal with the Dallas School System. They said, "School system, you raise money from taxes. You

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seminal article The History and Principles of Managed Competition for more.  
[http://elsa.berkeley.edu/pub/users/webfac/held/157\\_VC2.pdf](http://elsa.berkeley.edu/pub/users/webfac/held/157_VC2.pdf)

<sup>64</sup> See Gawande's second book 'Better', chapter entitled Piecework

<sup>65</sup> This suggestion comes from Richmond and Fein, The Healthcare Mess, page 30.

always have money. Pay us \$.50 every other week, \$.25 a week, for each of your employees and when they get sick, they come to us and we'll take care of them." Employer based health insurance arrives.

A few comments about this.

First, it's a nice deal. It's a nice deal for the hospital because they stay in business. They don't have to worry about going out of business. They don't have to worry about turning people away as long as they get the numbers right (which apparently they did), \$.50 per employee every other week. That was the true cost. The school system payments protected the hospital's cash flow, so the hospital stayed in business.

Second, this was very efficient. The hospital signs one contract with one employer group and received back enough money to stay in business. Sweet. That's a pretty good incentive to look for more large employer groups.

Third, there was no prevention or provider choice, but theoretically the teachers and other employees of the school system were happy because they got medical care essentially for free.

Fourth, this was for hospitalization only. There was no outpatient doctor's coverage.

Fifth, community rating. The Dallas School System paid \$.50 per person every other week, regardless of individual medical status. There was no medical underwriting.

Sixth, there were no quality controls, no outcome based incentives, no holdbacks for poor hospital performance. Health insurance began simply to save the financial health of the hospital.

This was a vertically integrated system, almost textbook variety. And it exhibited the classic flaw of vertically integrated healthcare system: lack of consumer choice. As developed initially with Baylor University Hospital, the Dallas school system employees could only go to one hospital. This has advantages and disadvantages.

Advantages:

1. Lower Costs
2. Reasonable medical care from a small number of 'in-network' providers

Disadvantage:

1. Little provider choice as few hospitals 'in-network'

The Baylor Hospital / Dallas School System deal worked so well that other hospitals soon copied it. Different hospitals looked for different large employers, offering the same kind of deal. Large manufacturers, the Dallas Morning News, and others. What problem begins to arise?

## **The Choice Problem**

Consumers (school system employees or manufacturing workers, for example) wanted to choose among various hospitals. 'What do I know about Baylor University Hospital? I only know one thing. I know someone who went there and didn't get good treatment, so I want to go somewhere else.' Someone always knows of someone else who had a negative experience there. So you want to go somewhere else - consumers want choice.

Remember vertical integration, where finance and service provision are the same company? Once you introduce choice, then you have one group handling finance and another handling service provision. You have a split and you lost vertical integration. (More on this coming up soon.)

Back to Dallas. The hospitals are cranking along with the employer based financing model. They're very happy. They're making money. And then one of the Blues brothers comes along – Cross or Shield, I don't remember which – and offers to provide financing for lots of Dallas hospitals. 'Dallas teachers' they might have said, 'you can sign up with Baylor University Hospital only, or, for just a little more money, sign up with us and we'll give you the choice of many hospitals in Dallas. We contract with lots of hospitals. We have a large network.' Sounds pretty appealing, right?

Doctors looked at this and said, "Hey, we want in on this too." They organized a second Blues brother so doctors could get paid because the same depression was affecting all medical providers, both hospitals and physicians. Blue Cross for your doctor's bills and Blue Shield for your hospital bills (or maybe the other way around. Wikipedia didn't say when I looked it up.) Both organized to protect provider incomes.

And both – conceptually, if not in real life – competed with vertically integrated hospitals, like Baylor University Hospital was at the beginning with the Dallas School System.

The Blues developed a couple of very clever ideas in the 1930s. First, from a marketing point of view, they offered this very attractive provider choice option. Very appealing to many consumers.

Second, they began searching for the healthiest subscribers. An interesting business idea: if they could find the healthiest people, they could offer lower priced policies and gain a competitive edge vs. their vertically integrated competitors signing up large employers at a fixed price per person.

## **Underwriting vs. Community Rating**

The Blues figured that they would underwrite better than the competition so people would join them because their premiums would be a little bit lower. The community rating folks faced higher premiums because they took all employees.

Underwriting serves the economic interests of the carriers. It doesn't improve healthcare outcomes. It doesn't improve the healthcare system. It doesn't differentiate medical quality. It doesn't create patient value. It only makes one carrier lower cost than another carrier by having sick people pay more. The healthy pay less, the sick pay more but there's no value created: the total medical costs remain the same. But some people win and others lose.

This financing system has little to do with getting people healthy, or creating value. That was not its intention. It was designed to protect physician and hospital income. That was the original Baylor idea. Then carriers came along to make a profit on consumer demand for choice. The demand for choice leads to the Split.

### **The Split and the Provider Payment Problem**

Once you split finance from service provision, you have a wider consumer choice and you have to figure out how to pay doctors and hospitals. We're still, today, trying to get this one right.

The original and still most popular payment mechanism is fee-for-service. The doctor gets paid \$100 for treating each broken arm and \$350 for each rotator cuff surgery.

As soon as you split finance and service provision there's an incentive on me, the doctor, to do more treatments. You're paying me by treatments, so I will do more treatments. 'That guy's got a sore shoulder that's probably due to a rotator cuff tear, so I'll operate on his rotator cuff.' Fee for service provides an incentive for doctors to do more procedures and hospitals to admit more people.

You, on the other hand, the carrier, want to limit the number of treatments. You want to ask if I have to do that procedure. We fight all the time. My clinical judgment (influenced, perhaps – at least psychologically – by the fee-for-service payment formula) vs. your financial judgment (influenced, perhaps – at least psychologically – by the same fee-for-service formula. You don't really trust my clinical judgment.) That's the conflict between healthcare payers and medical service providers.

Let's remember where we are. We're still in the 1930's and we're talking about the growth of the employer based system. Little cost control. We've developed the split between finance and service provision. Finance people will say, "You really don't need to do that procedure," and the service provider says, "Yes I do. Yes I do."

### **The Problem of Measurement in Fee for Service Medicine**

There's a related problem in fee-for-service medicine – the problem of measurement. How well does a particular physician treat his/her patients? How well does a particular hospital perform certain surgical procedures? How well does a particular treatment work?

These are enormously difficult questions to answer. We do not even today have good measurement criteria or good data – and we had even poorer criteria and data in the 1930s. The data that we can measure might not be the most important. Remember that our healthcare goal is to extend life or improve life quality. We do not yet fully understand which treatments today will lead to longer lives in 30 or 40 years. Nor do we fully understand which treatment qualities will lead to long term life quality improvements.

We can only measure some aspects of medical treatments – surgical mortality rates, hospital infection rates, 30-day hospital readmission rates, for example. These may not always be the most significant outcome data, though they may be useful for some patients.

Whose interests are served by measuring or publicizing this information? Not the providers. They get paid fee-for-service for the *quantity* of medical care, not the *quality*. Publicizing outcome data may harm them economically. Thirty day hospital readmission rates may show that Hospital A provides poorer patient treatments than Hospital B. Or that Surgeon Z has a higher mortality rate than Surgeon X.

The risks of either inappropriate or unflattering outcome data becoming public were so great during the inception of our employer based system that providers fought against its release. The fee-for-service system suited their interests far better than any outcome based payment mechanism.

The fee-for-service / component payment structure suited their interests in a different way also. Absent good data collection, each physician – responsible only for his/her specific tasks – can argue ‘I did my job correctly. The fault lies elsewhere.’ Physicians act as subcontractors, narrowly defining their individual tasks, rather than as general contractors responsible for the life of the patient. This follows directly from payment systems that developed from the Split between finance and service delivery.

Fee-for-service / component financing serves provider interests, is inflationary and expensive, and is not designed to improve patient health. It’s only designed to reward providers, which it did quite well historically. We, in the US, have traditionally performed more procedures / 1000 of population than similar developed countries around the world. Things today like spinal fusion surgery, hip replacements, knee replacements, coronary bypass surgeries. The Split between finance and service provision led us down this road.

### **The Impact of World War II**

Let’s continue with our historical / conceptual history of employer based health insurance.

During World War II, or perhaps as a function of it, more and more people got insured, most notably people in the military. They continued with insurance coverage after the

war. In the relatively short post-war period we get lots more Americans covered for hospitalization insurance.

1942: 10 million hospital insurance / health insurance subscribers

1946: 32 million

1951: 77 million <sup>66</sup>

World War II plays an important role in our story for three main reasons.

First, the soldiers who received health coverage while in the military wanted to continue with it afterward. They saw the advantages of having health coverage. They married and wanted their families to receive coverage also. This created demand for health insurance.

Second, our wartime economy devoted significant resources to medical technology improvements. Perhaps most significant was the introduction of sulfa drugs to combat infections. These helped turn hospitals from infection breeding institutions into patient treatment and improvement centers. Other technological innovations followed. These improved the quality of medical care, or the supply.

Third, the Federal wartime wage and price freezes fostered the development of 'fringe benefits' such as health insurance. These reduced the cost of insurance to the individual consumer and further helped stimulate demand. It's a pretty interesting story just how these developed.

The government decided during the War to freeze wages and prices - to avoid domestic economic difficulties and help focus our economy on war production. Employers could not raise wages to attract new workers or to reward their best employees. The government controlled this aspect of employee compensation very tightly.

But the government allowed employers to offer fringe benefits such as health insurance. This was how employers could attract new talent and retain their current employees. The concept of 'fringe' meant 'outside the normal compensation' and 'benefits' meant 'advantages of working here'. Employers couldn't simply raise wages – the traditional way of attracting labor – as that was illegal during the war. Fringe benefits were simply a mechanism to get around the wartime wage freeze.

As we grew in 9 years from having 10 million to 77 million insurance subscribers in this country, the health insurance industry developed and gained political power. It lobbied Congress for favorable legislation. It applied political pressure. It acted, in short, just like all other powerful industrial groups.

### **The Hill Burton Act and IRS decisions strengthen hospitals**

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<sup>66</sup> Richmond and Fein, The Health Care Mess pages 30 - 38

Congress, just after World War II, passed the Hill Burton Act to fund hospital expansion. This increased the number of hospital beds in this country by about 40%, from 3.2 per 1000 people to 4.5. It also made hospitals the centerpiece of our medical care system; the travelling doctor who made house calls started to disappear.

Shortly thereafter, in 1953, the IRS decided that fringe benefits were exempt from federal income tax: those became *tax deductible to the employer* but *not income taxable to the employee*. **This was essentially a government subsidy for hospital care**, since that's what health insurance ultimately financed. The government stimulated sales of employer based health insurance by subsidizing the price through the tax exemption.

To understand how this is a subsidy, let's look at both the employer and employee tax situations. The employer buys a \$100 insurance policy for an employee, and, prior to the IRS regs, pays corporate income tax on the \$100 ---- let's say that was 50%. So the employer's total cost was \$150: \$100 for the policy and \$50 for the income tax on that \$100.

By making the payment tax deductible to the employer – that means by foregoing the corporate income tax on that \$100 - the government reduced the cost. Health insurance now only costs the employer \$50; the employer takes a 50% tax deduction on the \$100 payment. That's a big savings compared to the previous \$150 expense.

The employee received this \$100 employment benefit. Prior to the IRS regulatory change, he/she would have paid their marginal tax rate on this income --- let's say 30%. By making this tax free to the employee – that means by foregoing the personal income tax on the \$100 – the government contributed \$30. In other words, the government subsidized the employee who received health insurance by \$30.

An interesting note from the employee point of view. \$100 in benefits is more valuable than \$100 in salary. The \$100 in salary is taxable, so nets only \$70. Remember our discussion above that 'My employer pays 75% of my premium.' I suggested that the employer doesn't care if he/she pays salary or benefits – the employer only cares about the total cost.

But the employee, according to many economists, does care. The employee prefers benefits since they're not taxed. The employee's foregone salary, according to this argument, is more valuable than benefits since it's not taxed. (I'm not sure I buy this argument completely but it does give me pause to consider.)

This subsidy for health insurance was so effective that the rate of Americans with hospital coverage skyrocketed. In the mid-1950s, about 45% of Americans had hospital



insurance. By 1963, 77% had hospital coverage, and an additional 50% had some form of physician coverage.<sup>67</sup>

The favorable tax treatment of fringe benefits led to healthcare inflation from higher *hospital* prices – because more people could afford to use hospitals.

Over this time period two strange incentives evolved in our healthcare marketplace: an *excessive hospitalization* incentive and an incentive to *cover the unemployed*. These two conditions merged in the late 1960s and 1970s. Their combined effect became clear by the 1980s as our health insurance costs skyrocketed and our employer based financing model became even more firmly entrenched.

### **Excessive Hospitalization Incentives**

By the mid-1960s over three quarters of Americans had hospitalization insurance, paid for by employers and subsidized by the government. Hospitalizations became essentially free to patients, creating, in the words of Harvard Professors Richmond and Fein a 'not-so-subtle perverse incentive to hospitalize individuals.'

This was the case even for diagnostic tests that could have been performed on a less costly outpatient basis, they say. Over time the hospital became all the more important and central to the delivery of healthcare services.

This increased the need for health insurance:

Since medical care became more costly, insurance became more useful (indeed, necessary). In turn, the presence of insurance helped underwrite a buildup of resources and an upgrading of technology that added to costs and made insurance even more valuable.<sup>68</sup>

Remember the incentives here.

- Employees liked the system because it appeared free to them;
- Carriers liked the system because the government subsidized their product (health insurance policies);
- Hospitals loved the system because they received patients and insurance payments – a wonderful recipe for making money.
- Employers objected somewhat to this system, but not terribly strenuously. After all, the government was subsidizing their health insurance payments, so they felt the pain only partially.

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<sup>67</sup> Enthoven and Fuchs, 'Employment Based Health Insurance: Past, Present and Future' Health Affairs, Nov/Dec 2006

<sup>68</sup> Richmond and Fein, op. cit., pages 38 - 39

Our healthcare system was hospital based – not really interested in preventive care (hospitals couldn't charge much for that); not really interested in public health (the field was only just developing); not really interested in outpatient or chronic care. Providers focused on hospital care because that's where the money was.

Hospital insurance stimulated the excess use of hospitals, which created more need for hospital insurance. Three byproducts:

- First, we used hospitals for almost all medical care, even if less expensive setting existed;
- Second, we developed fewer outpatient, home based, preventive or non-hospital types of medical care;
- Third, we continued to underfund social program. All this hospital growth and funding (largely from government programs and tax subsidies) crowded out social service investments.

Yet this third issue was tremendously important. Let me quote Professors Richmond and Fein on the relative importance of hospital investment and public health investments.<sup>69</sup> And remember: these were two highly respected Harvard Medical School professors. Richmond, in fact, was US Surgeon General in the Carter administration.

- 'A growing professional consensus holds that the health gains since WWII were largely **the consequence of applying our knowledge of health promotion and disease prevention rather than improved clinical care...**' (i.e. public health investments)
- 'The revolution in biology subsequent to World War II, a revolution that had brought many advances to clinical care, as yet **had only marginal effects on improving our vital statistics**'

Social spending had a bigger impact on our national health gains than did hospital investments! We invested the wrong way (assuming our healthcare investments were aimed at promoting health).

### **How Could Employers Afford Health Insurance Premiums after World War II?**

What set of circumstances allowed this system to develop? Why was the employer based system healthy and growing until the late 1900's, then in decline?

It turns out that for a number of years, this 40 year period more or less, many countries were (a) recovering from World War II or (b) gaining independence and expanding their

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<sup>69</sup> Richmond and Fein, op cit, pages 92 and 94

educational systems. They were not economic threats to the United States – countries like Japan, India, Korea, China, or Western Europe. We dominated economically.

Our big firms in particular were very profitable. They didn't have much foreign competition. They could afford to pay for employee healthcare. They could raise prices because nobody was competing with them to keep prices low. That's the trend that you see from World War II to about the 1980s or so. Big firms could set the standard and then small businesses filled in the holes. All competed for labor based on offering attractive 'salary + benefits packages' and all could because the big firms were managing the world economy.

This allowed the U.S. to have an extra cushion of money available for healthcare benefits. Even though people complained, the economy could support the excess premiums. Regulated industries - for political and various other reasons - were able to pass on the cost because our economy was stronger than any other. Unions were strong. They could demand health insurance and the big firms could afford it.

The key factors that fostered employer based health insurance post World War II all changed in the 1980s and 1990s:

#### World Economy, 1945 – 2000 +/-

Little foreign competition for American manufacturers;

Japan and Western Europe needed time to rebuild;

US manufacturers could keep prices high and afford health benefits

#### Importance of Large Firms, Regulated Industries and Unions

GM, US Steel, ALCOA, etc – profitable with little foreign competition. Able to share profits with employees as benefits;

Regulated industries (AT&T) – regulated monopolies were able to pass health insurance costs to consumers; they had little or no competition;

Unions were relatively strong, could bargain effectively for benefits

All these conditions changed in the 1980s and 1990s. Our ability to generate excess profits, if you will, to afford for the employers to pay for healthcare starts to disintegrate as foreign competition gets going. From World War II until about 1980 or 1990 we could afford employer based health insurance and there was no significant political group that was lobbying or arguing against it.

### **Medicare and Medicaid Remove Potential Political Threats to Employer Based Insurance**

One major potential political threat to our employer based health insurance system could have come from the unemployed – that significant percent of the population that is

too old to work or unable to find full time work with benefits. This is potentially a very potent political force that could have lobbied in favor of single payer healthcare, universal coverage or something like that – like in other countries.

By introducing Medicare and Medicaid in the 1960s, this political force goes away. People are happy. They're not under pressure. They're not demanding universal coverage because they've got coverage. Where are politicians going to find a block of supporters who are going to argue for single payer systems, universal healthcare? They don't exist because Medicare and Medicaid took the potential block off the table.

Here is an estimate of the population size that these two entitlement programs satisfied. I'll use Medicare, because this covers the elderly who vote in particularly high numbers and in particularly important electoral states like Florida. This large voting bloc could have become a potent political force for universal coverage. Instead it became satisfied with Medicare.

#### Medicare Enrollment 1970 – 2000

| <u>Year</u> | <u>Number Medicare Enrollees</u> | <u>% of US population</u> |
|-------------|----------------------------------|---------------------------|
| 1970        | 20 million                       | 10%                       |
| 1980        | 28 million                       | 12%                       |
| 1990        | 34 million                       | 13.5%                     |
| 2000        | 39 million                       | 13.8%                     |

Medicaid covers about the same population size.

The argument is that Medicare and Medicaid are key supporters of our employer based health insurance system. They allowed the system to grow and become entrenched nationally in the second half of the last century.

The employer based system reaches its peak of 165 million people in 2000 and then it starts to decline. Why did it decline? Because the international economic conditions changed. American firms could no longer pass on benefit costs to their customers.

At the same time, the hospital lobbies and related groups had done such a good job of protecting their constituencies that healthcare became hugely expensive. Healthcare grew from about 4% of US GDP in 1950 to 14% in 2000 to about 19% today.

Lower cost alternatives to large general hospitals – freestanding outpatient clinics, for example – never took hold, presumably due to hospital lobbying efforts. Similarly, specialty hospitals – local diabetes clinics, for example – also failed to establish themselves, again presumably, for the same reasons. The Affordable Care Act, for example, didn't actually prohibit establishment of physician-owned specialty hospitals, but placed such burdensome requirements on their establishment as to destroy this as a potential market force.

By the early 2000s we had developed a perfect storm for healthcare system financial catastrophe. Our healthcare costs – primarily hospitalizations due to the government subsidies of fringe benefits – rose far faster than GDP. Meanwhile, American businesses' abilities to pay for their employee's health coverage diminished in the face of foreign economic competition.

### **Mandates**

As healthcare became increasingly costly, carriers (reflecting employer's interests) tried denying services to patients. This spurred a political reaction, pitting patients and medical provider interests against employers. Perhaps the most impressive display of patient and special interest power presented itself by the growth of healthcare mandates.

The number of state mandated services grew from 7 in 1965 to 1961 in 2008. These reflected the political power of special interests to protect the incomes of their members. Chiropractors lobbied for chiropractic to be included as a benefit in insurance policies. Nurses lobbied for minimum nurse-to-patient ratios. Voters generally supported mandates as protection against insurance carrier abuses.

Mandates raise prices. This increases the need for insurance but makes insurance less affordable, which increases the need for government subsidies (tax breaks and, in some states like Massachusetts, premium supports), which reduces the amount of money available for social programs and 'health promotion and disease prevention' activities (in the words of Richmond and Fein <sup>70</sup>) which in turn medicalizes social problems and raises costs.

But perhaps most disappointing of all, mandates don't improve patient health much. Consider this graph comparing American life expectancies to French and Canadian as we increased the number of healthcare mandates between 1965 and 2010. You can see how our life expectancy rates fell slightly below the trend line of the French and Canadians even as we required more healthcare services for our patients.

Instead, healthcare mandates are political reflections of the economic power of various healthcare groups. They have, apparently, little impact on health. But they ensure that the various medical interest groups get paid.

### **Consumer Driven Healthcare to the rescue (or not)**

The first major attempt to adapt employer based healthcare to these new economic realities was CDHC or Consumer Driven Health Care. The term 'consumer driven health care' arose primarily from the Medicare Modernization Act of 2003 which established Health Savings Accounts.

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<sup>70</sup> Richmond and Fein, *The Healthcare Mess*, page 92

'Consumer driven products' are high deductible health insurance policies with certain tax benefits. Each consumer spends the deductible as he/she sees fit – for physician visits, medications, tests, therapies etc – more or less employing the consumer sovereignty idea we discussed earlier in this chapter. Only after satisfying the deductible does insurance pay. Then, depending on the specific plan design, insurance pays all or part of additional medical expenses.

### **Problems equating high deductibles with consumerism in healthcare**

Unfortunately, CDHC policies as 'consumer sovereignty light' fail in healthcare for two main reasons.

**First**, an annual \$1000 deductible (or even \$3000) is too small to act as a real medical spending brake. Once satisfied, and depending on the specific plan design, all other medical care is free.

A patient might satisfy that deductible hurdle in January and then enjoy lots of excessive and unnecessary medical care for free during the next 12 months.

Or the deductible has little impact on a patient facing an expensive procedure. What's the difference to this patient if the procedure costs \$45,000 .... \$50,000....\$60,000 or \$100,000? Once the deductible is satisfied, the rest is free. 'Consumerism' fails to affect patient behavior in these expensive cases.

This fundamental flaw in the 'high deductible = consumer driven healthcare' thesis exists because the vast majority of healthcare spending goes to a very small group of high cost patients. Here's spending by percentage of the population. These numbers have remained remarkably constant for the past several years.

#### Healthcare Consumption by % of Our Population <sup>71</sup>

1% of our population accounts for about 24% of medical spending

5% of our population accounts for about 49% of medical spending

10% of our population accounts for about 64% of medical spending

50% of our population accounts for about 97% of medical spending

So the healthiest 50% of our population accounts for only about 3% of medical spending. These are typically the folks who purchase CDHC products and who often spend less than \$1000 annually. Cutting their spending by 20 or 30% would have *virtually no impact* on *overall* medical spending or trend.

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<sup>71</sup> Yu, et al, 'Medical Expenditure Panel Survey Statistical Brief #81', May 2005, Agency for Healthcare Research and Quality

Here's the same chart using 2010 spending data. In 2010, total US healthcare costs reached about \$2.7 trillion for the approximately 310 million of us. Though the 2010 average annual healthcare spending per person was about \$8,700,

The 1% heaviest users (3.1 million people) averaged about \$209,000 each;

The 5% heaviest users (15.5 million people) averaged about \$85,000 each;

The 10% heaviest users (33 million people) averaged about \$52,000 each;

The 50% lightest users (155 million people) averaged about \$500 each

Very few of the 10% of users who account for about 2/3 of all medical spending will change their medical choices based on a \$1000 (or even \$2500 or \$5000) deductible. *Whatever* the deductible, their medical care needs far exceed it.

**Second**, medical consumers have little meaningful quality information, and even if they have it, they rarely know how to use it. This makes medical decisions different from, say, car purchasing decisions. The car buyer can compare the quality of various cars before deciding which to purchase. Large or small, good gas mileage or poor, lots of luxuries or few, high resale value or low, etc.

But the medical purchaser generally has very little similar information. Which doctor has the best outcomes? Which hospital? How effective is this medication compared to that one? We generally lack detailed answers to these questions.

For these two reasons – unequal healthcare spending and lack of medical quality information / well educated medical consumers - so-called Consumer Driven Health Care had only a small impact on medical trend which has run at our gdp growth rate plus 3 – 5% annually for years. CDH policies became the vogue in the early 2000s. They pretty much ran their course within about a dozen years.

Americans continue to spend about twice as much on healthcare as other developed countries without getting any value for the excess spending, just as we did prior to CDHC policy introduction. Here are the estimates for 2019, the last year before Covid hit and altered these statistics with a unique set of circumstances. (I don't know if or how Covid is representative of 'normal' healthcare trends so try to leave that out of this analysis.) <sup>72</sup> I could have included more countries but you get the idea from this limited comparison.

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<sup>72</sup> OECD Health Data statistic updated annually <https://stats.oecd.org/Index.aspx?ThemeTreeId=9>

| 2019   | Annual spending / capita | Life expectancy at birth |
|--------|--------------------------|--------------------------|
| US     | \$10,855                 | 78.8                     |
| Canada | \$6,730                  | 82.3                     |
| France | \$4,014                  | 83                       |
| Spain  | \$2,412                  | 84                       |
| UK     | \$3,334                  | 81.4                     |

We clearly haven't figured out how to generate good value for our healthcare system costs.

### **Three additional problems with having employer based health insurance as the centerpiece of our healthcare financing system**

**Price structure:** Today's health insurance policies are priced at 'employer contribution + employee contribution'. Losing your job may lead to a quadrupling of your health insurance premiums, assuming that your employer pays 75% of the premium.

**Labor market distortions:** Some employees either choose jobs or remain on their jobs for the health insurance. Two main reasons for this are

- cost – employer contributions reduce employee costs, and
- access – pre-existing conditions traditionally made health insurance unavailable to some people if they changed from their current jobs, though the Affordable Care Act has changed much of this.

One research paper estimated that employer based insurance reduced job mobility by 25 – 40% <sup>73</sup> at least until the ACA impacts work their way through our healthcare system.

**Impact on the Federal budget:** Tax breaks for employer based health insurance (not income taxable to the employer or employee) constitute the biggest tax break / loophole in the federal budget, an estimated \$260 billion annually. <sup>74</sup> This is roughly 3x the mortgage interest tax deduction.

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<sup>73</sup> Gruber & Madrian, 'Health Insurance, Labor Supply and Job Mobility' Working Paper 8817, NBER, March 2002

<sup>74</sup> Health Affairs *Health Policy Brief*, August 1, 2013 'Premium Tax Credits', [http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief\\_id=97](http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=97)



This tax break is regressive: higher income people with expensive policies are subsidized by lower income people with less expensive policies.

Many on Capitol Hill seek to reduce this tax break. Here, for example, is Representative Paul Ryan who ran for Vice President in 2012 with Mitt Romney. The tax deductibility of employer based health premiums

tilts the compensation scale toward ever-greater (tax free) benefits and away from higher (taxable) wages. This isn't just a big driver of runaway healthcare costs, as more dollars chase the same amount of services. It's also a big reason why too many Americans haven't seen a raise in a long time.<sup>75</sup>

Ryan, among other things, echoes my suggestion that employers pay premiums by withholding wage increases from employees. \$1 of benefits is worth more to the employee than \$1 of wages since the wages are taxed.

Paul Starr, Princeton Professor of Sociology who normally sits far to the left of Ryan, agrees with him on this point, saying the employer based premium tax exclusion has

long been the target of criticism on both distributive and allocative grounds: it provides the biggest subsidies to higher income employees with the most generous insurance, and it contributes to America's inflated health spending by obscuring the true costs. Nixon and Clinton considered limiting the exclusion, but each rejected the idea because of political opposition.<sup>76</sup>

### **Summary: Employer Based Health Insurance**

Employer based insurance provides some 160 million Americans with health coverage. But it does so remarkably poorly.

- By setting powerful employer business interest groups against far weaker population health interest groups, it's a key cause of underfunding our various (health related) social services
- The employer based structure harms **employers** by putting an unnecessary (for widget production) economic and administrative burden on them.
- It harms **employees** by reducing their medical care options
- It harms **patients** by locking our system into one focused on short term cost control rather than long term outcome improvement, or, in economic terms, value creation

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<sup>75</sup> Turner, Capretta, Miller and Moffit, Why ObamaCare is Wrong for America, Forward

<sup>76</sup> Paul Starr, Remedy and Reaction, page 258

- It harms **carriers** by reducing their ability to develop high value products and by forcing them to satisfy employer needs rather than patient, and
- It harms **providers** – doctors and hospitals – by reducing their ability to focus on long term outcomes and treatment excellence, but rather on short term costs, carrier and network referral requirements and associated administrative tasks aimed at reducing moral hazard.

Where will this take our healthcare system? Stanford Business School Professor Alain Enthoven summarizes in prophetic terms. Our employer based model, he suggests, will unfold 'like a Shakespearean tragedy: known, tragic flaws taking their inexorable toll.' <sup>77</sup>

Or, as Lady Macbeth might put it,

*The employer based healthcare financing system simply doesn't work. Band-aids and piecemeal reforms cannot not fix this fundamentally flawed model.*

(I've admittedly taken some pretty generous poetic liberties here. Lady Macbeth actually said 'Here's the smell of the blood still. All the perfumes of Arabia will not sweeten this little hand'. It's not easy ending a chapter on employer based healthcare financing with a Shakespearean quote!)

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<sup>77</sup> Health Affairs, Forum on Employer Sponsored Health Insurance, 2006  
<http://content.healthaffairs.org/content/25/6/1537.full>

## **Review Questions**

Answers on next page

1. This chapter suggested that Moral Hazard is endemic to health insurance. What is moral hazard?

- a. People get more care than they need because it appears free to them
- b. People with poor moral standards get more care than appropriate because they are greedy
- c. There is a close correlation between high morals and low healthcare costs
- d. 'Moral hazard' addresses the mind-body relationship. Basically moral people sleep better so remain healthier than lose moral people who more typically suffer from sleep disorders

2. This chapter suggested that disconnecting health insurance payers from healthcare users leads to inefficiencies. What does 'disconnecting health insurance payers from users' mean?

- a. Payers are employers but users are employees
- b. Payers are generally government entities that pass rules and legislation but users – who must implement those rules – are employers
- c. Payers are, in reality, tax payers who fund most healthcare in this country even though employers are the biggest cohort of users
- d. Payers are carriers who actually pay doctors and hospitals for their services while 'users' are all the entities that make up the bills, like pharmaceuticals, device manufacturers etc

3. This chapter suggested that having 1 year long health insurance policies leads to systemic inefficiencies. Why?

- a. Carriers and providers try to control short term spending to keep renewal increases low, while some 70% of spending goes to patients with chronic diseases that require a long term focus.
- b. Renewing annually creates far more paperwork, and therefore costs, than a more efficient system would have
- c. Most employers would prefer longer term policies – 10 or even 20 year long policies – so they could plan and cut overhead
- d. One year long policies opens the door to expanded lobbying on Capitol Hill from groups that offer the 'newest and greatest' short term health insurance fixes

4. This chapter suggested that having employment as the core of our healthcare financing system leads to underfunding social programs (that often have a major impact on health). Why is that?

- a. Many of the social causes of medical problems – poor nutrition or poor housing, for example – are not the employer's financial responsibility. As such,

they are often left out of our health insurance discussion, since carriers and employers focus so intently on the next year's policy renewal price.

- b. Social programs, as many studies have shown, have little to no impact on medical care or spending
- c. Employers lobby aggressively to cut social spending programs which might, if they worked well, increase the employer's premium costs
- d. Employers, brokers and carriers combine to develop fully comprehensive insurance plans. Anything not included in those plans, virtually by definition, is not relevant to promoting good health.

5. Who pays health insurance premiums?

- a. The employee by foregoing wages
- b. The employer by foregoing profits
- c. The government by crediting the premiums equally to the employer and employee
- d. Hospitals by undercharging for their service

6. Why do we have healthcare mandates in this country?

- a. To improve care quality. Since the introduction of mandates our 30 day readmission rates have fallen almost to zero
- b. To improve care outcomes. Since the introduction of mandates, our average longevity at birth has increased by almost 100 years
- c. To reduce infant mortality. Since the introduction of mandates, our infant mortality rates have fallen to the lowest in the world
- d. To reward lobbying by influential groups like nurses (who lobby for nursing mandates), chiropractors (who lobby for chiropractic mandates), pharmaceuticals (who lobby for pharmaceutical mandates) and similar.

7. Which country exhibits the shortest life expectancy at birth?

- a. US
- b. France
- c. Canada
- d. Britain

8. Which country uniquely bases healthcare financing on employment?

- a. Britain
- b. Canada
- c. US
- d. France

9. About how much medical care is 'unnecessary' according to scholars at Dartmouth and other research institutions?

- a. 1%
- b. 30%
- c. 90%
- d. 95%

10. Who actually pays the employee's premiums in our employer based system?

- a. The employer
- b. The employee via foregone wages and the government via foregone taxes
- c. The insurance carrier
- d. The primary care doctor

11. How does our employer based healthcare financing system affect job mobility?

- a. It has no impact on job mobility
- b. It increases job mobility
- c. It reduces job mobility because people may be reluctant to switch insurance types and coverage because the switch may lead to provider and treatment differences
- d. It increases job mobility in the public sector but reduces it in the private sector

12. Which is the biggest tax break allowed by the IRS?

- a. Employer based healthcare premiums
- b. State sales taxes
- c. Foreign travel
- d. Home office deduction

## Review Questions

Correct answers in bold

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## **Understanding Medicare and Medicare for all**

Medicare became law on July 30, 1965, when President Lyndon B. Johnson signed the Social Security Amendments of 1965 into law. The legislation created both the Medicare and Medicaid programs as amendments to the Social Security Act.<sup>78</sup>

Medicare was established to provide health insurance coverage for Americans aged 65 and older, as well as certain younger individuals with disabilities. It was designed to address the growing healthcare needs of older adults and provide them with access to affordable healthcare services. Prior to the establishment of Medicare, many older Americans struggled to afford medical care, leading to significant financial burdens and barriers to accessing necessary healthcare services.

The creation of Medicare was a significant milestone in U.S. healthcare history, marking the federal government's commitment to ensuring access to healthcare for older adults and individuals with disabilities. Since its inception, Medicare has undergone several expansions and reforms to improve coverage and access to care for its beneficiaries, making it one of the most important and widely used healthcare programs in the United States.

Medicare consists of 4 main parts:

**1. Part A (Hospital Insurance):**

- Covers inpatient hospital stays, skilled nursing facility care, hospice care, and some home health care services.
- Most people do not pay a premium for Part A if they or their spouse paid Medicare taxes while working.

**2. Part B (Medical Insurance):**

- Covers outpatient care, doctor visits, preventive services, and some medical equipment and supplies.
- Requires a monthly premium, which can vary depending on income.

**3. Part C (Medicare Advantage):**

- Private insurance plans approved by Medicare that provide all Part A and Part B benefits.
- Often includes additional benefits such as vision, dental, and prescription drug coverage.
- Plans may have different costs and coverage rules.

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<sup>78</sup> Much of this section comes from ChatGPT, written in April 2024.

#### 4. **Part D (Prescription Drug Coverage):**

- Helps cover the cost of prescription drugs.
- Offered by private insurance companies approved by Medicare.
- Monthly premiums, deductibles, and copayments or coinsurance apply.

#### 5. **Medigap (Medicare Supplement Insurance):**

- Sold by private insurance companies to fill "gaps" in Original Medicare coverage, such as copayments, coinsurance, and deductibles.
- Helps pay for expenses not covered by Original Medicare.

#### 6. **Other Coverage Options:**

- Some people may qualify for other Medicare programs, such as Medicare Savings Programs or programs for people with specific health conditions.

Overall, Medicare provides essential healthcare coverage for millions of Americans, though it's crucial for individuals to understand the different parts and options available to choose the coverage that best suits their needs.

### **The Four Components Medicare**

**Medicare Part A**, often referred to as Hospital Insurance, covers a range of inpatient hospital services and certain types of post-hospital care. Here's a more detailed breakdown of what Medicare Part A covers:

#### 1. **Inpatient Hospital Care:**

- Part A covers semi-private rooms, meals, general nursing, and other hospital services and supplies when you're formally admitted as an inpatient by a doctor.
- It includes care received in acute care hospitals, critical access hospitals, inpatient rehabilitation facilities, and long-term care hospitals.

#### 2. **Skilled Nursing Facility (SNF) Care:**

- Part A covers a stay in a skilled nursing facility (SNF) if it's medically necessary following a hospital stay of at least three days.
- SNF care includes services such as skilled nursing care, rehabilitation services, and other related health services.

#### 3. **Hospice Care:**

- Part A covers hospice care for individuals with a terminal illness whose life expectancy is six months or less.

- Hospice care includes services like pain relief, symptom management, and emotional and spiritual support for both the individual and their family.

#### **4. Home Health Care:**

- Part A covers certain home health services if you're homebound and require skilled nursing care, physical therapy, speech-language pathology services, or continued occupational therapy.

#### **5. Blood:**

- Part A covers the cost of the first three pints of blood you receive in a calendar year, or the blood you get as a hospital inpatient during a stay, after you've paid a deductible.

It's important to note that while Medicare Part A covers a significant portion of inpatient hospital services and related care, it doesn't cover everything. For example, it typically doesn't cover private-duty nursing, a private room (unless medically necessary), or personal care items like toothpaste or razors.

Most people don't have to pay a premium for Medicare Part A if they or their spouse paid Medicare taxes while working. However, there are deductibles, coinsurance, and copayments associated with Part A services. It's essential to understand these costs and coverage limitations to make informed decisions about your healthcare needs.

Inpatient hospital care covered by Medicare Part A includes a range of services and supplies necessary for treating acute medical conditions and providing necessary care during a hospital stay. Here are some services that are typically included:

##### **1. Room and Board:**

- Coverage for semi-private rooms (unless medically necessary for a private room), meals, and general nursing care.

##### **2. Nursing Care:**

- Skilled nursing services provided by registered nurses (RNs) or licensed practical nurses (LPNs) for the management and monitoring of medical conditions.

##### **3. Medical Services and Supplies:**

- Physician services, including consultations, exams, and medical procedures performed during the hospital stay.
- Necessary medical supplies and equipment used during the hospitalization, such as IVs, oxygen, and other medical devices.

##### **4. Diagnostic Tests and Procedures:**

- Coverage for diagnostic tests, laboratory work, and medical imaging procedures necessary for diagnosing and treating the patient's medical condition.

**5. Surgical Services:**

- Coverage for medically necessary surgeries performed during the hospital stay, including pre-operative and post-operative care.

**6. Hospital Services:**

- Coverage for hospital services such as operating rooms, recovery rooms, and emergency room services used during the hospital stay.

**7. Medications:**

- Coverage for medications administered during the hospitalization, including those administered intravenously or through other means.

**8. Therapies:**

- Coverage for therapies provided during the hospital stay, such as physical therapy, occupational therapy, and speech-language pathology services.

Services typically excluded from Medicare Part A coverage for inpatient hospital care include:

**1. Personal Comfort Items:**

- Personal comfort items such as telephone or television services, unless provided as part of the hospital's standard care.

**2. Private Duty Nursing:**

- Nursing services provided by individuals not employed or contracted by the hospital, unless specifically authorized by Medicare under certain circumstances.

**3. Private Room Charges:**

- Charges associated with a private room unless medically necessary as determined by the attending physician.

**4. Certain Medical Procedures and Treatments:**

- Some elective procedures or treatments not deemed medically necessary by Medicare may not be covered.

Skilled Nursing vs. Long Term Care

Medicare Part A covers skilled nursing facility (SNF) care under certain circumstances. A Medicare beneficiary can stay in a skilled nursing facility as long as they meet specific criteria and as long as the care remains medically necessary. Here are the key points regarding Medicare coverage for skilled nursing facility stays:

**1. Qualifying Hospital Stay:**

- The beneficiary must have a qualifying hospital stay of at least three consecutive days as an inpatient. Observation days do not count toward this requirement.

**2. Medically Necessary Care:**

- The skilled nursing care must be medically necessary and related to the condition for which the beneficiary was hospitalized.

**3. Skilled Care Requirement:**

- The care provided in the skilled nursing facility must require skilled nursing or rehabilitation services on a daily basis. This includes services such as physical therapy, occupational therapy, or skilled nursing care.

**4. Coverage Period:**

- Medicare Part A covers up to 100 days of skilled nursing facility care per benefit period.
- The first 20 days are covered in full by Medicare.
- For days 21 through 100, the beneficiary is responsible for a daily coinsurance amount.

**5. Benefit Period:**

- A benefit period begins the day the beneficiary is admitted to a hospital or skilled nursing facility as an inpatient and ends when they haven't received any inpatient hospital care or skilled nursing care in a skilled nursing facility for 60 consecutive days.
- If the beneficiary needs skilled nursing care again after the benefit period ends, a new benefit period begins, and they may qualify for another 100 days of coverage.

While Medicare covers skilled nursing facility care for a limited period, it does not cover long-term care services or custodial care (assistance with activities of daily living like bathing, dressing, and eating) in a skilled nursing facility. After Medicare coverage ends, beneficiaries may need to explore other options for long-term care, such as Medicaid or private long-term care insurance, if they require ongoing assistance.

Medicare makes a distinction between skilled nursing care and long-term care based on the level of care required and the specific services provided. Understanding this difference is crucial for Medicare beneficiaries to determine their coverage eligibility. Here's how Medicare distinguishes between skilled nursing care and long-term care:

**1. Skilled Nursing Care:**

- Skilled nursing care refers to services provided by licensed healthcare professionals, such as registered nurses (RNs) or licensed practical nurses (LPNs), that are necessary for the treatment and management of a medical condition.
- Skilled nursing care involves services that require the expertise of trained medical professionals and cannot be safely performed by individuals without medical training.
- Examples of skilled nursing care include wound care, intravenous medication administration, physical therapy, and rehabilitation services following surgery or illness.

**2. Rehabilitation Services:**

- Medicare covers skilled nursing facility care when it is primarily for skilled nursing or rehabilitation services on a daily basis. This includes services such as physical therapy, occupational therapy, or speech-language pathology services that are needed to improve the beneficiary's condition or help them regain function.

**3. Time-Limited Care:**

- Skilled nursing care provided under Medicare is typically time-limited and intended to help the beneficiary recover from an acute illness, injury, or surgical procedure.
- Medicare Part A covers up to 100 days of skilled nursing facility care per benefit period, with the understanding that the care is expected to result in improvement or stabilization of the beneficiary's condition.

**4. Long-Term Care:**

- Long-term care refers to assistance with activities of daily living (ADLs) and other support services that are needed on an ongoing basis due to chronic illness, disability, or advanced age.
- Long-term care includes services such as assistance with bathing, dressing, eating, toileting, and mobility, as well as supervision and assistance with medications.

- Medicare does not generally cover long-term care services, as they are considered custodial care and not primarily skilled nursing or rehabilitative services.

**Medicare Part B**, also known as Medical Insurance, covers a wide range of outpatient services, preventive care, and medically necessary services that are not covered by Medicare Part A. Here's an overview of what Medicare Part B covers:

**1. Doctor Visits and Services:**

- Coverage for visits to doctors, including primary care physicians, specialists, and other healthcare providers.
- Services provided during doctor visits, such as physical exams, consultations, and evaluations.

**2. Outpatient Care:**

- Coverage for outpatient medical services and procedures received outside of a hospital setting.
- This includes services such as lab tests, X-rays, diagnostic imaging, and outpatient surgeries.

**3. Preventive Care:**

- Coverage for preventive services to help prevent illness or detect health problems early when they are most treatable.
- Examples include flu shots, vaccines, screenings for various conditions (e.g., cancer screenings, mammograms, colonoscopies), and counseling services.

**4. Durable Medical Equipment (DME):**

- Coverage for durable medical equipment prescribed by a doctor for use at home.
- Examples include wheelchairs, walkers, oxygen equipment, and hospital beds.

**5. Ambulance Services:**

- Coverage for emergency and non-emergency ambulance transportation to a hospital or other medical facility when medically necessary.

**6. Outpatient Mental Health Services:**

- Coverage for outpatient mental health services, including individual and group therapy sessions, counseling, and psychiatric evaluations.

**7. Outpatient Rehabilitation Services:**

- Coverage for outpatient therapy services, including physical therapy, occupational therapy, and speech-language pathology services.

**8. Some Prescription Drugs:**

- Limited coverage for certain outpatient prescription drugs that cannot be self-administered and are typically administered by a healthcare provider.

**9. Some Preventive Medications:**

- Coverage for certain preventive medications, such as certain vaccines (e.g., flu shots) and injectable osteoporosis drugs.

**10. Clinical Research Studies:**

- Coverage for certain costs associated with participating in approved clinical research studies.

While Medicare Part B covers many services, beneficiaries are generally responsible for paying a monthly premium, an annual deductible, and coinsurance or copayments for covered services. Additionally, not all services are covered at 100%, so beneficiaries may have out-of-pocket costs associated with their care.

What are some physician or outpatient services that typically are not covered by Medicare?

While Medicare Part B covers a wide range of physician and outpatient services, there are certain services and expenses that are typically not covered by Medicare. These may include:

1. **Routine Dental Care:** Medicare does not cover most routine dental care, including cleanings, fillings, extractions, dentures, and dental plates.
2. **Routine Vision Care:** Medicare does not cover routine eye exams for eyeglasses or contact lenses. However, it does cover some vision-related services if they are deemed medically necessary, such as exams for diabetic retinopathy or glaucoma.
3. **Routine Hearing Care:** Medicare does not cover routine hearing exams or hearing aids. However, it may cover diagnostic hearing and balance exams if they are ordered by a doctor for the evaluation of a suspected medical condition.
4. **Cosmetic Procedures:** Medicare does not cover cosmetic procedures or surgeries performed solely for cosmetic purposes. This includes procedures such as cosmetic surgery, Botox injections for wrinkles, and hair transplants.



5. **Acupuncture:** While acupuncture may be considered an alternative therapy for certain medical conditions, Medicare typically does not cover acupuncture treatments.
6. **Long-Term Care:** Medicare does not cover custodial or long-term care services, such as assistance with activities of daily living (e.g., bathing, dressing, eating) provided in a nursing home or at home.
7. **Over-the-Counter Medications:** Medicare does not cover most over-the-counter medications, vitamins, or supplements, even if they are recommended by a doctor.
8. **Alternative Medicine:** Medicare generally does not cover alternative or complementary medicine services, such as chiropractic care, massage therapy, or herbal supplements.
9. **Medical Services Outside the United States:** Except in certain limited circumstances, Medicare does not cover medical services received outside of the United States.
10. **Experimental or Investigational Procedures:** Medicare typically does not cover services or treatments that are considered experimental or investigational and not proven to be effective.

How can a Medicare beneficiary get access to these services? Specifically, how can a beneficiary get financial coverage for these?

Medicare beneficiaries seeking coverage for services that are not covered by traditional Medicare Part A and Part B have a few options to explore alternative coverage or financial assistance:

1. **Medicare Advantage (Part C) Plans:**

- Medicare Advantage plans are offered by private insurance companies approved by Medicare. These plans provide all of the benefits covered by Medicare Part A and Part B and often include additional benefits beyond what Original Medicare covers.
- Many Medicare Advantage plans offer coverage for services such as routine dental care, vision care, and hearing care that are not covered by Original Medicare.
- Some Medicare Advantage plans also offer coverage for services like acupuncture, chiropractic care, and fitness programs that are not covered by traditional Medicare.
- Beneficiaries should review the specific benefits and costs associated with each Medicare Advantage plan to determine if it meets their needs.

## **2. Medicare Supplement Insurance (Medigap):**

- Medigap plans are supplemental insurance policies sold by private insurance companies to help fill the "gaps" in Original Medicare coverage, such as copayments, coinsurance, and deductibles.
- While Medigap plans do not typically cover services that are not covered by Medicare, they can help beneficiaries pay for out-of-pocket costs associated with covered services.
- Some Medigap plans may offer additional benefits beyond what Original Medicare covers, such as coverage for foreign travel emergencies.

## **3. Other Insurance Coverage:**

- Some beneficiaries may have access to other insurance coverage through employer-sponsored plans, retiree health plans, or union plans that offer coverage for services not covered by Medicare.
- Veterans may be eligible for coverage through the Department of Veterans Affairs (VA) for certain healthcare services not covered by Medicare.

## **4. State and Local Assistance Programs:**

- Some states offer assistance programs that provide coverage or financial assistance for services not covered by Medicare, such as prescription drugs, dental care, and vision care.
- Beneficiaries can contact their State Health Insurance Assistance Program (SHIP) or State Medicaid office to inquire about available assistance programs in their area.

## **5. Out-of-Pocket Payment:**

- In some cases, beneficiaries may need to pay out-of-pocket for services that are not covered by Medicare or other insurance plans.
- Beneficiaries can explore payment options with healthcare providers, such as setting up payment plans or negotiating discounted rates for services.

**Medicare Part C**, also known as Medicare Advantage, is an alternative way for Medicare beneficiaries to receive their Medicare benefits through private insurance plans approved by Medicare. Unlike traditional Medicare (Parts A and B), which is administered by the federal government, Medicare Advantage plans are offered by private insurance companies that contract with Medicare to provide all of the beneficiary's Part A and Part B benefits.

Here are some key features of Medicare Part C or Medicare Advantage:

### **1. All-in-One Coverage:**

- Medicare Advantage plans provide all of the benefits covered by Medicare Part A (Hospital Insurance) and Part B (Medical Insurance), and often include additional benefits beyond what Original Medicare covers.
- These additional benefits may include coverage for prescription drugs (Part D), routine dental care, vision care, hearing aids, and wellness programs.

## **2. Variety of Plan Options:**

- Medicare Advantage plans come in various types, including Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), Private Fee-for-Service (PFFS) plans, Special Needs Plans (SNPs), and Medicare Medical Savings Account (MSA) plans.
- Each plan type has different rules and restrictions regarding network providers, out-of-pocket costs, and coverage limitations.

## **3. Managed Care Approach:**

- Many Medicare Advantage plans use a managed care approach to healthcare delivery, which may involve network restrictions and requirements for referrals to see specialists.
- HMOs typically require beneficiaries to use network providers and obtain referrals from a primary care physician to see specialists.
- PPOs offer more flexibility in provider choice but may have higher out-of-pocket costs for services received out of network.

## **4. Annual Enrollment Period:**

- Beneficiaries can enroll in or switch Medicare Advantage plans during the annual Medicare Open Enrollment Period, which runs from October 15 to December 7 each year.
- Some beneficiaries may also be eligible for special enrollment periods based on certain qualifying events, such as moving to a new area or losing other coverage.

## **5. Premiums and Cost-Sharing:**

- Medicare Advantage plans may have premiums in addition to the standard Medicare Part B premium, although some plans offer \$0 premium options.
- Beneficiaries are still responsible for paying their Medicare Part B premium, as well as any copayments, coinsurance, and deductibles associated with their Medicare Advantage plan.

## **6. Coverage Limitations:**

- While Medicare Advantage plans must provide at least the same level of coverage as Original Medicare, they may have different rules, restrictions, and coverage limitations.
- Beneficiaries should carefully review the benefits and costs of each Medicare Advantage plan to ensure it meets their healthcare needs and budget.

Medicare Part C has become increasingly popular among Medicare beneficiaries for several reasons:

**1. All-in-One Coverage:**

- Medicare Advantage plans often provide comprehensive coverage that includes all the benefits of Original Medicare (Parts A and B), along with additional benefits such as prescription drug coverage (Part D), dental, vision, and hearing benefits, wellness programs, and sometimes even gym memberships.
- This all-in-one coverage simplifies healthcare management for beneficiaries by consolidating their coverage into a single plan.

**2. Cost Savings:**

- Medicare Advantage plans may offer lower out-of-pocket costs compared to Original Medicare, including lower deductibles, copayments, and coinsurance.
- Many Medicare Advantage plans have annual out-of-pocket maximums, providing financial protection for beneficiaries in case of significant medical expenses.
- Some Medicare Advantage plans offer \$0 monthly premiums, providing an affordable option for beneficiaries on a fixed income.

**3. Additional Benefits:**

- Medicare Advantage plans often offer additional benefits beyond what Original Medicare covers, such as vision, dental, and hearing benefits, which can be particularly appealing to beneficiaries who need these services.
- Many plans also offer wellness programs, preventive care services, and access to telehealth services, which can help beneficiaries stay healthy and manage chronic conditions more effectively.

**4. Provider Networks:**

- While some Medicare Advantage plans have restrictive provider networks, others offer broader networks or even out-of-network coverage in certain circumstances, providing beneficiaries with flexibility in choosing their healthcare providers.
- Beneficiaries who prefer having a primary care physician to coordinate their care may find the managed care approach of Medicare Advantage appealing.

#### **5. Value-Added Services:**

- Some Medicare Advantage plans offer value-added services such as care coordination, disease management programs, transportation assistance, and home health services, which can improve the overall quality of care for beneficiaries.

#### **6. Annual Enrollment Period:**

- The annual Medicare Open Enrollment Period provides beneficiaries with an opportunity to review and change their Medicare coverage each year, including switching to a Medicare Advantage plan if it better meets their needs.

#### **7. Market Competition:**

- Medicare Advantage plans are offered by private insurance companies competing for beneficiaries' business, leading to innovation, improved benefits, and enhanced customer service.
- The availability of a wide range of plan options allows beneficiaries to choose a plan that best suits their individual healthcare needs and preferences.

Still, some 35% of Medicare beneficiaries remain in traditional Medicare for several reasons.

#### **1. Freedom of Provider Choice:**

- Original Medicare allows beneficiaries to see any healthcare provider who accepts Medicare, without the need for referrals or obtaining permission from a primary care physician.
- Some beneficiaries prefer the flexibility of choosing their healthcare providers, including specialists and hospitals, without restrictions imposed by network limitations.

#### **2. Predictable Coverage:**

- Original Medicare provides standardized coverage, making it easier for beneficiaries to understand their benefits and costs.
- While copayments, coinsurance, and deductibles still apply, beneficiaries may appreciate the transparency and predictability of costs associated with Original Medicare.

### **3. Consistency of Coverage:**

- Original Medicare coverage remains consistent regardless of where beneficiaries live or travel within the United States.
- Beneficiaries who frequently travel or live in multiple states may find Original Medicare more convenient than Medicare Advantage plans, which may have limited provider networks or coverage areas.

### **4. Access to Specialists:**

- Some beneficiaries with complex medical conditions or specialized healthcare needs may prefer Original Medicare because it allows them to see specialists without requiring referrals or network restrictions.
- Original Medicare generally offers more flexibility in accessing specialized care, which can be important for individuals with chronic or serious health conditions.

### **5. Supplemental Coverage Options:**

- Beneficiaries who choose Original Medicare can supplement their coverage with a Medicare Supplement Insurance (Medigap) policy to help cover out-of-pocket costs, such as deductibles, copayments, and coinsurance.
- Medigap plans offer standardized benefits across different insurance companies, providing beneficiaries with additional financial protection and peace of mind.

### **6. Preference for Fee-for-Service Model:**

- Some beneficiaries prefer the fee-for-service model of Original Medicare, where healthcare providers are paid for each service rendered, rather than the managed care approach of Medicare Advantage plans.
- Fee-for-service Medicare allows beneficiaries to have more control over their healthcare decisions and treatment options.

### **7. Concerns About Plan Stability:**

- Medicare Advantage plans may change their benefits, provider networks, premiums, and formularies annually, which can be a concern for beneficiaries who prefer the stability and consistency of Original Medicare.

#### **8. Lack of Availability:**

- In some areas, particularly rural or underserved areas, there may be limited availability of Medicare Advantage plans, making Original Medicare the only viable option for beneficiaries.

Some beneficiaries may prefer the flexibility, consistency, and freedom of choice provided by Original Medicare. The decision to remain in traditional Medicare versus enrolling in Medicare Advantage is highly individual and depends on each beneficiary's healthcare needs, preferences, and priorities.

**Medicare Part D** is the prescription drug coverage component of Medicare. It was introduced as part of the Medicare Modernization Act of 2003 and became effective in 2006. Part D is designed to help Medicare beneficiaries afford the costs of prescription drugs, whether they are taken at home or administered in a clinical setting. Here are the key features of Medicare Part D:

#### **1. Coverage through Private Insurance Plans:**

- Medicare Part D is provided through private insurance plans approved by Medicare. These plans are offered by insurance companies and other private companies that contract with Medicare.
- Beneficiaries can choose from a variety of Part D plans available in their area, each offering a different list of covered drugs (formulary), premiums, deductibles, and copayments or coinsurance.

#### **2. Prescription Drug Formulary:**

- Each Medicare Part D plan maintains a formulary, which is a list of covered prescription drugs. Formularies vary between plans and can change from year to year.
- Part D plans are required to cover at least two drugs in each therapeutic category and class, ensuring beneficiaries have access to a range of treatment options.

#### **3. Annual Enrollment Period:**

- Beneficiaries can enroll in or make changes to their Medicare Part D coverage during the annual Medicare Open Enrollment Period, which runs from October 15 to December 7 each year.

- Outside of this period, beneficiaries may be eligible for a Special Enrollment Period if they experience certain qualifying events, such as losing other prescription drug coverage.

#### **4. Premiums and Cost-Sharing:**

- Beneficiaries typically pay a monthly premium for Medicare Part D coverage, in addition to any premiums they pay for Medicare Part A (if applicable) and Part B.
- Part D plans also have an annual deductible, which beneficiaries must pay out-of-pocket before their plan begins to cover prescription drug costs.
- After meeting the deductible, beneficiaries typically pay a copayment or coinsurance for each prescription filled, and the plan covers the remaining cost.

#### **5. Coverage Gap (Donut Hole):**

- Until recently, Medicare Part D included a coverage gap, often referred to as the "donut hole," where beneficiaries had to pay a larger share of their prescription drug costs.
- However, due to changes in the Affordable Care Act, the coverage gap has been gradually closing. As of 2021, beneficiaries only pay 25% of the cost of their brand-name drugs and 25% of the cost of generic drugs while in the coverage gap.
- The coverage gap will be fully phased out by 2024, at which point beneficiaries will pay no more than 25% of the cost of their drugs, both generic and brand-name, until they reach catastrophic coverage.

#### **6. Catastrophic Coverage:**

- Once a beneficiary's out-of-pocket spending on prescription drugs reaches a certain threshold, they qualify for catastrophic coverage. At this point, they pay a reduced copayment or coinsurance for covered drugs for the remainder of the year.

Medicare Part D provides essential prescription drug coverage for millions of Medicare beneficiaries, helping them afford the medications they need to manage chronic conditions, prevent illness, and improve their overall health and well-being.

The George W. Bush administration proposed and championed Medicare Part C (Medicare Advantage) and Part D (Prescription Drug Coverage) as part of the Medicare Modernization Act of 2003. There were several reasons behind the decision to propose these additions to Medicare:

#### **1. Addressing Rising Prescription Drug Costs:**



- One of the primary motivations for introducing Medicare Part D was to address the rising costs of prescription drugs for Medicare beneficiaries.
- Prescription drug coverage was seen as a critical component of comprehensive healthcare coverage, particularly as prescription drug costs were becoming increasingly burdensome for seniors and individuals with disabilities.

## **2. Expanding Medicare Coverage Options:**

- Medicare Part C (Medicare Advantage) was introduced to provide beneficiaries with more choices and flexibility in how they receive their Medicare benefits.
- Medicare Advantage plans, offered by private insurance companies, were intended to offer additional benefits and services beyond what Original Medicare covers, such as prescription drug coverage, dental, vision, and wellness programs.

## **3. Promoting Competition and Market-Based Solutions:**

- The Bush administration favored market-based solutions and competition to improve efficiency and drive down costs in healthcare.
- By introducing Medicare Advantage and Part D, the administration aimed to encourage competition among private insurance plans, leading to innovation, improved benefits, and better value for beneficiaries.

## **4. Political and Legislative Priorities:**

- The proposal for Medicare Part D and Medicare Advantage was part of the broader legislative agenda of the Bush administration, which sought to enact significant reforms in healthcare and social policy.
- Medicare Part D and Medicare Advantage were ultimately included in the Medicare Modernization Act of 2003, which was passed by Congress and signed into law by President Bush in December 2003.

Overall, the introduction of Medicare Part C (Medicare Advantage) and Part D (Prescription Drug Coverage) was driven by a combination of factors, including the need to address rising prescription drug costs, expand coverage options for beneficiaries, promote market competition, and advance the administration's legislative priorities in healthcare reform.

Medicare is generally quite popular among its beneficiaries. Surveys and polls consistently show high levels of satisfaction with Medicare among older adults and individuals with disabilities who are enrolled in the program. According to data from the

Centers for Medicare & Medicaid Services (CMS), the vast majority of Medicare beneficiaries express satisfaction with their coverage and access to care.

Here are some key factors contributing to the popularity of Medicare among beneficiaries:

**1. Comprehensive Coverage:**

- Medicare provides comprehensive healthcare coverage, including hospital insurance (Part A), medical insurance (Part B), and prescription drug coverage (Part D), as well as options for supplemental coverage through Medicare Advantage (Part C) and Medigap plans.
- The breadth of coverage offered by Medicare helps ensure that beneficiaries have access to essential healthcare services without facing significant financial barriers.

**2. Provider Choice:**

- Medicare beneficiaries have the freedom to choose their healthcare providers, including doctors, specialists, hospitals, and other healthcare facilities.
- The ability to see the providers of their choice without needing referrals or obtaining permission from a primary care physician is highly valued by many beneficiaries.

**3. Affordability:**

- While beneficiaries may still have out-of-pocket costs such as premiums, deductibles, and coinsurance, Medicare generally offers more affordable coverage options compared to private insurance plans, particularly for older adults and individuals with pre-existing health conditions.

**4. Stability and Reliability:**

- Medicare is a longstanding and well-established program with a strong track record of providing healthcare coverage to millions of Americans.
- The stability and reliability of Medicare contribute to its popularity and trustworthiness among beneficiaries.

Comparatively, private insurance plans vary widely in popularity among subscribers, depending on factors such as plan features, network coverage, cost, and individual preferences. While some individuals may prefer the flexibility and additional benefits offered by private insurance plans, others may find that Medicare provides more comprehensive coverage and greater peace of mind, particularly as they age and their healthcare needs become more complex.

## How Medicare is Funded

Medicare is funded through a combination of general revenue contributions, payroll taxes, beneficiary premiums, and other sources. Here's an overview of how Medicare is funded:

### 1. Payroll Taxes:

- The largest source of funding for Medicare comes from payroll taxes paid by employees and employers under the Federal Insurance Contributions Act (FICA).
- The Medicare payroll tax is composed of two parts: the Hospital Insurance (HI) tax and the Supplementary Medical Insurance (SMI) tax.
- The HI tax funds Medicare Part A (Hospital Insurance), while the SMI tax funds Medicare Part B (Medical Insurance) and Medicare Part D (Prescription Drug Coverage).

### 2. General Revenue Contributions:

- Medicare Part A (Hospital Insurance) is primarily funded through payroll taxes, but it also receives contributions from general revenues to cover any shortfalls in funding.
- General revenue contributions help ensure that Medicare Part A remains adequately funded to cover the costs of hospital and inpatient care for beneficiaries.

### 3. Beneficiary Premiums:

- Medicare beneficiaries also contribute to the funding of Medicare through premiums for certain parts of the program.
- Most beneficiaries do not pay premiums for Medicare Part A if they or their spouse paid Medicare taxes while working. However, beneficiaries may be required to pay premiums for Medicare Part B (Medical Insurance) and Medicare Part D (Prescription Drug Coverage).
- Premiums for Medicare Part B and Part D are set annually and may vary depending on factors such as income level and enrollment status.

### 4. Medicare Advantage Payments:

- Medicare Advantage plans receive payments from the federal government to provide Medicare-covered benefits to beneficiaries enrolled in their plans.

- These payments are based on a complex formula known as the Medicare Advantage capitated payment system, which takes into account factors such as beneficiary demographics, health status, and regional costs.

## 5. Other Sources:

- In addition to payroll taxes, general revenue contributions, and beneficiary premiums, Medicare may receive funding from other sources, such as interest earned on the Medicare trust funds, state contributions to the Medicaid program (which helps cover some Medicare costs for dually eligible beneficiaries), and certain taxes on high-income individuals.

Medicare cost about \$929 billion in 2021, or about \$13,000 per beneficiary. The cost per beneficiary has been increasing at a slower rate than overall inflation and private insurance costs over the past 5-8 years. Here are some key points:

- According to data from the Centers for Medicare & Medicaid Services (CMS), Medicare costs per beneficiary grew by about 2-3% annually from 2015 to 2022. This is well below the overall inflation rate during this period.
- Specifically, Medicare spending per beneficiary increased 2.3% in 2021 and 2.9% in 2022, while overall inflation was around 7-9% those years.
- In comparison, private health insurance premiums for employer-sponsored family coverage increased around 4-6% annually from 2015-2022 according to the Kaiser Family Foundation.
- The slower growth in Medicare costs is attributed to payment reforms, increased use of cheaper generic drugs, and delivery system reforms encouraging more cost-effective care.
- However, Medicare costs are expected to rise more rapidly in the coming years due to an aging population and rising healthcare costs overall.

Medicare's funding situation has been a longstanding issue of concern. The program currently gets funding from three main sources:

- Payroll taxes
- Premiums paid by beneficiaries
- General revenues from the federal government

There are two separate trust funds - one for Hospital Insurance (Part A, covering inpatient hospital care) and one for Supplementary Medical Insurance (Parts B and D, covering outpatient care and prescription drugs).

The often-cited projection that the Medicare Hospital Insurance Trust Fund will be depleted or "run out of money" in around 7 years (specifically 2028 according to the

latest Medicare Trustees report) does not mean Medicare itself is going bankrupt or will cease operating altogether.

What it means is that the Hospital Insurance Trust Fund's reserves will be depleted by 2028 based on current income and expenditure projections. After 2028, income to the fund from payroll taxes and other revenue would cover only 90% of projected Part A costs.

The Supplementary Medical Insurance Trust Fund is expected to remain adequately financed into the indefinite future because its funding can be adjusted through changes in premiums and general revenue contributions.

However, shoring up the financial condition of the Hospital Insurance Trust Fund will likely require significant legislative reforms by Congress, such as increasing payroll taxes allocated to Medicare, reducing expenditures through further cost-saving measures, or supplementing the fund with general revenues.

Here are some key points to consider:

**1. Trust Fund Depletion:**

- The Medicare Trustees issue annual reports that project the financial status of the HI Trust Fund based on revenue and expenditure projections. These reports include estimates of when the trust fund will be depleted if current trends continue.
- The projected depletion date has fluctuated over time due to various factors such as changes in healthcare costs, enrollment trends, economic conditions, and legislative changes.

**2. Impact on Benefits:**

- If the HI Trust Fund were to be depleted, it would not mean that Medicare benefits would disappear entirely. Instead, it would mean that the trust fund would no longer have sufficient funds to cover all of its obligations fully.
- In the event of trust fund depletion, Medicare Part A would still be able to pay a portion of its costs through ongoing revenue from payroll taxes and other sources, but benefits might need to be reduced, or additional funding sources might need to be allocated to cover the shortfall.

**3. Need for Policy Changes:**

- The projected depletion of the HI Trust Fund underscores the need for policy changes to address the long-term financial sustainability of the Medicare program.

- Potential policy solutions to address trust fund depletion include increasing revenue through payroll taxes or other sources, reducing expenditures through benefit reforms or cost-saving measures, improving the efficiency of healthcare delivery, and implementing measures to address the underlying drivers of healthcare costs.

### Measuring Medicare's Outcomes

The easiest way to measure a healthcare system's outcomes or quality is by measuring life expectancy. I like this admittedly imperfect metric for a couple of reasons:

- The data are relatively easy to access.
- Life expectancy generally improves in lock-step with a healthcare system. A well functioning system generally will generate longer life expectancies than a poorly functioning one.
- Life expectancy data also include variables that a narrowly defined medical care system might miss. Access to healthy foods, for example, probably play a life expectancy role. This suggests that a well functioning healthcare system should address the population's nutritional needs, not just their acute care needs.

Let's compare American life expectancies at age 65 to other countries.<sup>79</sup>

- For American men who survived to age 65 in 2021, their remaining life expectancy was around 18.1 years.
- For American women at age 65, remaining life expectancy was around 20.6 years in 2021.
- This places the U.S. below the average among OECD countries for life expectancy at age 65. For example, a 65-year-old man in Switzerland could expect to live around 19.8 more years on average.

Some key comparisons on life expectancy at birth and age 65 from 2021 OECD data:

- Switzerland: 81.1 years at birth, 21.1 remaining at age 65
- Norway: 82.7 years at birth, 20.3 remaining at 65
- Australia: 83.3 years at birth, 21.1 remaining at 65
- Canada: 82.2 years at birth, 21.3 remaining at 65
- United States: 77.0 years at birth, 18.5 remaining at 65

The correlation between life expectancy and overall healthcare system quality is complex, as life expectancy can be influenced by many socioeconomic and

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<sup>79</sup> This section comes from Claude.ai, April 2024

environmental factors beyond just the healthcare system itself. However, most research suggests there is a meaningful but moderate correlation.

- Access to high-quality healthcare is undoubtedly a key determinant of life expectancy, especially through prevention and effective management of chronic diseases that affect mortality.
- Countries that rank highly on measures of healthcare access, affordability, and clinical outcomes tend to have higher life expectancies on average.

However, factors like poverty, education levels, diet, rates of smoking/obesity, air pollution, and income inequality also significantly impact life expectancy independently of healthcare.

Statistical analysis estimates that differences in healthcare system performance may account for around 25-40% of the life expectancy gap between the U.S. and other wealthy nations.

The remaining gap is attributed to the socioeconomic, environmental, and behavioral factors prevalent in the U.S. population.

Within countries, individuals with higher incomes and better healthy behaviors tend to experience longer life expectancies, even with similar healthcare access.

That's why I suggest that life expectancy is a good but definitely imperfect measure of Medicare's quality.

### Summary

Medicare has been one of the most significant and impactful social programs in American history since its establishment in 1965.

What Medicare Accomplished:

- Provided access to health insurance for millions of elderly Americans age 65+ who previously could not afford or qualify for private coverage.
- Helped dramatically reduce elderly poverty and financial insecurity by covering major hospital and medical expenses.
- Improved access to preventive services and treatment for the elderly population.
- Along with Medicaid, helped desegregate some hospitals that previously refused Black patients.
- Established a national health insurance model and system that other programs like Medicaid and CHIP were built upon.

How Medicare Changed the World:

- Served as a model for other nations to establish universal healthcare programs for their citizens.
- Shifted the physician reimbursement system and expanded the role of private health insurance companies as contractors.
- Created a massive new sector of the economy around the administration of government-funded health insurance.
- Facilitated the integration of new medical technologies and drugs by covering them nationwide.
- Demonstrated how a large social insurance program could be successfully implemented and administered.

#### Overall Quality and Impact:

- While not perfect, Medicare has been incredibly successful in providing essential health coverage to the elderly.
- It remains one of the most popular and solidly supported government programs in American public opinion.
- Medicare has greatly improved quality of life and financial security for tens of millions of American seniors.
- However, its long-term financial sustainability remains an ongoing challenge that may require reforms.

Overall, Medicare drastically improved access to healthcare for America's senior citizens, served as a model for other countries, fundamentally changed the healthcare system's economics, and continues to provide vital health security today despite future financing concerns.

### **A word about Medicaid**

Medicaid fills critical gaps in health coverage for tens of millions of America's most vulnerable low-income populations.<sup>80</sup> It is a joint federal and state program that provides health coverage to low-income Americans. Here's an overview of this major government health insurance program:

#### Purpose & Eligibility:

- Medicaid's main purpose is to provide health coverage for low-income adults, children, pregnant women, elderly adults, and people with disabilities.
- Eligibility is based on income level, which must be below a certain federal poverty line threshold. This threshold varies by state.

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<sup>80</sup> Much of this section comes from Claude ai.



- As of 2022, over 83 million Americans were enrolled in Medicaid and the related Children's Health Insurance Program (CHIP).

#### Benefits Covered:

- Mandatory benefits covered by all state programs include inpatient/outpatient hospital services, physician services, laboratory/x-ray services, and early and periodic screening for children.
- States can choose to provide additional optional benefits like prescription drug coverage, physical therapy, dental, vision, and others.

#### Funding:

- Medicaid is funded jointly by the states and the federal government.
- The federal government pays states a matching rate (averaged 64% in 2020) based on the state's per capita income.
- Total Medicaid spending was over \$670 billion in 2020.

#### Program Administration:

- Medicaid is a federal-state partnership program. The states administer their own Medicaid programs while following federal guidelines.
- This allows for state flexibility in program rules, benefits, eligibility, and provider payments.

#### Impact:

- Medicaid covers a large share of low-income children, pregnant women, seniors in nursing homes, and people with disabilities.
- It helps provide services that promote care in home/community settings rather than institutions.
- Critics argue for more uniformity across state programs and better cost control measures.

Medicaid generally provides more comprehensive benefits particularly for long-term care services. Here's a brief summary of benefits in both programs:

#### Medicare Benefits:

- Hospital Insurance (Part A) - Inpatient hospital care, skilled nursing facility care, hospice, home health services
- Medical Insurance (Part B) - Physician services, outpatient care, preventive services, durable medical equipment

- Prescription Drug Coverage (Part D) - Outpatient prescription drugs
- Medicare Advantage (Part C) - Managed care plans that provide Parts A, B and usually D

#### Medicaid Benefits:

- Inpatient/outpatient hospital services
- Physician/certified nurse practitioner services
- Lab/x-ray services
- Nursing facility/home health care services for over 21
- Early periodic screening, diagnosis and treatment for under 21
- Family planning services
- Rural health clinic/FQHC services
- Transportation to medical care

Additionally, states can choose to provide optional Medicaid benefits like:

- Prescription drugs
- Rehabilitation services
- Personal care services
- Dental, vision, physical therapy and other therapies

#### Key Differences:

- Medicaid provides more comprehensive long-term care coverage
- Medicaid covers a broader range of benefits like dental, vision, therapies that Medicare does not
- But Medicaid varies significantly by state, while Medicare benefits are nationally uniform
- Lower-income Medicare beneficiaries can have Medicaid as a supplement

Medicaid generally provides more comprehensive benefits particularly for long-term care services and non-medical benefits that promote overall health for low-income populations.

Medicaid's financial strength and sustainability are an ongoing issue of concern, though its funding outlook is somewhat better than Medicare's in the near-term.

#### Funding Sources:

- Medicaid is jointly funded by the federal government and states.
- The federal share is around 64% on average, though this federal matching rate varies by state based on per capita income.
- Total Medicaid spending was over \$670 billion in fiscal year 2020.

#### Cost Growth:

- Medicaid costs have been growing faster than the overall economy, driven by enrollment growth, rising healthcare costs, and expansion of benefits.
- Total Medicaid spending increased by around 6% annually from 2017-2020.
- This growth rate is projected to continue in the range of 5-6% per year over the next decade.

#### Future Outlook:

- Medicaid's funding is not facing the same insolvency projections as Medicare's Hospital Insurance Trust Fund in the short-term.
- As an entitlement, federal/state funding is obligated to match enrollment and costs.
- However, the program's growing expense poses significant budgetary pressures long-term.
- Cost-controls and potential delivery system reforms may be needed to rein in spending growth.

#### Challenges:

- Economic downturns increase Medicaid enrollment as more people qualify due to low incomes.
- An aging population will increase Medicaid long-term care costs substantially in coming decades.
- State budgets can be strained during recessions, making their matching funding requirements difficult.

Medicaid accounts for a significant portion of state budgets across the country.

According to data from the Kaiser Family Foundation:

- In fiscal year 2021, Medicaid made up 16.8% of total state spending on average across all 50 states and D.C.
- However, there is considerable variation between states in terms of how much of their budget goes to Medicaid:

#### High Percentages:

- New York (34.8%)
- Missouri (33.4%)
- Pennsylvania (31.3%)
- New Mexico (30.9%)
- West Virginia (30.8%)

#### Low Percentages:

- Wyoming (7.9%)
- Nevada (8.9%)
- Utah (9.9%)
- Idaho (10.6%)
- Hawaii (11.1%)
- The 10 states with the highest percentage of spending on Medicaid averaged 28.9% in 2021.
- The 10 states with the lowest percentage averaged 13.3%.

This high degree of variation is due to factors like:

- A state's Medicaid enrollment and eligible population
- The state's Federal Medical Assistance Percentage (FMAP) match rate
- Decisions to expand Medicaid eligibility under the ACA
- Cost of living and healthcare costs in each state

So while Medicaid does not face the same short-term funding crisis as Medicare, its long-term cost trajectory and pressure on state/federal budgets remain major fiscal policy concerns that could necessitate cost-saving reforms or measures to raise more program revenue over time.

### **An Eye on the Future Medicare for All**

"Medicare for All" is a healthcare policy proposal that advocates for a single-payer, government-funded healthcare system in which all residents of a country are covered

for medical services.<sup>81</sup> While opinions on this approach may vary, proponents highlight several potential advantages:

**1. Universal Coverage:**

- One of the primary advantages is the achievement of universal healthcare coverage. Under Medicare for All, everyone would have access to necessary medical services, regardless of income or employment status.

**2. Simplified Administration:**

- A single-payer system could reduce administrative complexity by streamlining billing and paperwork. This simplification might lead to cost savings and more efficient healthcare delivery.

**3. Cost Control:**

- Proponents argue that a single-payer system could potentially control healthcare costs more effectively through negotiation with providers, bulk purchasing of medications, and overall cost management.

**4. Preventive Care Emphasis:**

- With a focus on preventive care, Medicare for All could encourage early intervention and wellness programs, potentially reducing the overall burden of disease and the associated costs.

**5. Elimination of Health Disparities:**

- Advocates claim that a single-payer system could help address health disparities by ensuring that everyone, regardless of socioeconomic status, has equal access to healthcare services.

**6. Financial Security:**

- With universal coverage, individuals would not face financial ruin due to medical expenses. This could provide greater financial security and reduce the fear of bankruptcy related to healthcare costs.

**7. Improved Health Outcomes:**

- By providing access to healthcare services for everyone, proponents argue that Medicare for All could lead to improved health outcomes on a population level.

**8. Simplified Choice of Providers:**

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<sup>81</sup> Much of this section comes from ChatGPT

- A single-payer system could simplify the choice of healthcare providers for individuals, as everyone would be covered under the same system.

#### **9. Reduced Administrative Costs:**

- Streamlining administrative processes and reducing the complexity of dealing with multiple insurers could lead to significant cost savings.

It's important to note that while these advantages are highlighted by proponents, there are also concerns and criticisms related to the potential costs, the impact on the healthcare industry, and the role of government in healthcare. The debate over healthcare policy is complex, and different stakeholders may have varied perspectives on the best approach.

### **How Medicare for All Achieves Universal Coverage**

Medicare for All aims to achieve universal coverage by implementing a single-payer healthcare system, where the government serves as the sole payer for healthcare services. This means that all residents of a country would be covered under a single, comprehensive healthcare plan. Here are key features of how Medicare for All achieves universal coverage:

#### **1. Single-Payer System:**

- In a single-payer system, the government is the primary entity responsible for paying healthcare providers for medical services. This eliminates the need for multiple private insurance plans.

#### **2. Comprehensive Benefits:**

- Medicare for All typically proposes comprehensive coverage, including hospital services, preventive care, mental health services, prescription drugs, and other necessary medical treatments. This ensures that all essential healthcare needs are covered.

#### **3. No Exclusions for Pre-Existing Conditions:**

- Unlike some private insurance plans that may deny coverage or charge higher premiums based on pre-existing conditions, Medicare for All is designed to provide coverage without such exclusions or discriminatory practices.

#### **4. Automatic Enrollment:**

- The system may involve automatic enrollment for all residents, ensuring that everyone is covered by default. This eliminates the need for individuals to navigate complex insurance markets or worry about being uninsured.

## **5. No Out-of-Pocket Costs for Essential Services:**

- Medicare for All proposals often aim to eliminate or significantly reduce out-of-pocket costs for essential healthcare services, making healthcare more affordable and accessible.

## **6. Standardized Benefits:**

- The system typically establishes standardized benefits, ensuring that everyone receives the same level of coverage for basic healthcare needs. This promotes equity in access to medical services.

## **7. Public Funding:**

- Medicare for All relies on public funding, usually through taxation. This ensures that the financial burden is distributed across the population, and everyone contributes to the healthcare system based on their ability to pay.

## **8. Negotiation with Healthcare Providers:**

- The government, as the single payer, can negotiate directly with healthcare providers, pharmaceutical companies, and other stakeholders to control costs and ensure fair pricing for medical services and medications.

## **9. Preventive and Primary Care Focus:**

- By emphasizing preventive and primary care, Medicare for All aims to address health issues at an early stage, reducing the overall burden of disease and potentially lowering long-term healthcare costs.

It's important to note that the specific details of Medicare for All proposals can vary, and the implementation process may involve significant legislative and administrative changes. The concept of achieving universal coverage through a single-payer system is a central tenet of these proposals. The success of such a system depends on effective planning, funding mechanisms, and public support.

## **How Medicare for All Simplifies Healthcare Administration**

Medicare for All simplifies healthcare administration in several ways:

### **1. Elimination of Multiple Payers:**

- Medicare for All envisions a single-payer system, where the government becomes the sole payer for healthcare services. This eliminates the need for multiple private insurance companies, each with its own set of policies, forms, and administrative processes.

### **2. Streamlined Billing and Claims Processing:**

- With a single-payer system, healthcare providers would submit claims to the government payer. This simplifies billing and claims processing, reducing the complexity and paperwork associated with dealing with numerous private insurers.

### **3. Standardized Benefits and Reimbursement:**

- Medicare for All proposals often include standardized benefits and reimbursement rates for healthcare services. This standardization simplifies the process for both healthcare providers and payers, reducing the need for negotiations and complex contracts.

### **4. Automatic Enrollment:**

- The system may involve automatic enrollment for all residents, eliminating the need for individuals to navigate private insurance markets or apply for coverage. This reduces administrative overhead associated with enrollment processes.

### **5. Reduced Administrative Costs:**

- By consolidating the administration under a single-payer, Medicare for All aims to reduce administrative costs related to marketing, underwriting, and managing multiple insurance plans. This can lead to overall cost savings within the healthcare system.

### **6. Simplified Provider Networks:**

- Healthcare providers would deal with a single payer, simplifying their interactions with payers and reducing the need to navigate and contract with multiple insurance networks.

### **7. Unified Electronic Health Records (EHR):**

- A single-payer system could facilitate the development of a unified electronic health records (EHR) system, making it easier to share patient information among healthcare providers and reduce the need for disparate systems.

### **8. Consistent Coverage Rules:**

- With standardized benefits and coverage rules, Medicare for All seeks to create consistency in healthcare coverage. This reduces confusion for both patients and healthcare providers regarding what is covered under the plan.

### **9. Efficient Negotiation and Drug Pricing:**



- The government, as the single payer, would have more bargaining power to negotiate with pharmaceutical companies for drug prices. This could lead to more efficient negotiations and potentially lower drug costs.

While the simplification of healthcare administration is a significant goal, it's important to acknowledge that the transition to a single-payer system involves complex challenges and considerations. Critics argue that the potential benefits should be carefully weighed against the potential disruptions and changes to the existing healthcare infrastructure.

### **How Medicare for All Controls Healthcare Spending**

Proponent of Medicare for All argue that it helps control healthcare spending through various mechanisms. While there are different proposals and variations, here are common ways in which Medicare for All aims to control healthcare spending:

#### **1. Negotiating Power:**

- A single-payer system consolidates the negotiating power of the government, allowing it to negotiate directly with healthcare providers, pharmaceutical companies, and other stakeholders. This can lead to lower prices for medical services, drugs, and other healthcare-related expenses.

#### **2. Bulk Purchasing of Medications:**

- With a single-payer system, the government can engage in bulk purchasing of medications, negotiating lower prices for prescription drugs. This can result in significant cost savings and contribute to controlling overall healthcare spending.

#### **3. Administrative Efficiency:**

- By eliminating the administrative complexity associated with multiple private insurance plans, Medicare for All aims to increase administrative efficiency. Streamlining billing, claims processing, and administrative tasks can reduce overhead costs within the healthcare system.

#### **4. Preventive Care Emphasis:**

- Medicare for All often emphasizes preventive care and early intervention. By addressing health issues at an early stage, the system aims to reduce the overall burden of disease, potentially lowering long-term healthcare costs.

#### **5. Standardized Benefits and Reimbursement:**

- Standardizing benefits and reimbursement rates across the healthcare system can contribute to cost control. Healthcare providers and payers operate under consistent rules, reducing the need for complex negotiations and individual contracts.

## **6. Global Budgeting:**

- Some Medicare for All proposals consider implementing global budgeting for healthcare spending. This involves setting a predetermined budget for healthcare expenditures, which can encourage efficiency and resource allocation within the system.

## **7. Reduced Administrative Costs:**

- The consolidation of administrative functions under a single-payer system is expected to reduce administrative costs associated with marketing, underwriting, and managing multiple private insurance plans.

## **8. Preventing Price Gouging:**

- Advocates argue that a single-payer system can prevent price gouging by setting reasonable reimbursement rates for healthcare services. This can prevent excessive charges from healthcare providers.

## **9. Addressing Overutilization:**

- Some Medicare for All proposals include measures to address overutilization of healthcare services. By promoting evidence-based practices and discouraging unnecessary procedures, the system aims to control costs associated with unnecessary medical interventions.

It's important to note that the effectiveness of these cost-control measures depends on the specific details of the Medicare for All proposal and its implementation. Critics argue that potential savings may be offset by increased demand for healthcare services, and the overall impact on healthcare spending is a subject of ongoing debate.

### **How Medicare for All Emphasizes Preventive Care**

Medicare for All emphasizes preventive care as a key component of its healthcare approach. The goal is to shift the focus from treating illnesses and conditions after they occur to preventing them in the first place. Here are ways in which Medicare for All aims to prioritize and promote preventive care:

#### **1. Comprehensive Coverage:**

- Medicare for All proposals typically include comprehensive coverage for preventive services. This can include routine check-ups, vaccinations, screenings, and other preventive measures without cost-sharing for patients.

#### **2. Early Detection and Screening:**

- The emphasis is placed on early detection and screening for common diseases and conditions. Regular screenings, such as mammograms,

colonoscopies, and vaccinations, are included in the covered services to detect potential health issues early when they may be more treatable.

**3. Immunizations:**

- Medicare for All supports and promotes access to immunizations for preventable diseases. By ensuring that vaccinations are readily available and covered, the goal is to protect individuals and communities from vaccine-preventable illnesses.

**4. Health Education and Promotion:**

- The system may include health education and promotion efforts to inform individuals about healthy lifestyles, nutrition, exercise, and other factors that contribute to overall well-being. Educating the public about healthy choices can help prevent various health issues.

**5. Chronic Disease Management:**

- Medicare for All aims to address chronic diseases through preventive measures and management strategies. By providing ongoing care and support for individuals with chronic conditions, the system seeks to prevent complications and improve overall health outcomes.

**6. Access to Primary Care:**

- Ensuring access to primary care is a fundamental aspect of preventive care. Medicare for All aims to provide individuals with consistent access to primary care physicians, promoting regular check-ups and health maintenance.

**7. Community-Based Health Initiatives:**

- Some proposals may allocate resources for community-based health initiatives. These initiatives can include programs that promote healthy living, provide education on preventive measures, and engage communities in activities that support overall well-being.

**8. Incentives for Providers:**

- Medicare for All proposals may include incentives for healthcare providers to prioritize preventive care. This can involve reimbursement models that reward healthcare professionals for delivering preventive services and promoting patient health.

**9. Integration of Behavioral Health Services:**

- Addressing mental health is often part of preventive care. By integrating behavioral health services into the healthcare system, Medicare for All

aims to identify and address mental health concerns early on, preventing more serious issues.

By incorporating these elements into the healthcare system, Medicare for All seeks to create a proactive and preventive approach that not only improves health outcomes for individuals but also contributes to the overall health of the population.

### **How Medicare for All Eliminates Health Disparities**

Medicare for All aims to address and reduce health disparities through various mechanisms designed to ensure equitable access to healthcare services. Here are ways in which Medicare for All seeks to eliminate health disparities:

#### **1. Universal Coverage:**

- By providing universal coverage, Medicare for All ensures that everyone, regardless of socioeconomic status, has access to necessary healthcare services. Universal coverage is a fundamental step toward reducing disparities in healthcare access.

#### **2. Equal Access to Services:**

- Medicare for All seeks to provide equal access to a comprehensive set of healthcare services for all individuals. This includes preventive care, primary care, specialty services, mental health services, and other essential healthcare components.

#### **3. Elimination of Cost Barriers:**

- By eliminating or significantly reducing out-of-pocket costs for essential services, Medicare for All aims to remove financial barriers that can disproportionately affect individuals with lower incomes. This can help ensure that cost is not a barrier to receiving necessary medical care.

#### **4. Standardized Benefits:**

- Standardizing benefits across the healthcare system helps ensure that all individuals receive the same level of coverage for basic healthcare needs. This consistency can contribute to reducing disparities in access to specific services.

#### **5. Culturally Competent Care:**

- Medicare for All proposals often emphasize the importance of culturally competent care. This involves recognizing and addressing the unique cultural, linguistic, and social factors that can impact healthcare outcomes, particularly for marginalized communities.

#### **6. Community-Based Health Initiatives:**

- Some proposals may allocate resources for community-based health initiatives. These initiatives can address social determinants of health and focus on improving health outcomes in specific communities facing disparities.

#### **7. Focus on Preventive Care:**

- Preventive care is a key aspect of Medicare for All, and promoting early detection and intervention can help address health issues before they become more severe. This approach is crucial for reducing disparities in health outcomes.

#### **8. Health Education and Outreach:**

- Medicare for All may include initiatives to provide health education and outreach to underserved communities. Informing individuals about preventive measures, healthy lifestyles, and available healthcare resources can empower communities to make informed decisions about their health.

#### **9. Investment in Underserved Areas:**

- Some proposals may prioritize investments in healthcare infrastructure in underserved areas. This can involve increasing the number of healthcare facilities, ensuring an adequate healthcare workforce, and addressing geographic disparities in healthcare access.

#### **10. Data Collection and Monitoring:**

- Implementing robust data collection and monitoring systems can help identify and address disparities in healthcare outcomes. By understanding the specific challenges faced by different populations, policymakers can tailor interventions to reduce disparities.

It's important to note that while Medicare for All aims to address health disparities, the effectiveness of these measures depends on the specific details of the proposal, its implementation, and ongoing efforts to monitor and adapt strategies to evolving needs. Reducing health disparities requires a comprehensive and sustained approach across multiple dimensions of healthcare delivery and social determinants of health.

### **How Medicare for All Improves the Financial Security of All Americans**

Medicare for All proponents argue that implementing a single-payer healthcare system could improve the financial security of all Americans through several mechanisms. Here are ways in which Medicare for All aims to enhance financial security:

#### **1. Elimination of Out-of-Pocket Costs:**

- Medicare for All typically envisions reducing or eliminating out-of-pocket costs for essential healthcare services. By doing so, individuals would be less likely to face financial hardship due to medical expenses.

## **2. Universal Coverage:**

- The provision of universal healthcare coverage ensures that all Americans have access to necessary medical services. With everyone covered, individuals are less likely to face financial ruin due to medical emergencies or untreated health conditions.

## **3. No Medical Bankruptcy:**

- By removing the financial burden associated with high healthcare costs, Medicare for All aims to reduce the incidence of medical bankruptcies. Individuals and families would not face the prospect of financial devastation due to overwhelming medical bills.

## **4. Preventive Care Emphasis:**

- Medicare for All emphasizes preventive care, which can help identify and address health issues before they become more severe and costly. Preventive measures can contribute to long-term financial savings by avoiding expensive treatments for advanced illnesses.

## **5. Stable Premiums and Deductibles:**

- A single-payer system could lead to more stable premiums and deductibles. With a government-administered healthcare plan, the pricing structure may be more predictable, providing individuals with a clearer understanding of their healthcare expenses.

## **6. Income-Linked Financing:**

- Financing Medicare for All through progressive taxation ensures that individuals contribute based on their ability to pay. This approach aims to distribute the financial burden more equitably, reducing the strain on lower-income individuals and families.

## **7. Negotiation for Lower Drug Prices:**

- The government, as the single payer, would have more negotiating power over drug prices. This could lead to lower prescription drug costs, contributing to financial relief for individuals who rely on medications.

## **8. Financial Predictability:**

- Knowing that essential healthcare services are covered without significant out-of-pocket costs provides individuals with greater financial predictability.

This stability allows for better financial planning and reduces the anxiety associated with unexpected medical expenses.

**9. Freed-up Disposable Income:**

- With reduced or eliminated healthcare costs, individuals and families may have more disposable income. This can be used for other essential needs, contributing to overall economic well-being.

**10. Job Flexibility:**

- Individuals may experience increased job flexibility as they are not tied to employer-sponsored health insurance. This can facilitate career changes, entrepreneurship, and other professional pursuits without the concern of losing healthcare coverage.

While proponents argue that Medicare for All could enhance financial security, critics raise concerns about potential tax implications, the overall cost of implementing such a system, and potential trade-offs. The debate over the financial implications of Medicare for All is complex and involves considerations of both costs and benefits.

**How Does Medicare for All Improve Health Outcomes**

Proponents of Medicare for All argue that implementing a single-payer healthcare system could lead to improved health outcomes for the population. Here are ways in which Medicare for All aims to enhance health outcomes:

**1. Universal Access to Healthcare:**

- Medicare for All provides universal access to healthcare services, ensuring that all residents have coverage for essential medical treatments, preventive care, and health services. This universal access is intended to reduce disparities in healthcare utilization and outcomes.

**2. Early Detection and Prevention:**

- The emphasis on preventive care and regular check-ups in Medicare for All aims to detect health issues at an early stage. Early detection allows for timely intervention and preventive measures, reducing the severity of illnesses and improving overall health outcomes.

**3. Comprehensive Coverage:**

- Medicare for All typically offers comprehensive coverage, including preventive services, primary care, specialty care, mental health services, and prescription drugs. Comprehensive coverage addresses a wide range of health needs and contributes to holistic healthcare.

**4. Elimination of Financial Barriers:**

- By reducing or eliminating out-of-pocket costs for essential healthcare services, Medicare for All aims to remove financial barriers that may prevent individuals from seeking necessary medical care. Financial accessibility is crucial for timely and appropriate healthcare utilization.

#### **5. Focus on Social Determinants of Health:**

- Medicare for All may incorporate initiatives addressing social determinants of health, such as housing, education, and nutrition. Addressing these broader factors can positively impact health outcomes and contribute to overall well-being.

#### **6. Health Education and Promotion:**

- Initiatives promoting health education and prevention can be integrated into the healthcare system. Educating the public about healthy lifestyles, nutrition, and disease prevention contributes to better health awareness and outcomes.

#### **7. Reduced Delayed Care:**

- With universal coverage, individuals are less likely to delay seeking medical care due to concerns about affordability. Timely access to healthcare services can prevent the progression of illnesses and improve outcomes.

#### **8. Coordination of Care:**

- A single-payer system can facilitate better coordination of care among healthcare providers. Improved communication and collaboration can enhance the management of chronic conditions and complex medical cases, leading to better health outcomes.

#### **9. Mental Health Integration:**

- Integrating mental health services into the overall healthcare system addresses the importance of mental health in overall well-being. Comprehensive mental health support can positively impact mental health outcomes.

#### **10. Evidence-Based Medicine:**

- Medicare for All may emphasize evidence-based medicine, encouraging healthcare providers to follow established guidelines and practices supported by scientific evidence. This approach can lead to more effective and standardized care.

It's important to note that the effectiveness of Medicare for All in improving health outcomes depends on various factors, including the specific design of the program,



implementation strategies, and ongoing efforts to address challenges in the healthcare system. The debate around the impact of Medicare for All on health outcomes is multifaceted and involves considerations of access, quality of care, and overall public health.

### **Simplified Choice of Providers**

Medicare for All simplifies the choice of healthcare providers by streamlining the healthcare system and offering a single, comprehensive coverage plan. Here are ways in which it aims to simplify the choice of providers:

#### **1. Universal Coverage:**

- Medicare for All provides universal coverage, ensuring that everyone has access to the same set of healthcare providers. This eliminates the need to navigate complex networks associated with multiple private insurance plans.

#### **2. No Network Restrictions:**

- Unlike many private insurance plans that may have specific networks of providers, Medicare for All aims to eliminate network restrictions. Individuals can choose healthcare providers based on their preferences, without concerns about in-network or out-of-network distinctions.

#### **3. Freedom to Choose Any Doctor or Hospital:**

- With Medicare for All, individuals have the freedom to choose any doctor, specialist, or hospital that accepts the coverage. This flexibility simplifies the process of selecting healthcare providers and allows individuals to maintain existing relationships with their preferred providers.

#### **4. Consistent Benefits Across Providers:**

- Standardized benefits across the healthcare system mean that individuals receive the same level of coverage regardless of the healthcare provider they choose. This consistency simplifies the decision-making process for individuals seeking medical care.

#### **5. No Referral Requirements:**

- Some insurance plans require referrals from primary care physicians to see specialists. Medicare for All typically eliminates the need for referrals, allowing individuals to directly access the healthcare providers they need without additional administrative steps.

#### **6. Simplified Billing and Administration:**

- Medicare for All streamlines billing and administrative processes. Healthcare providers deal with a single payer, reducing the administrative burden associated with managing multiple insurance plans with varying reimbursement rules.

#### **7. Access to Primary Care:**

- The system emphasizes access to primary care, ensuring that individuals can easily find and choose a primary care physician. Access to primary care is crucial for preventive services and managing overall health.

#### **8. Continuity of Care:**

- Medicare for All supports continuity of care, allowing individuals to maintain relationships with their healthcare providers over time. This can contribute to better-coordinated and personalized care.

#### **9. Elimination of Employer-Based Networks:**

- With Medicare for All, individuals are not bound by employer-based networks. This flexibility is particularly beneficial for those who change jobs or pursue self-employment, as their choice of providers is not tied to employer-sponsored plans.

#### **10. Reduced Administrative Complexity for Providers:**

- Healthcare providers experience reduced administrative complexity by dealing with a single payer. This simplification can contribute to more efficient and streamlined interactions between providers and the healthcare system.

While the aim is to simplify the choice of providers, it's important to consider that the actual implementation and the specifics of the Medicare for All plan can vary. Additionally, ongoing efforts are needed to monitor and address any challenges that may arise in the transition to a single-payer system.

### **How Does Medicare for All Reduce Healthcare Administration Costs**

Medicare for All is designed to reduce healthcare administration costs through the implementation of a single-payer system. Here are ways in which it aims to achieve this:

#### **1. Simplified Billing and Claims Processing:**

- With Medicare for All, healthcare providers would submit claims to a single payer (the government), streamlining billing and claims processing. This simplification reduces the administrative burden associated with dealing with multiple private insurers, each with its own billing processes and requirements.

## **2. Reduced Administrative Overhead for Providers:**

- Healthcare providers would experience reduced administrative overhead as they interact with a single, standardized system. This includes fewer resources dedicated to managing billing, claims, and administrative tasks associated with multiple insurers.

## **3. Elimination of Private Insurance Administrative Costs:**

- Medicare for All aims to eliminate the administrative costs associated with managing private insurance plans. This includes marketing, underwriting, and administrative overhead specific to each private insurer, leading to overall cost savings.

## **4. Standardized Benefits and Reimbursement:**

- Standardizing benefits and reimbursement rates across the healthcare system simplifies the negotiation process for healthcare providers. This reduces the need for complex negotiations and individual contracts, contributing to administrative efficiency.

## **5. Reduced Marketing and Advertising Expenses:**

- Private insurers currently spend significant resources on marketing and advertising to attract and retain customers. With a single-payer system, the need for such marketing efforts diminishes, leading to cost savings.

## **6. Efficient Allocation of Resources:**

- Medicare for All eliminates the need for insurance companies to allocate resources for tasks such as profit margins, shareholder returns, and executive compensation. This allows for a more efficient allocation of resources directly to healthcare services.

## **7. Consolidated Administrative Functions:**

- Administrative functions related to insurance coverage, claims processing, and other tasks are consolidated under a single-payer system. This consolidation reduces redundancy, simplifies processes, and minimizes administrative complexity.

## **8. Savings on Fraud Prevention:**

- A single-payer system can result in more effective fraud prevention measures. With a unified system, it becomes easier to implement standardized fraud detection and prevention practices, reducing the resources required for individual insurers to combat fraud.

## **9. Streamlined Enrollment Processes:**

- Medicare for All typically involves simplified enrollment processes. With universal coverage and potentially automatic enrollment, the need for complex enrollment procedures and paperwork is reduced, leading to administrative efficiency.

#### **10. Lower Administrative Costs per Beneficiary:**

- The administrative costs per beneficiary can be lower in a single-payer system due to economies of scale. The efficiency gained from serving a larger population under a unified system can contribute to lower administrative costs per individual covered.

It's important to note that while proponents argue that Medicare for All can lead to significant administrative cost savings, critics raise concerns about potential challenges in implementing and managing such a system. The actual impact on administrative costs may depend on the specific design and implementation of the single-payer system.

### **Why Medicare for All is a Bad Idea**

Critics of Medicare for All typically raise several concerns and potential drawbacks, including:

#### **1. Cost:**

- Critics argue that implementing Medicare for All could result in substantial increases in government spending. Financing such a program might require higher taxes, which could impact the economy and individual incomes.

#### **2. Impact on Quality of Care:**

- Some opponents express concerns about potential reductions in the quality of healthcare. They argue that a single-payer system may lead to longer wait times for medical services and less innovation in the healthcare sector.

#### **3. Disruption to Existing Systems:**

- Transitioning to a single-payer system could involve significant disruptions to existing healthcare systems, including the private insurance industry. Critics worry about the potential negative impact on jobs and the overall economy during the transition.

#### **4. Loss of Choice:**

- Critics argue that a single-payer system may limit individuals' choices by eliminating private insurance options. Some people value the ability to

choose their healthcare plans and providers, and they fear that a government-controlled system could restrict those choices.

**5. Bureaucracy and Administrative Challenges:**

- Concerns are raised about potential bureaucratic challenges and administrative inefficiencies in a government-run healthcare system. Critics worry that a single-payer system might lead to increased red tape, delays in care, and administrative complexities.

**6. Incentives for Innovation:**

- Opponents argue that a competitive healthcare market fosters innovation and technological advancements. They express concerns that a government-dominated system might reduce the incentives for medical research and innovation.

**7. Potential Tax Burden:**

- Implementing Medicare for All could require substantial tax increases to fund the program. Critics are concerned about the potential burden on taxpayers and the economic consequences of higher taxes.

**8. Resistance to Change:**

- Some individuals may resist the idea of a major overhaul of the healthcare system, especially if they are satisfied with their current insurance arrangements. Opposition may come from those who fear uncertainty or perceive a loss of control over their healthcare choices.

**9. Variability in Healthcare Needs:**

- Critics argue that a one-size-fits-all approach may not adequately address the diverse healthcare needs of different populations and demographics. Tailoring healthcare plans to individual preferences and needs may be more challenging in a single-payer system.

**10. Political and Ideological Divisions:**

- The debate over Medicare for All is often influenced by political and ideological divisions. Opposition may stem from differing views on the role of government in healthcare and the balance between individual freedom and collective responsibility.

It's important to note that these concerns are raised by critics, and supporters of Medicare for All contend that the proposed system would address current shortcomings in the healthcare system, provide universal access to care, and reduce overall healthcare costs. The ongoing debate revolves around finding a balance that addresses

the needs of the population while considering the potential drawbacks and challenges associated with a significant healthcare system overhaul.

### **How Will Medicare for All Raise Healthcare Costs**

Some potential ways Medicare for All might increase healthcare spending:

**1. Increased Demand for Services:**

- Critics suggest that the elimination of out-of-pocket costs and the provision of universal coverage could lead to an increase in the demand for healthcare services. A surge in demand, especially for elective or non-urgent procedures, could strain the healthcare system and potentially lead to higher costs.

**2. Reduced Incentives for Cost Containment:**

- Some critics argue that a government-run, single-payer system may reduce incentives for cost containment and efficiency. In a competitive market, providers and insurers have an incentive to control costs to remain competitive. In a single-payer system, critics express concerns that such market forces may be diminished.

**3. Potential for Overutilization:**

- Critics worry that the absence of cost-sharing measures could lead to overutilization of healthcare services. Without financial barriers, individuals might be more inclined to seek unnecessary or excessive medical care, contributing to increased healthcare costs.

**4. Challenges in Controlling Drug Prices:**

- While proponents argue that a single-payer system could negotiate lower drug prices, critics express concerns about the potential challenges in effectively controlling pharmaceutical costs. Negotiating with drug manufacturers may not guarantee significant reductions in drug prices.

**5. Transition Costs:**

- Critics point out that the transition to a Medicare for All system may involve significant upfront costs. The process of implementing the new system, including changes to administrative structures, workforce training, and infrastructure development, could lead to temporary increases in overall healthcare spending.

**6. Potential for Bureaucratic Inefficiencies:**

- Concerns are raised about the potential for bureaucratic inefficiencies in a government-administered system. Critics argue that a single-payer system

might introduce administrative complexities, red tape, and delays in decision-making, which could impact overall healthcare costs.

#### **7. Impact on Provider Reimbursement:**

- Critics express concerns that a government-run system might result in lower reimbursement rates for healthcare providers. If reimbursement rates are set too low, there could be challenges in maintaining an adequate supply of healthcare professionals and facilities, potentially affecting the quality of care.

#### **8. Resistance from Healthcare Industry:**

- Some critics argue that the healthcare industry, including pharmaceutical companies, insurers, and certain healthcare providers, may resist cost containment efforts associated with a single-payer system. This resistance could pose challenges in achieving cost savings.

#### **9. Economic Impact of Tax Increases:**

- Financing Medicare for All could require substantial tax increases to fund the program. Critics argue that higher taxes could have broader economic consequences, potentially impacting economic growth, individual incomes, and job creation.

It's important to recognize that the potential impact on healthcare costs is a complex and debated aspect of Medicare for All. Proponents argue that the system could lead to overall cost savings through administrative efficiencies, negotiation of lower prices, and a focus on preventive care. The ongoing discussion revolves around finding a balance that addresses cost concerns while ensuring access to quality healthcare for all.

### **How Medicare for All Will Reduce Medicare Care Quality**

Medicare for All critics raise concerns about potential challenges that could affect the quality of care. Here are some arguments made by critics:

#### **1. Provider Reimbursement Rates:**

- Critics express concerns that Medicare for All might lead to lower reimbursement rates for healthcare providers. If reimbursement rates are set too low, there could be challenges in attracting and retaining skilled healthcare professionals. This, in turn, could potentially impact the quality of care provided.

#### **2. Reduced Incentives for Innovation:**

- Some opponents argue that a single-payer system might reduce incentives for innovation in healthcare. In a competitive market, providers and pharmaceutical companies have incentives to invest in research and

development to stay ahead. Critics worry that a government-dominated system may result in fewer innovations in medical treatments and technologies.

### **3. Impact on Access to Specialized Care:**

- Critics express concerns about the potential impact on access to specialized and advanced medical treatments. If reimbursement rates are not sufficient, healthcare providers may limit certain services or technologies, potentially affecting the availability of specialized care options.

### **4. Bureaucratic Inefficiencies:**

- Concerns are raised about the potential for bureaucratic inefficiencies in a government-run healthcare system. Critics argue that increased bureaucracy, red tape, and administrative complexities could slow down decision-making processes, potentially affecting the efficiency and quality of care.

### **5. Difficulty in Addressing Regional Variances:**

- Critics worry that a single-payer system might face challenges in addressing regional variances in healthcare needs and costs. Healthcare requirements can vary significantly across different regions, and critics argue that a one-size-fits-all approach may not adequately address these variations.

### **6. Possible Impact on Provider Networks:**

- The restructuring associated with Medicare for All could potentially impact existing provider networks. If healthcare providers face challenges in adapting to the new system, it may lead to disruptions in established patient-provider relationships, potentially affecting the continuity and quality of care.

### **7. Potential for Longer Wait Times:**

- Critics express concerns that increased demand for healthcare services, especially in the absence of cost-sharing measures, could lead to longer wait times for medical treatments. Longer wait times may impact patient outcomes and satisfaction.

### **8. Resistance to Change:**

- Some individuals and healthcare professionals may resist the significant changes associated with transitioning to a single-payer system.



Resistance to change could pose challenges in adapting to new care delivery models and may affect the overall quality of healthcare services.

It's important to note that these concerns are raised by critics, and proponents of Medicare for All argue that the system could lead to improved quality through better coordination of care, emphasis on preventive services, and standardized benefits. The debate over the impact on healthcare quality involves considerations of access, efficiency, and the overall healthcare delivery model. The effectiveness of Medicare for All in maintaining or enhancing healthcare quality would depend on the specific design and implementation of the program.

### **How Medicare for All Will Negatively Disrupt the Existing Healthcare System**

The transition to Medicare for All could potentially lead to disruptions in the existing healthcare system, and critics often raise concerns about various aspects of this transformation. While proponents argue that a single-payer system could bring about positive changes, opponents highlight potential negative impacts. Here are some concerns raised by critics:

#### **1. Job Displacement:**

- Critics worry that the shift to Medicare for All could result in job displacement, particularly in the private health insurance sector. Employees working in administrative roles related to private insurance may face challenges during the transition.

#### **2. Impact on Private Insurance Industry:**

- The implementation of Medicare for All could have a significant impact on the private health insurance industry. Critics argue that the elimination or reduction of private insurance options could disrupt the existing market and lead to economic challenges for companies in this sector.

#### **3. Transition Costs:**

- The transition to a single-payer system may involve significant upfront costs. Critics express concerns about the financial implications of the transition, including the costs associated with restructuring administrative systems, implementing new technology, and retraining healthcare professionals.

#### **4. Potential for Provider Disruptions:**

- Healthcare providers may experience disruptions during the transition, especially if there are changes in reimbursement rates or adjustments to administrative processes. Critics worry that these disruptions could impact the stability of healthcare delivery.

## **5. Resistance from Stakeholders:**

- Various stakeholders in the healthcare system, including healthcare providers, pharmaceutical companies, and insurers, may resist the changes associated with Medicare for All. Resistance from these stakeholders could pose challenges in the implementation of the new system.

## **6. Uncertainty for Healthcare Professionals:**

- Healthcare professionals may face uncertainties about the impact of Medicare for All on their practices, reimbursement rates, and overall job stability. This uncertainty could potentially affect the morale and job satisfaction of healthcare professionals.

## **7. Potential for Reduced Innovation:**

- Critics argue that a government-run system might reduce incentives for innovation in healthcare. In a competitive market, providers and pharmaceutical companies have incentives to invest in research and development. The shift to a single-payer system may impact these incentives.

## **8. Challenges in Managing Increased Demand:**

- The elimination of out-of-pocket costs and the provision of universal coverage could potentially lead to increased demand for healthcare services. Critics express concerns about the healthcare system's ability to effectively manage and respond to this surge in demand.

## **9. Regional Variations in Healthcare Needs:**

- Healthcare needs can vary significantly across different regions. Critics worry that a one-size-fits-all approach may not adequately address regional variations in healthcare requirements, potentially leading to disparities in access and quality of care.

## **10. Political and Public Resistance:**

- The implementation of Medicare for All may face political and public resistance. Some individuals may be resistant to major changes in the healthcare system, and opposition could pose challenges in achieving widespread acceptance and support.

It's important to note that these concerns are raised by critics, and proponents of Medicare for All argue that the system could address current shortcomings in the healthcare system, provide universal access to care, and reduce overall healthcare

costs. The ongoing debate involves finding a balance that considers the potential disruptions while aiming to achieve the goals of improved access and affordability.

### **How Medicare for All Will Reduce Patient Choices and Options**

Medicare for All could potentially impact patient choices and options in the healthcare system. While proponents argue that a single-payer system may enhance access to care for all individuals, critics express concerns about potential limitations on patient choices. Here are some arguments made by critics regarding how Medicare for All might reduce patient choices:

#### **1. Limitation of Private Insurance Options:**

- Medicare for All proposals often involve the elimination or significant reduction of private health insurance options. Critics argue that this could limit individuals' ability to choose from a variety of plans with different coverage options and provider networks.

#### **2. Restrictions on Provider Choices:**

- In a single-payer system, the government may negotiate reimbursement rates with healthcare providers, potentially leading to limitations on the number of providers willing to accept those rates. Critics express concerns that this could restrict patients' choices of healthcare providers.

#### **3. Standardized Benefits:**

- Medicare for All typically involves standardizing benefits across the healthcare system. While this simplifies the process, critics argue that it may limit the ability of individuals to choose plans tailored to their specific healthcare needs and preferences.

#### **4. Impact on Specialty Care Access:**

- Critics worry that the emphasis on cost containment in a single-payer system might lead to limitations in access to specialized or elective medical services. Patients may have fewer options for seeking specialized care or choosing specific healthcare facilities.

#### **5. Reduced Flexibility in Plan Selection:**

- The elimination of private insurance options could result in reduced flexibility for individuals to choose plans that align with their preferences, including factors such as deductibles, co-pays, and coverage for specific medical services.

#### **6. Potential for Longer Wait Times:**

- Increased demand for healthcare services, coupled with potential cost-containment measures, could lead to longer wait times for medical treatments. Critics argue that this may limit patients' ability to promptly access the care they need.

#### **7. Impact on Provider Networks:**

- The restructuring associated with Medicare for All might impact existing provider networks. Critics express concerns that changes in reimbursement rates or administrative processes may lead to disruptions in established patient-provider relationships.

#### **8. Limited Control Over Healthcare Decisions:**

- Critics argue that a government-administered system may limit individuals' control over their healthcare decisions. The standardization of benefits and potential restrictions on certain medical services could reduce patient autonomy in choosing the care that best suits their needs.

#### **9. Potential for Reduced Innovation in Care Models:**

- In a single-payer system, critics express concerns about potential reductions in innovation in healthcare delivery models. A more centralized system may be less conducive to experimentation with new care models and approaches.

#### **10. Resistance to Change:**

- Patients and healthcare professionals may resist major changes in the healthcare system. The transition to Medicare for All could face opposition from those who value their current insurance arrangements and fear a loss of control over their healthcare choices.

It's important to note that these concerns are raised by critics, and the actual impact on patient choices and options would depend on the specific design and implementation of Medicare for All. Proponents argue that the system could increase overall access to care and simplify the healthcare process, while opponents highlight potential trade-offs in terms of choice and flexibility.

### **Medicare for All Raises Bureaucratic and Administrative Challenges**

Here are some of the bureaucratic and administrative challenges that some critics have been raised:

#### **1. System Overhaul and Implementation:**

- The shift to a single-payer system involves a comprehensive overhaul of the existing healthcare infrastructure. Implementing new administrative

structures, technology systems, and processes on a national scale can be a complex and resource-intensive task.

**2. Transition Costs:**

- The transition to Medicare for All may come with significant upfront costs. Adapting to new administrative requirements, retraining healthcare professionals, and updating technology systems could require substantial financial investments.

**3. Workforce Training:**

- Healthcare professionals and administrative staff may require training to adapt to the new system. Training a large workforce to navigate changes in billing, claims processing, and administrative procedures is a logistical challenge.

**4. Data Integration and Standardization:**

- Achieving seamless data integration and standardization across the healthcare system is crucial for the efficient operation of a single-payer system. This involves addressing interoperability issues and ensuring that diverse healthcare entities can effectively share information.

**5. Provider Reimbursement:**

- Establishing fair and effective provider reimbursement rates is a complex task. Determining rates that are acceptable to healthcare providers while maintaining cost control requires careful negotiation and administrative coordination.

**6. Coordination with State Programs:**

- Coordination with existing state-level healthcare programs and Medicaid systems may present challenges. Ensuring a smooth transition and integration with state-specific programs requires effective collaboration and administrative planning.

**7. Claims Processing and Billing:**

- Streamlining claims processing and billing is a key aspect of administrative efficiency. The implementation of a single-payer system requires the development of standardized processes to handle claims and billing on a national scale.

**8. Technology Infrastructure:**

- Upgrading and modernizing the technology infrastructure to support a national healthcare system is a significant undertaking. Ensuring the

security, interoperability, and efficiency of healthcare information systems is a complex administrative task.

#### **9. Resistance from Stakeholders:**

- Stakeholders, including healthcare providers, insurers, and pharmaceutical companies, may resist administrative changes associated with Medicare for All. Overcoming potential resistance and ensuring buy-in from diverse stakeholders is a challenge.

#### **10. Public Education and Communication:**

- Effectively communicating changes to the public and educating individuals about the new system is crucial. Public awareness campaigns and communication strategies are necessary to inform individuals about their rights, benefits, and changes in healthcare procedures.

#### **11. Addressing Regional Variations:**

- The administrative challenges include addressing regional variations in healthcare needs, costs, and delivery. Tailoring administrative processes to accommodate these variations while maintaining national standards requires careful consideration.

#### **12. Ensuring Adequate Healthcare Workforce:**

- The transition to a single-payer system may require adjustments in the healthcare workforce to meet increased demand. Ensuring an adequate number of healthcare professionals and support staff is an administrative challenge.

It's important to note that while critics highlight these administrative challenges, proponents argue that the long-term benefits of Medicare for All, such as improved access, simplified billing, and overall cost savings, could outweigh these initial complexities. The effectiveness of addressing administrative challenges would depend on the planning, implementation, and ongoing management of the transition to a single-payer system.

### **How Medicare for All Might Reduce Healthcare Innovation**

Critics of Medicare for All express concerns that a transition to a single-payer healthcare system could potentially reduce incentives for healthcare innovation. While proponents argue that a single-payer system could lead to cost savings and increased access to care, opponents highlight potential challenges related to innovation. Here are some arguments made by critics regarding how Medicare for All might impact healthcare innovation:

#### **1. Reduced Financial Incentives for Research and Development:**

- Critics argue that a single-payer system might reduce financial incentives for pharmaceutical companies and healthcare providers to invest in research and development. In a competitive market, the potential for high profits can drive innovation. A more centralized system may alter these financial dynamics.

## **2. Risk Aversion in a Government-Run System:**

- Some critics express concerns that a government-administered healthcare system may be more risk-averse when it comes to adopting new and innovative medical technologies. Bureaucratic processes and decision-making may prioritize cost containment over embracing novel, yet potentially more expensive, treatments.

## **3. Impact on Biotechnology and Life Sciences:**

- The biotechnology and life sciences sectors heavily rely on private investments for innovation. Critics argue that a reduction in private investment resulting from changes in the market dynamics under a single-payer system could impede progress in these fields.

## **4. Potential for Limited Choice of Treatments:**

- A single-payer system may negotiate prices and coverage for medical treatments on a national level. Critics worry that centralized decision-making could limit the variety of available treatments and reduce options for patients seeking innovative therapies.

## **5. Slower Adoption of New Technologies:**

- Critics express concerns that a more centralized healthcare system may lead to slower adoption of new medical technologies. The bureaucracy associated with decision-making and budgetary constraints may result in delays in incorporating innovative treatments into standard medical practice.

## **6. Impact on Academic Medical Centers:**

- Academic medical centers often play a crucial role in medical research and innovation. Critics argue that changes in funding mechanisms and reimbursement rates under a single-payer system may affect the ability of academic institutions to invest in groundbreaking research.

## **7. Potential Brain Drain in Healthcare Professions:**

- Some critics suggest that the potential for lower earning potential and reduced financial rewards for innovation could lead to a "brain drain" in

healthcare professions. Skilled professionals may be drawn to sectors or countries that offer more favorable incentives for innovation.

#### **8. Incentives for Cost Control Over Innovation:**

- In a system that prioritizes cost control, critics argue that healthcare providers may face pressure to focus on cost-effective treatments rather than invest in cutting-edge, albeit more expensive, medical innovations.

#### **9. Impact on Startups and Small Biotech Companies:**

- Critics express concerns about the potential challenges faced by startups and small biotech companies in securing funding under a single-payer system. Reduced profitability and increased regulatory hurdles could impact the ability of these entities to contribute to innovation.

#### **10. Potential Disincentives for Entrepreneurship:**

- A shift to a single-payer system may alter the incentives for entrepreneurship in the healthcare sector. Critics worry that reduced profit margins and increased regulation may discourage entrepreneurs from entering the healthcare industry.

It's important to note that these concerns are raised by critics, and the impact on healthcare innovation would depend on various factors, including the specific design of the single-payer system, ongoing policy adjustments, and efforts to balance cost containment with support for innovation. Proponents argue that a single-payer system could foster a more efficient and equitable healthcare system, but the potential trade-offs with innovation remain a part of the broader debate.

### **How Might Medicare for All Affect Individual and Corporate Taxes**

While specific policy details can vary, here are general considerations regarding how Medicare for All might affect taxes:

#### **Individual Taxes:**

##### **1. Potential for Increased Taxes:**

- Financing a comprehensive healthcare system like Medicare for All would likely require additional government revenue. Proponents often discuss funding sources such as progressive income taxes, payroll taxes, and other measures. Consequently, some individuals, particularly those with higher incomes, could see an increase in their tax burden.

##### **2. Offset by Elimination of Premiums and Out-of-Pocket Costs:**

- Supporters argue that while taxes may increase, individuals and families would no longer be required to pay premiums, deductibles, or copayments



associated with private health insurance. This could offset the impact of higher taxes, especially for those who currently face significant healthcare-related costs.

### **3. Progressive Taxation Approach:**

- Proponents often advocate for a progressive taxation approach, where higher-income individuals contribute a larger percentage of their income toward funding Medicare for All. This is seen as a way to distribute the financial burden more equitably.

### **4. Potential for Savings:**

- Supporters argue that the overall cost of healthcare for individuals and families would decrease under Medicare for All. While taxes may go up, the elimination of private insurance premiums and reduced out-of-pocket expenses could result in net savings for many households.

## **Corporate Taxes:**

### **1. Impact on Employers:**

- Under Medicare for All, employers may see changes in their financial responsibilities related to employee healthcare. While some proponents argue that businesses could experience cost savings by no longer providing private health insurance plans, critics suggest that increased corporate taxes may offset these potential savings.

### **2. Potential for Employer Payroll Taxes:**

- One proposed funding mechanism for Medicare for All involves implementing payroll taxes on employers. This could be a way to shift the financial responsibility for healthcare from businesses to the broader tax base.

### **3. Reduced Administrative Costs for Employers:**

- Supporters argue that employers could benefit from reduced administrative costs associated with managing private health insurance plans for their employees. A single-payer system may simplify administrative processes for businesses.

### **4. Economic Impact:**

- Critics express concerns that increased corporate taxes could have broader economic consequences, potentially affecting job creation, business investment, and economic growth. Proponents argue that the overall reduction in healthcare costs could positively impact the economy.

## **5. Potential for Redistribution of Costs:**

- The shift to Medicare for All could redistribute the costs of healthcare from employers to the government. This could lead to changes in corporate financial strategies and impact industries differently based on their current healthcare spending.

## **6. Sector-Specific Considerations:**

- Different industries may be affected in varying ways. Some sectors that currently provide generous health benefits may face higher taxes, while others with lower healthcare costs may benefit from a more level playing field.

It's important to note that the specific impact on taxes would depend on the details of the Medicare for All proposal, including the chosen funding mechanisms and how the transition is structured. The debate over the financial aspects of Medicare for All involves considerations of both the costs and potential savings for individuals, employers, and the government.

## **Can Medicare for All Address the Healthcare Needs of Americans?**

While proponents argue that a single-payer system can provide more equitable access to care, critics raise concerns about potential challenges in addressing the diverse healthcare needs of the population. Here are considerations on both sides of the debate:

### **Proponents' Arguments:**

#### **1. Universal Access to Basic Healthcare:**

- Proponents contend that Medicare for All aims to ensure universal access to basic healthcare services for all Americans. By providing a baseline level of coverage, the system seeks to address fundamental healthcare needs across the population.

#### **2. Standardized Benefits:**

- Medicare for All proposals often include standardized benefits, eliminating variations in coverage between different insurance plans. This standardization is intended to ensure that individuals receive consistent and comprehensive healthcare services regardless of their specific circumstances.

#### **3. Preventive Care Emphasis:**

- Supporters argue that a single-payer system can emphasize preventive care, addressing health needs at an earlier stage and potentially reducing

the overall burden on the healthcare system. By focusing on preventive measures, the system aims to improve population health.

**4. Elimination of Disparities in Access:**

- Proponents suggest that Medicare for All can help eliminate disparities in access to healthcare. By providing coverage to all individuals, regardless of factors such as income or employment status, the system seeks to reduce variations in healthcare access.

**5. Efficient Resource Allocation:**

- A single-payer system could streamline administrative processes and resource allocation, ensuring that healthcare resources are distributed more efficiently. This efficiency may contribute to a more equitable distribution of healthcare services.

**Critics' Concerns:**

**1. One-Size-Fits-All Approach:**

- Critics argue that a single-payer system may adopt a one-size-fits-all approach that does not adequately address the diverse healthcare needs of individuals and communities. Different populations may have unique health requirements that may not be fully accommodated.

**2. Regional Variations:**

- Healthcare needs can vary significantly across regions due to factors such as demographics, prevalence of certain health conditions, and local healthcare infrastructure. Critics express concerns that a nationalized system may struggle to address these regional variations effectively.

**3. Limited Choice of Providers:**

- Critics worry that a single-payer system might limit individuals' choices of healthcare providers. While proponents argue for cost containment, critics express concerns that reduced provider options could impact the ability of individuals to access specialized or preferred care.

**4. Inadequate Addressing of Specific Conditions:**

- Some critics suggest that certain specialized or rare health conditions may not receive sufficient attention or resources in a more centralized healthcare system. Tailoring care to specific conditions or demographic groups could be challenging.

**5. Resistance to Innovations in Care Models:**

- Critics argue that a government-dominated system may be less conducive to experimenting with innovative care models and approaches. The potential for bureaucratic hurdles and resistance to change could impede the adoption of new and effective healthcare solutions.

#### **6. Potential for Longer Wait Times:**

- Increased demand for healthcare services, combined with potential resource constraints, could lead to longer wait times for medical treatments. Critics express concerns that longer wait times may negatively impact patient outcomes.

The debate over whether Medicare for All can effectively address variations in healthcare needs revolves around finding a balance between providing universal access and accommodating the diverse health requirements of the population. The effectiveness of the system would depend on the specific design, implementation, and ongoing adjustments made to address these considerations.

#### **How Will Our Divisive Political Environment Affect Medicare for All?**

The divisive political environment in the United States has a significant impact on discussions and potential implementations of policies, including Medicare for All. The perspectives and stances of political actors, policymakers, and the general public contribute to the challenges and opportunities for advancing such proposals. Here are key considerations regarding how the divisive political environment may affect Medicare for All:

#### **Challenges:**

##### **1. Partisan Divisions:**

- Healthcare policy, including proposals like Medicare for All, has become deeply polarized along party lines. Divisions between Democrats and Republicans can hinder bipartisan support for comprehensive healthcare reform, making it challenging to pass legislation.

##### **2. Ideological Differences:**

- Ideological differences regarding the role of government in healthcare and the balance between individual choice and collective responsibility contribute to the political divide. Finding common ground on the fundamental principles of healthcare policy is a significant hurdle.

##### **3. Interest Group Opposition:**

- Powerful interest groups, including those representing insurance companies, pharmaceuticals, and healthcare providers, may actively oppose or lobby against significant changes to the healthcare system. The

influence of these groups can create obstacles for transformative healthcare proposals.

**4. Public Opinion Variability:**

- Public opinion on healthcare reform, including Medicare for All, varies across political affiliations. Bridging the gap in public support and addressing concerns from different ideological perspectives is a complex task.

**5. Fiscal Concerns:**

- Discussions around how to fund Medicare for All often involve debates on tax increases and government spending. Fiscal conservatives may express concerns about the potential economic impact and sustainability of such a large-scale healthcare program.

**Opportunities:**

**1. Public Demand for Change:**

- Despite political divisions, there is public demand for improvements in the healthcare system. The impact of the COVID-19 pandemic has further highlighted the importance of accessible and affordable healthcare. Public pressure may create opportunities for policymakers to revisit healthcare reform proposals.

**2. Evolving Policy Discourse:**

- The political landscape is dynamic, and policy priorities can evolve over time. Shifting public attitudes, changes in leadership, and external factors may contribute to a reevaluation of healthcare policies, potentially creating openings for new proposals.

**3. State-Level Initiatives:**

- Some states have explored or implemented their own healthcare reforms. State-level initiatives, even if limited in scope, could serve as test cases for certain aspects of healthcare reform and inform national discussions.

**4. Incremental Changes:**

- Given the challenges of passing comprehensive reform, there may be opportunities for incremental changes to the healthcare system. Policymakers may explore targeted measures that address specific issues, gradually building towards broader reforms.

**5. Coalitions and Compromise:**

- Building coalitions and finding areas of compromise can be crucial for advancing healthcare policy. While comprehensive reform may face hurdles, targeted measures that garner bipartisan support could lay the groundwork for broader changes.

## 6. External Events Shaping Priorities:

- Unforeseen events, such as public health crises or economic challenges, can reshape political priorities. External factors may create windows of opportunity for reexamining and reforming healthcare policy.

The future of Medicare for All is intricately tied to the dynamics of the political environment. Achieving consensus and overcoming political divisions will require strategic policymaking, effective communication, and a willingness to find common ground on the complex issues surrounding healthcare reform. The interplay of political, economic, and societal factors will continue to shape the trajectory of healthcare policy discussions in the United States.

### Rationing and treatment rejection in Medicare

Medicare typically does not cover certain services, treatments, or items that are considered elective, cosmetic, or not medically necessary. Here are some examples:

1. **Cosmetic Surgery:** Procedures performed solely for cosmetic purposes, such as facelifts, breast augmentation, and liposuction, are generally not covered.
2. **Acupuncture:** While some private Medicare Advantage plans may offer coverage for acupuncture, traditional Medicare typically does not cover this service.
3. **Long-Term Care:** Medicare does not cover most long-term care services, including assisted living facilities, custodial care, and nursing home care.
4. **Dental Care:** Routine dental care, such as cleanings, fillings, and extractions, is generally not covered by Medicare. Some Medicare Advantage plans may offer limited dental coverage.
5. **Vision Care:** Routine eye exams, eyeglasses, and contact lenses are typically not covered by Medicare, though there are exceptions for certain eye diseases and conditions.
6. **Hearing Aids:** Medicare does not cover hearing aids or routine hearing exams, though some Medicare Advantage plans may offer coverage for these services.
7. **Foot Care:** Routine foot care, including podiatry services, is generally not covered unless it's related to a medical condition such as diabetes.

8. **Acupressure, Massage Therapy, and Chiropractic Services:** These services are typically not covered by traditional Medicare, though coverage may be available through certain Medicare Advantage plans.
9. **Experimental or Investigational Treatments:** Medicare does not cover treatments that are considered experimental or not proven to be effective.

### **How does Medicare decide which services to fund and which to reject?**

Medicare determines which services to cover based on several factors, including:

1. **Medical Necessity:** Medicare covers services and treatments that are deemed medically necessary to diagnose or treat a medical condition. This means the service must be considered reasonable and necessary for the diagnosis or treatment of an illness or injury.
2. **Evidence-Based Medicine:** Medicare evaluates medical treatments and services based on scientific evidence of their effectiveness. Services that have been proven through clinical studies to improve health outcomes or quality of life are more likely to be covered.
3. **National Coverage Determinations (NCDs):** The Centers for Medicare & Medicaid Services (CMS) establishes National Coverage Determinations (NCDs) to specify whether Medicare will cover a particular item or service. These determinations are based on factors such as clinical evidence, expert opinions, and public comments.
4. **Local Coverage Determinations (LCDs):** Medicare Administrative Contractors (MACs) develop Local Coverage Determinations (LCDs) that provide additional guidance on coverage for specific services within their geographic jurisdictions. LCDs may vary by region and can provide more detailed criteria for coverage.
5. **Cost-Effectiveness:** Medicare considers the cost-effectiveness of services when making coverage decisions. While Medicare aims to provide access to necessary healthcare services, it also seeks to manage costs and ensure the sustainability of the program.
6. **Statutory Exclusions:** Some services are explicitly excluded from Medicare coverage by law. For example, Medicare cannot cover most dental care, eyeglasses, and hearing aids under the original Medicare program.
7. **Public Input and Stakeholder Feedback:** Medicare may consider input from healthcare providers, beneficiary advocacy groups, medical societies, and other stakeholders when making coverage decisions. Public comments and feedback are often solicited during the decision-making process for NCDs and LCDs.

Overall, Medicare aims to strike a balance between providing access to essential healthcare services while managing costs and ensuring the quality and effectiveness of

care. Coverage decisions are based on a combination of medical evidence, clinical judgment, statutory requirements, and input from stakeholders.

Medicare's coverage policies evolve over time, and they may update their coverage decisions periodically to reflect advancements in medical technology and changes in clinical evidence. However, there are certain technology-based treatments or services that Medicare historically has been cautious about covering due to various factors such as limited evidence of effectiveness, high costs, or ongoing research. Here are some examples:

1. **Virtual Reality Therapy:** While virtual reality (VR) therapy shows promise in various healthcare applications, including pain management and mental health treatment, Medicare's coverage for VR therapy may be limited due to a lack of extensive clinical evidence supporting its effectiveness in specific medical conditions.
2. **Telehealth Services:** While Medicare has expanded coverage for telehealth services in response to the COVID-19 pandemic, coverage for certain telehealth modalities and services may still be limited. For example, coverage for remote patient monitoring devices or certain telehealth platforms may vary based on specific criteria.
3. **Genetic Testing and Personalized Medicine:** Medicare may cover certain genetic tests for specific medical conditions or hereditary diseases. However, coverage for more comprehensive genetic testing panels or personalized medicine approaches may be limited due to concerns about cost-effectiveness and the need for additional evidence of clinical utility.
4. **Robotic Surgery:** While robotic-assisted surgical procedures have become more common in recent years, Medicare's coverage for robotic surgery may be limited to specific indications and procedures. Coverage decisions may depend on factors such as the availability of clinical evidence demonstrating improved outcomes compared to traditional surgical approaches.
5. **Stem Cell Therapy:** Medicare's coverage for stem cell therapy may be limited due to concerns about the safety, efficacy, and regulation of stem cell treatments. Coverage decisions may vary depending on whether the stem cell therapy is considered standard of care for a specific medical condition or is part of an approved clinical trial.
6. **Artificial Intelligence (AI) Applications:** Medicare's coverage for AI-based diagnostic tools or decision support systems may be limited to specific applications with robust clinical evidence supporting their accuracy and clinical utility. Coverage decisions may also depend on regulatory approval and compliance with Medicare billing requirements.



It's essential to note that Medicare's coverage decisions are subject to change, and coverage for specific technology-based treatments or services may evolve over time as new evidence emerges and healthcare practices evolve. Individuals should consult with healthcare providers and Medicare representatives to understand the current coverage policies and options available to them.

Medicare aims to provide coverage for medically necessary treatments that are proven to be effective and appropriate for the patient's condition. However, there may be instances where Medicare does not cover certain treatments that could be considered potentially life-saving. Here are some reasons why this might occur:

1. **Lack of Sufficient Evidence:** Medicare typically requires strong evidence of a treatment's effectiveness before providing coverage. If there is insufficient clinical evidence to support the effectiveness of a particular treatment for a specific condition, Medicare may not cover it, even if it has the potential to be life-saving.
2. **Experimental or Investigational Treatments:** Medicare generally does not cover treatments that are considered experimental or investigational, meaning they have not yet been proven through rigorous clinical trials to be safe and effective for the intended use.
3. **Off-Label Use of Drugs:** Medicare may not cover the off-label use of drugs, meaning the use of a medication for a condition or indication not approved by the Food and Drug Administration (FDA). While off-label use is common in medical practice, Medicare may only cover medications for FDA-approved indications.
4. **Cost Considerations:** In some cases, the cost of a treatment may be prohibitively high, and Medicare may determine that the cost outweighs the potential benefit, especially if there are other, more cost-effective treatments available.
5. **Statutory Exclusions:** Certain treatments or services may be explicitly excluded from Medicare coverage by law. For example, Medicare cannot cover most dental care, hearing aids, or cosmetic surgery under the original Medicare program.

It's important to note that Medicare's coverage policies may vary depending on factors such as the specific medical condition, the individual's health status, and the availability of alternative treatments. In some cases, individuals may have the option to appeal Medicare's coverage decision or seek coverage through other avenues, such as clinical trials, private insurance, or financial assistance programs.

Medicare typically covers a wide range of cancer treatments that are considered medically necessary and proven to be effective. However, there may be certain cancer treatments or related services that Medicare does not cover or has limitations on coverage. Here are some examples:

1. **Off-Label Use of Drugs:** Medicare may not cover the off-label use of drugs for cancer treatment, meaning the use of a medication for a purpose other than its FDA-approved indication. Coverage for off-label use is evaluated on a case-by-case basis and may depend on the availability of strong clinical evidence supporting the treatment's effectiveness.
2. **Experimental or Investigational Treatments:** Medicare generally does not cover treatments that are considered experimental or investigational for cancer, meaning they have not yet been proven through rigorous clinical trials to be safe and effective. Coverage for experimental treatments may be available through clinical trials or other research studies but is not typically covered by Medicare outside of these contexts.
3. **Alternative or Complementary Therapies:** Medicare typically does not cover alternative or complementary therapies for cancer treatment that have not been proven to be effective through scientific research. This may include treatments such as acupuncture, herbal remedies, and dietary supplements.
4. **High-Cost Drugs or Therapies:** Medicare may have limitations on coverage for certain high-cost cancer drugs or therapies, particularly if the cost exceeds Medicare's established payment limits or if the treatment is considered to be of limited clinical benefit.
5. **Non-Medically Necessary Services:** Medicare generally does not cover cancer treatments that are not considered medically necessary or appropriate for the patient's condition. This may include treatments that are considered to be primarily palliative or supportive in nature and do not directly target the underlying cancer.

It's important for individuals with cancer and their caregivers to work closely with healthcare providers and Medicare representatives to understand the coverage options available and any potential limitations or restrictions on coverage for specific treatments. In some cases, individuals may have the option to appeal Medicare's coverage decision or explore alternative sources of coverage or financial assistance for cancer treatment costs.

### **Some coronary treatments that Medicare rejects as an example**

Medicare generally provides coverage for a wide range of treatments for coronary artery disease and related conditions, particularly those that are considered medically necessary and proven to be effective. However, there may be certain coronary treatments or related services that Medicare does not cover or has limitations on coverage. Here are some examples:

1. **Elective Angioplasty or Stenting:** Medicare may not cover elective coronary angioplasty or stenting procedures if they are not deemed medically necessary.

Coverage is typically provided for these procedures when they are performed to alleviate symptoms of coronary artery disease or to treat acute coronary syndromes.

2. **High-Risk or Investigational Procedures:** Medicare may not cover certain high-risk or investigational coronary procedures that have not been proven through rigorous clinical trials to be safe and effective. This may include emerging techniques or devices for treating coronary artery disease that are still undergoing evaluation.
3. **Preventive Screening Tests:** Medicare generally does not cover routine screening tests for coronary artery disease in asymptomatic individuals who do not have risk factors. Coverage for screening tests such as coronary calcium scoring or coronary CT angiography may be limited to certain high-risk populations or individuals with specific indications.
4. **Alternative or Complementary Therapies:** Medicare typically does not cover alternative or complementary therapies for coronary artery disease that have not been proven to be effective through scientific research. This may include treatments such as chelation therapy, acupuncture, or herbal remedies.
5. **Non-Medically Necessary Services:** Medicare generally does not cover coronary treatments or procedures that are not considered medically necessary or appropriate for the patient's condition. This may include treatments that are considered to be primarily preventive in nature or that do not directly address the underlying coronary artery disease.

It's important for individuals with coronary artery disease and their healthcare providers to carefully review Medicare's coverage policies and guidelines to understand the options available and any potential limitations or restrictions on coverage for specific treatments. In some cases, individuals may have the option to appeal Medicare's coverage decision or explore alternative sources of coverage or financial assistance for coronary treatment costs.

### **How Medicare's treatment approval / rejection protocols compare to NICE's protocols in the UK's National Health Service**

Medicare in the United States and the National Health Service (NHS) in the United Kingdom operate under different healthcare systems and have different protocols for determining coverage and treatment approval. While both systems aim to provide access to high-quality healthcare services, there are some key differences in their approaches to treatment approval and rejection:

1. **Medicare in the United States:**
  - Medicare is a federal health insurance program primarily for people aged 65 and older, as well as some younger individuals with disabilities.

- Coverage decisions are made by the Centers for Medicare & Medicaid Services (CMS), which sets coverage policies based on factors such as medical necessity, clinical evidence, cost-effectiveness, and statutory requirements.
- Medicare coverage decisions may vary by region and may be influenced by input from stakeholders, including healthcare providers, beneficiary advocacy groups, and medical societies.
- Medicare generally provides coverage for treatments that are deemed medically necessary and proven to be effective, although coverage for certain treatments may be limited or subject to specific criteria.

## **2. National Institute for Health and Care Excellence (NICE) in the United Kingdom:**

- NICE is an independent organization responsible for providing national guidance and recommendations on health technologies and clinical practices in England and Wales.
- NICE evaluates the clinical and cost-effectiveness of treatments and interventions through its technology appraisal and clinical guideline programs.
- NICE assesses the evidence base for treatments and issues guidance on whether they should be recommended for use within the NHS based on considerations such as clinical effectiveness, cost-effectiveness, and impact on patient outcomes.
- NICE's recommendations are influential in determining access to treatments within the NHS, and healthcare providers are generally expected to follow NICE guidance in their clinical practice.

In terms of stringency, it's challenging to make a direct comparison between Medicare's coverage protocols and NICE's protocols, as they operate within different healthcare systems with unique priorities and constraints. Both systems strive to ensure that patients have access to effective and appropriate treatments while managing costs and promoting high-quality care. However, the specific criteria and processes for treatment approval and rejection may differ between the two systems based on their respective healthcare delivery models and organizational structures.

### **A brief description of NICE's rationing protocol**

The National Institute for Health and Care Excellence (NICE) in the United Kingdom does not operate under a formal "rationing" protocol per se, but it does employ a rigorous system to assess the clinical and cost-effectiveness of healthcare interventions. Here's an overview of NICE's approach:

1. **Health Technology Assessment (HTA):** NICE conducts health technology assessments to evaluate the clinical and cost-effectiveness of healthcare interventions, including drugs, medical devices, procedures, and public health programs. These assessments are based on systematic reviews of available evidence, economic analyses, and consultation with clinical experts.
2. **Evidence Review and Appraisal:** NICE reviews the available evidence on the effectiveness and safety of the intervention in question, considering data from clinical trials, observational studies, and other sources. The quality and reliability of the evidence are carefully assessed to ensure robustness.
3. **Cost-Effectiveness Analysis:** NICE evaluates the cost-effectiveness of the intervention by comparing its clinical benefits with its costs. Economic analyses are conducted to assess factors such as the cost per quality-adjusted life year (QALY) gained. NICE uses a cost-effectiveness threshold to determine whether an intervention represents value for money within the context of the NHS budget.
4. **Guidance Development:** Based on its assessment, NICE develops guidance recommending whether the intervention should be adopted within the NHS. This guidance is published in the form of technology appraisals, clinical guidelines, diagnostics guidance, and public health guidance. Recommendations may include advice on which patient groups are most likely to benefit from the intervention, dosage and administration details, and any conditions or criteria for use.
5. **Consultation and Stakeholder Involvement:** NICE involves various stakeholders, including patient representatives, healthcare professionals, industry stakeholders, and the public, throughout the guidance development process. Stakeholder input is sought during scoping, evidence review, and consultation phases to ensure that multiple perspectives are considered.
6. **Implementation:** NICE guidance is intended to inform clinical practice and decision-making within the NHS. While NICE recommendations are not legally binding, healthcare providers and commissioners are generally expected to adhere to NICE guidance in their decision-making processes, subject to local variation and individual patient circumstances.

Overall, NICE's approach aims to ensure that NHS resources are allocated efficiently and that patients have access to effective, evidence-based healthcare interventions that represent value for money. While difficult decisions may arise regarding the funding and provision of certain interventions, NICE's transparent and evidence-based approach seeks to balance clinical need, patient benefit, and affordability within the context of finite healthcare resources.

### **NICE uses QALYs to determine treatment cost effectiveness**

The National Institute for Health and Care Excellence (NICE) in the United Kingdom uses Quality-Adjusted Life Years (QALYs) as a measure of health outcomes to assess the cost-effectiveness of healthcare interventions. QALYs combine both the quantity and quality of life gained from a healthcare intervention into a single measure. Here's how NICE uses QALYs to determine treatment cost-effectiveness:

7. **Definition of QALY:** A QALY is a measure of health outcome that combines both the length of life (quantity) and the quality of life (utility or health-related quality of life) experienced during that time. One QALY is equivalent to one year of life lived in perfect health. Health states considered less desirable than perfect health have QALY values less than 1.
8. **Utility Values:** Utility values represent the quality of life associated with different health states. These values are typically obtained through preference-based measures such as the EuroQol 5-Dimension (EQ-5D) questionnaire, which assesses health-related quality of life across five dimensions (mobility, self-care, usual activities, pain/discomfort, and anxiety/depression). Utility values range from 0 (representing death) to 1 (representing perfect health), with negative values indicating health states worse than death.
9. **Assessment of Health Benefits:** When evaluating a healthcare intervention, NICE considers the impact of the intervention on patients' health-related quality of life over time. This is done by estimating the number of QALYs gained or lost as a result of the intervention compared to the relevant comparator or standard of care.
10. **Cost per QALY:** NICE assesses the cost-effectiveness of a healthcare intervention by calculating the incremental cost per QALY gained compared to the next best alternative or comparator. This involves comparing the additional costs of the intervention (e.g., drug costs, administration costs, monitoring costs) with the additional health benefits in terms of QALYs gained. Interventions with lower incremental cost per QALY gained are generally considered more cost-effective.
11. **Cost-Effectiveness Threshold:** NICE uses a cost-effectiveness threshold to determine whether an intervention represents value for money within the context of the National Health Service (NHS) budget. This threshold represents the maximum amount that the NHS is willing to pay for each additional QALY gained. While the exact threshold may vary over time, it is typically set at around £20,000 to £30,000 per QALY gained.
12. **Decision Making:** Based on its assessment of cost-effectiveness, NICE provides recommendations on whether the intervention should be funded and adopted within the NHS. Interventions with incremental cost-effectiveness ratios below the cost-effectiveness threshold are generally recommended for adoption, while

those above the threshold may face greater scrutiny or may not be recommended for routine use.

Overall, QALYs provide a standardized and quantitative measure of health outcomes that allows NICE to compare the costs and benefits of different healthcare interventions in a consistent and transparent manner. By considering both the costs and health benefits of interventions in terms of QALYs, NICE aims to ensure that NHS resources are allocated efficiently and that patients have access to cost-effective treatments that provide meaningful improvements in health-related quality of life.

### **What is the EuroQol 5-Dimension (EQ-5D) questionnaire?**

The EuroQol 5-Dimension (EQ-5D) questionnaire is a widely used instrument for measuring health-related quality of life (HRQoL) across five dimensions. It is a standardized, generic measure designed to provide a simple, generic measure of health for clinical and economic appraisal. The EQ-5D is used in a variety of healthcare settings, including clinical trials, health technology assessments, and population health surveys. Here's an overview of the EQ-5D questionnaire:

1. **Dimensions:** The EQ-5D assesses health-related quality of life across five dimensions:
  - Mobility: Assessing the respondent's ability to move around.
  - Self-care: Assessing the respondent's ability to perform self-care activities (e.g., bathing, dressing).
  - Usual activities: Assessing the respondent's ability to perform usual activities (e.g., work, study, housework, family or leisure activities).
  - Pain/discomfort: Assessing the respondent's level of pain or discomfort.
  - Anxiety/depression: Assessing the respondent's level of anxiety or depression.
2. **Levels:** Within each dimension, respondents indicate their current health state by selecting one of three levels:
  - No problems
  - Some problems
  - Extreme problems
3. **Scoring:** The EQ-5D descriptive system can be converted into a health utility index by applying country-specific value sets. These value sets are based on preferences elicited from general population surveys using methods such as time trade-off (TTO) or visual analogue scale (VAS). Health utility index scores typically range from 0 (representing death or a health state equivalent to death)

to 1 (representing full health or perfect health). Negative scores are possible, indicating health states considered worse than death.

4. **EQ VAS:** In addition to the EQ-5D descriptive system, the EQ-5D questionnaire includes a visual analogue scale (EQ VAS) where respondents rate their current health status on a vertical scale ranging from 0 (worst imaginable health state) to 100 (best imaginable health state).
5. **Versions:** The EQ-5D questionnaire is available in several versions, including the EQ-5D-3L (3-level version) and the EQ-5D-5L (5-level version), which offers greater sensitivity by providing five response levels for each dimension.

The EQ-5D questionnaire is used to assess and quantify health-related quality of life from the patient's perspective, allowing for comparisons of health outcomes across different populations, interventions, and healthcare settings. Its simplicity and ease of administration make it a valuable tool for health outcome measurement in both research and clinical practice.

### **QALY value in US dollars, 2024**

The value of a Quality-Adjusted Life Year (QALY) in US dollars in 2024 is not a fixed or standard figure. The concept of a QALY is used primarily in health economics and healthcare decision-making to assess the cost-effectiveness of medical interventions. The value of a QALY can vary depending on several factors, including the perspective of the analysis, the healthcare system context, the specific intervention being evaluated, and the willingness-to-pay threshold used by decision-makers.

In the United States, there isn't a universally accepted value for a QALY as there is in some other countries with government-funded healthcare systems. Instead, decision-makers such as insurers, healthcare providers, and policymakers may use different methods or criteria to determine the value of a QALY within their specific contexts.

Some economic evaluations in the US healthcare system may use a willingness-to-pay threshold, which represents the maximum amount that society is willing to pay for a QALY gained. This threshold can vary but is often cited to be in the range of \$50,000 to \$150,000 per QALY gained. However, it's important to note that these values are not fixed and can vary depending on the context and the preferences of decision-makers.

In summary, the value of a QALY in US dollars in 2024 is not a set figure and would depend on the specific analysis, context, and willingness-to-pay threshold used in the evaluation.

### **How the dollar value of 1 QALY is determined**

The dollar value of 1 Quality-Adjusted Life Year (QALY) is not determined based on an individual's income or earnings. Instead, it is typically assessed in health economics



studies and healthcare decision-making processes using a willingness-to-pay (WTP) threshold or cost-effectiveness threshold.

The willingness-to-pay threshold represents the maximum amount that society is willing to pay for one additional QALY gained from a healthcare intervention. This threshold is often determined based on various factors, including societal preferences, budget constraints, opportunity costs, and the value of health improvements relative to other goods and services.

Decision-makers such as government agencies, insurers, and healthcare providers may use different methods to establish a willingness-to-pay threshold within their specific contexts. Some countries with government-funded healthcare systems have established explicit thresholds for cost-effectiveness analysis. For example, in the United Kingdom, the National Institute for Health and Care Excellence (NICE) has historically used a threshold range of £20,000 to £30,000 per QALY gained as a reference point for assessing the cost-effectiveness of healthcare interventions within the National Health Service (NHS).

In the United States, willingness-to-pay thresholds may vary depending on the payer, the specific healthcare intervention being evaluated, and other contextual factors. While there is no universally accepted threshold, some studies have suggested thresholds in the range of \$50,000 to \$150,000 per QALY gained based on empirical analyses and surveys of societal preferences.

It's important to note that the dollar value of a QALY is not directly tied to an individual's income or earnings. Instead, it reflects societal preferences and the value placed on health improvements relative to other goods and services. Therefore, 1 QALY gained from a healthcare intervention would generally be considered equally valuable regardless of the individual's income level.

The difference in estimated values of a Quality-Adjusted Life Year (QALY) between Harvard Professor David Cutler's estimation in 2003, in his book *Your Money or Your Life*, and current estimations can be attributed to several factors:

1. **Methodological Differences:** Different researchers may use different methods and assumptions to estimate the value of a QALY, leading to variation in results. David Cutler's estimation in 2003 may have relied on different data sources, economic models, or approaches compared to more recent estimations.
2. **Changes in Healthcare Costs:** Healthcare costs and the cost-effectiveness of medical interventions can change over time due to factors such as advances in medical technology, changes in treatment patterns, and shifts in healthcare delivery models. These changes can affect the perceived value of health improvements and may contribute to differences in estimated values of a QALY over time.

3. **Changes in Societal Preferences:** Societal preferences regarding the value of health improvements and the allocation of healthcare resources may evolve over time. Attitudes towards healthcare spending, willingness to pay for health benefits, and ethical considerations can influence the perceived value of a QALY and may vary across different time periods and contexts.
4. **Inflation Adjustments:** While inflation is a factor to consider when comparing economic values over time, it's important to note that the value of a QALY is not solely determined by inflation. Changes in healthcare costs, healthcare utilization patterns, and societal preferences can also influence the estimated value of a QALY, independent of inflation.
5. **Data Availability and Quality:** The availability and quality of data used to estimate the value of a QALY may have improved over time, leading to more accurate and reliable estimates in recent years. Advances in data collection methods, health outcomes research, and economic modeling techniques can contribute to more robust estimations of the value of health outcomes.

Overall, the discrepancy in estimated values of a QALY between David Cutler's estimation in 2003 and current estimations may reflect differences in methodology, changes in healthcare costs and societal preferences, and improvements in data availability and quality over time. It's essential to interpret estimates of the value of a QALY within the specific context of the analysis and to consider the underlying assumptions and limitations of the methods used to generate these estimates.

Quality-Adjusted Life Years (QALYs) have been widely used in health economics and healthcare decision-making for several decades, and the theory and methodology behind QALYs are generally accepted within the healthcare research and administration community. Here are some reasons why QALYs are widely accepted:

1. **Standardized Measure:** QALYs provide a standardized and quantitative measure of health outcomes that allows for comparisons across different health interventions, populations, and healthcare settings. This makes QALYs a valuable tool for assessing the effectiveness and value of healthcare interventions in a consistent and transparent manner.
2. **Incorporation of Patient Preferences:** QALYs incorporate patient preferences for health states, as measured through preference-based instruments such as the EuroQol 5-Dimension (EQ-5D) questionnaire or the Health Utilities Index (HUI). By capturing individuals' subjective valuations of health-related quality of life, QALYs provide a patient-centered perspective on health outcomes.
3. **Cost-Effectiveness Analysis:** QALYs are commonly used in cost-effectiveness analysis to assess the value for money of healthcare interventions. By comparing the costs of interventions with the health benefits in terms of QALYs gained,

decision-makers can prioritize resource allocation and identify interventions that offer the greatest health improvements for a given budget.

4. **Regulatory and Reimbursement Decisions:** QALYs are used by government agencies, insurers, and healthcare providers to inform regulatory decisions, reimbursement policies, and coverage determinations. For example, agencies such as the National Institute for Health and Care Excellence (NICE) in the United Kingdom use QALYs to assess the cost-effectiveness of healthcare interventions and provide guidance on their adoption within the healthcare system.
5. **Transparency and Accountability:** QALYs promote transparency and accountability in healthcare decision-making by providing a clear and quantifiable measure of health outcomes. By explicitly considering both the costs and benefits of healthcare interventions in terms of QALYs, decision-makers can justify resource allocation decisions and prioritize interventions that offer the greatest health gains per dollar spent.

While QALYs are widely accepted and commonly used in healthcare research and administration, it's important to acknowledge that they are not without limitations. Criticisms of QALYs include concerns about equity, cultural differences in valuing health states, and challenges in measuring complex health outcomes comprehensively. Despite these limitations, QALYs remain a valuable tool for evaluating health outcomes and informing resource allocation decisions in healthcare.

### **QALYs and Medicare for All**

The inclusion of Quality-Adjusted Life Years (QALYs) in a Medicare for All system would depend on various factors, including the specific design of the healthcare system, policy priorities, and political considerations. Here are some points to consider:

1. **Cost-Effectiveness Analysis:** Medicare for All would likely aim to provide comprehensive healthcare coverage to all residents of the United States. While cost containment measures would be necessary to ensure the sustainability of the healthcare system, the extent to which cost-effectiveness analysis, including the use of QALYs, would be incorporated into decision-making could vary.
2. **Political Considerations:** The use of QALYs in healthcare decision-making is a topic of debate, and opinions on their appropriateness and ethical implications vary. Some stakeholders argue that QALYs can help ensure efficient resource allocation and promote value-based healthcare delivery, while others raise concerns about equity, fairness, and the potential for discriminatory practices.
3. **Patient-Centered Care:** Medicare for All would likely prioritize patient-centered care and equitable access to healthcare services. While QALYs provide a standardized measure of health outcomes, they may not fully capture individual

preferences, values, and priorities. As such, there may be a need to balance the use of QALYs with other considerations, such as patient-reported outcomes and shared decision-making.

4. **Regulatory and Reimbursement Policies:** If QALYs were to be incorporated into a Medicare for All system, they could potentially inform regulatory decisions, reimbursement policies, and coverage determinations. Government agencies responsible for healthcare oversight and administration, such as the Centers for Medicare & Medicaid Services (CMS), could use QALYs to assess the cost-effectiveness of healthcare interventions and guide resource allocation decisions.
5. **Public Perception and Acceptance:** The inclusion of QALYs in a Medicare for All system would likely be subject to public scrutiny and debate. Stakeholder engagement, transparency, and accountability would be important considerations in shaping healthcare policy and ensuring that decision-making processes are perceived as fair and equitable.

Ultimately, the inclusion of QALYs in a Medicare for All system would require careful consideration of the benefits, challenges, and implications for healthcare delivery, patient outcomes, and healthcare spending. Policymakers would need to weigh the potential advantages of using QALYs to inform resource allocation decisions against concerns about equity, access, and patient-centered care.

In Canada, the healthcare system is publicly funded and administered at the provincial and territorial level, with each province and territory responsible for delivering healthcare services to its residents. While Canada's healthcare system, often referred to as Medicare, provides universal coverage for medically necessary healthcare services, the use of Quality-Adjusted Life Years (QALYs) to determine treatment approval or rejection varies across jurisdictions.

Generally, Canadian healthcare decision-making processes prioritize evidence-based medicine, clinical effectiveness, and cost-effectiveness in treatment decisions. Health technology assessment (HTA) agencies, such as the Canadian Agency for Drugs and Technologies in Health (CADTH) and the Institut national d'excellence en santé et en services sociaux (INESSS) in Quebec, play a significant role in evaluating the clinical and economic evidence for healthcare interventions.

While QALYs are commonly used in health economics and healthcare decision-making worldwide, including in countries with government-funded healthcare systems such as the United Kingdom, their use in Canada may vary. Some HTA agencies in Canada may incorporate QALYs or similar measures of health-related quality of life into their assessments of healthcare interventions to assess their cost-effectiveness and value for money.

However, the extent to which QALYs are used to inform treatment approval or rejection decisions in Canada can depend on several factors, including jurisdictional differences,

institutional practices, stakeholder preferences, and public policy priorities. Other considerations, such as patient preferences, equity, and feasibility, may also influence healthcare decision-making in Canada.

In summary, while QALYs may be used as part of health technology assessment processes in Canada, their use and influence on treatment approval or rejection decisions may vary across provinces and territories. Decision-makers in Canada typically consider a range of factors, including clinical effectiveness, cost-effectiveness, patient preferences, and equity, when making decisions about the allocation of healthcare resources and coverage of healthcare interventions.

In France, healthcare decision-making is guided by the principles of solidarity, universality, and equity, with a strong emphasis on ensuring access to high-quality healthcare for all citizens. The French healthcare system, known as "l'Assurance Maladie" or "la Sécurité Sociale," is based on a mix of public and private financing and delivery of healthcare services.

While Quality-Adjusted Life Years (QALYs) are commonly used in health economics and healthcare decision-making in some countries, such as the United Kingdom, their use in France may be less prevalent. Instead, the French healthcare system relies on a combination of clinical effectiveness, evidence-based medicine, and economic evaluation to inform treatment approval or rejection decisions.

The French National Authority for Health (Haute Autorité de Santé, HAS) plays a key role in evaluating the clinical and economic evidence for healthcare interventions and providing recommendations to inform healthcare policy and practice. HAS conducts health technology assessments (HTAs) to assess the clinical benefits, safety, and cost-effectiveness of new drugs, medical devices, procedures, and healthcare technologies.

While HAS may consider measures of health-related quality of life, such as QALYs, as part of its HTA processes, the specific methods and criteria used to evaluate healthcare interventions in France may vary. HAS takes into account a range of factors, including clinical effectiveness, patient safety, public health impact, and economic considerations, when making recommendations about the adoption and reimbursement of healthcare interventions.

Decision-making in France typically emphasizes evidence-based medicine, clinical effectiveness, and patient-centered care to ensure the delivery of high-quality healthcare services to the population.

While the British National Health Service (NHS) incorporates Quality-Adjusted Life Years (QALYs) into its health technology assessment processes to assess the cost-effectiveness of healthcare interventions, and to provide guidance on treatment decisions, it's not accurate to characterize the French system as allowing for more subjective decisions made solely by individual doctors.

Both the NHS in the UK and the French healthcare system (l'Assurance Maladie) rely on evidence-based medicine, clinical guidelines, and health technology assessment to inform treatment decisions. Here's a nuanced view:

### **1. British National Health Service (NHS):**

- The NHS uses QALYs and other measures of health outcomes as part of its health technology assessment processes conducted by organizations like the National Institute for Health and Care Excellence (NICE). These assessments inform recommendations about which healthcare interventions should be funded and provided within the NHS.
- While NICE provides guidance on the cost-effectiveness of healthcare interventions, individual treatment decisions are typically made by healthcare professionals in consultation with patients, taking into account clinical considerations, patient preferences, and other factors.

### **2. French Healthcare System (l'Assurance Maladie):**

- In France, the Haute Autorité de Santé (HAS) conducts health technology assessments to evaluate the clinical and economic evidence for healthcare interventions. HAS provides recommendations to inform healthcare policy and practice, including reimbursement decisions.
- Like in the UK, individual treatment decisions in France involve healthcare professionals (including doctors) working with patients to make decisions based on clinical evidence, patient preferences, and other relevant factors.

In both systems, treatment decisions are guided by a combination of clinical evidence, patient preferences, and healthcare professionals' expertise. While QALYs and health technology assessment may play a more prominent role in decision-making within the NHS, and individual doctors in France may have more autonomy, both systems aim to ensure access to high-quality, evidence-based healthcare for their populations.

Ultimately, treatment decisions are made collaboratively between healthcare professionals and patients, taking into account the best available evidence and the individual needs and preferences of the patient.

## Health Insurance Forms

*I would take almost any system - from Medicare-for-all to a private insurance voucher system  
- over the one we have now.*

Atul Gawande, New York Times, 5/31/07

**Health insurance form** describes the relationship between healthcare system users (patients), fundors (insurance carriers) and service providers (physicians and hospitals). The clear goal of any health insurance form, or reform: make our system more efficient – i.e. generate the best possible patient outcomes per dollar spent.

### Where Does A Healthcare System Come From?

A healthcare system is embedded in the culture, history and values of a particular society. That's why the British system, with various access and payment restrictions for example, can work in Britain. Or why the Canadian system, which includes lengthy waits for various specialist procedures, can satisfy Canadians.

Similarly, the French system grew out of a particular, unique French social evolution, the German out of their history, etc. Absent, for example, Otto von Bismarck's contribution to German historical development, the German healthcare system may have developed very differently. But Bismarck made his contributions, and the German system evolved – differently from the French or Italian.

Interestingly, each different healthcare system typically enjoys strong support from its constituents. Surveys consistently show that Britons generally like their National Health Service and Canadians like their medicare.

Surveys also typically show that people in one country are suspect of the healthcare system in another. Americans typically object to the socialized medicine practiced in Britain, just as the British typically object to the private, non-guaranteed healthcare system in America. Canadians often shake their heads in wonder over our need to pay for medical care – they get it for free. Americans respond with equal skepticism at a Canadian system that prohibits private medical options.

People, it seems, are comfortable with the system that they have, know and understand – and uncomfortable with systems that differ significantly.

Not only did each healthcare system develop organically from its own social roots, but each system rests on the epidemiology of the specific population it serves. Thus, for example, the Canadian system has fewer open heart surgical demands than our system, so is organized differently. Similarly, Japanese women have far lower rates of ovarian cancer than American women, so their healthcare system is designed to accommodate that.

We'll suggest that a healthcare system reflects the social values of a country, and evolves over time within the framework of that country.

### Social Bases of the American Healthcare System

The various American healthcare reform debates seem to rest on our ***lack*** of shared values about the type of health insurance we desire. Some Americans prefer single payer healthcare, others managed care and still others consumer driven healthcare.

People sometimes seem to place their healthcare system preference on an almost metaphysical pedestal. Anecdotally, I've heard multiple consumer driven / market based healthcare supporters, for example, claim that the Obama public insurance option is a threat not only to our healthcare system, *but also to our entire way of life*. 'I'm worried' a prominent and influential broker once told me, 'about what this means for America.'

I've also heard some single payer proponents claim that that the healthcare deregulations embedded in consumer driven healthcare proposals may destroy the 'fabric of our country'.

People supporting different types of healthcare in this country sometimes see alternatives not only as *inappropriate*, but also as *evil and destructive*. 'If my proposal wins,' people sometimes seem to think, 'then American can continue as we know it. But if my opponents win, then our future prosperity, and even liberty, will be put in jeopardy.'

That's a very strong position to take about health insurance form! Why do we take it?

Our healthcare reform debates are, I think, really debates about underlying societal values.

This chapter will explore those values.

## **Social Values as a Basis of Health Insurance Form**

### **Healthcare as a Right**

Some people, and some countries, define access to healthcare as a **right**, much like access to national defense, primary education, clean air and clean water. They see provision of healthcare as a governmental responsibility, like education and defense. The British would, by and large, accept this point of view.

People holding this position sometimes argue that we all need health insurance, just like we all need national defense and primary education. Just like defense and education are provided to all for free - funded, of course, by taxpayers - so healthcare should be also.

This broad argument strikes me as fallacious. Yes, we all need defense, education and healthcare. But we also need food, clothing, housing and transportation. None of these are typically provided by the government, unless, of course, you are poor and they are unaffordable to you.

Yet there seems to be something special about healthcare that differentiates it from food, clothing and housing. The healthcare-is-a-right folks might argue that everyone needs exactly the same kind of health insurance, unlike food and clothing. The reason: people buy health insurance when they're healthy, before they know what illnesses they will get, and thus before they know what kinds of treatment they will need. As such, everyone needs to purchase the same coverage for everything.



Since everyone needs the same coverage according to these folks, it becomes a small step to argue that we should all receive it from the government, tax-paying and equality comprising key aspects of being 'American'. This then morphs into the healthcare-is-a-right conclusion.

Healthcare provision, thus, differs from food, housing or transportation provision. We prefer different kinds of food and choose to live in different types of houses. These are completely rational decisions. As such, they are inappropriate for 'one size fits all' provision by the government.

According to the healthcare-is-a-right crowd, healthcare is a 'one size fits all' product that we all need. Healthcare is a unique product in this regard. As such, it should be provided by the government, equally to all.

Or so goes that argument.

### **Healthcare as a Product**

Other people see access to healthcare as a **privilege** or a **consumer good** - available to those able to pay for it – much like owning an automobile, a house or a tennis racquet. They see provision of healthcare as primarily a private sector responsibility. Many Americans, including for example, both the Nixon and George W. Bush administrations, would probably accept this position.

This group would see provision of healthcare more like that of food, clothing, housing and transportation. People could purchase more or less healthcare according to their tastes, preferences and ability to pay – just like they buy different kinds of food, clothing and houses.

According to this group, people could buy catastrophic health insurance, buy coverage with or without prescription drug coverage, buy long term care insurance, buy coverage from a narrow provider network, or buy concierge healthcare services. They could – completely rationally – purchase different benefit packages at different times of their life.

The healthcare-is-a-privilege crowd would not see healthcare as a public good. Instead, they would say that consumers can understand enough about it, and about their own needs, to make wise purchases.

### **Our Uncomfortable Blending of These Two Positions**

Our health insurance history described in Chapter 4 shows an uncomfortable combination of both points of view. We developed health insurance initially as a private sector function (a **privilege**), to protect the cash flow of private sector hospitals. Initially health insurance was available only to those able to pay for it.

Later, we granted free healthcare as a **right** to certain groups in our society – the military, for example during World War II, and the elderly in Medicare.

We also blended the two ideas – right and privilege –to insure the poor through Medicaid. These people have a **right** to health insurance – funded by the government - but need to pay a portion of the cost according to their income. Massachusetts, for example, uses this type of formula in at least one of its Medicaid programs, the Insurance Partnership.

We've had a disagreement about the right vs. privilege question at least since Baylor University Hospital first contracted with the Dallas school system to provide health insurance to employees.

### **Both Sides Agree on Wide Choice of Provider**

We have more agreement on another social value that underlies our health insurance system – the importance of provider choice. The Split, described in Chapter 4, indicates that Americans value choice of provider very highly. We want the ability to choose our own physician and we object to health insurance forms that restrict this choice. This value seems common to both the 'healthcare is a privilege' and the 'healthcare is a right' crowds.

### **Translating Social Values into Insurance Policies**

Let's translate these various social value positions into actual health insurance policy forms and actual health insurance reform proposals.

To do this, I propose categorizing health insurance and reform proposals according to the answers to 2 fundamental questions, both of which reflect the values discussed above:

**Question 1: Is healthcare like, or not like, other goods and services in our economy?** and

**Question 2: Is competition good or bad in healthcare?**

The way you answer these questions likely reflects the way you see the 'right vs. privilege' argument.

Let's explore these questions in more detail.

#### **Question #1: Is healthcare like, or not like, other goods and services?**

Can we shop for healthcare like we shop for tennis racquets, cars or houses? Or must we all obtain exactly the same coverage?

There is no clear, objective answer. People answer these questions differently - almost as a matter of metaphysical belief. The healthcare-is-a-privilege crowd believes that individual consumers simply need the right **price** and **outcome** information to make wise and informed healthcare purchasing decisions. They think that this information can be made available to consumers.

Regina Herzlinger, from Harvard Business School and a strong healthcare-is-a-privilege proponent, is very strong on this point. The fact that we currently do not have quality price and outcome information, she says, is a minor issue. Comparing the current state of healthcare treatment information to the 1930's state of financial information in this country, she claims that 'when the federal government required disclosure, they got it.'<sup>82</sup> All we need, in her opinion, is a

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<sup>82</sup> Regina Herzlinger, Who Killed Healthcare, page 234

strong federal commitment to publishing audited price and outcome information. After that, our marketplace can take over.

People holding this set of beliefs tend to favor **consumer driven healthcare**.

Alternatively, the healthcare-is-a-right folks think that purchasing healthcare is fundamentally different from purchasing other consumer goods. They may think that purchasing different insurance packages, or specific medical services, is inappropriate for most consumers. **First**, most of us lack the technical training to make wise and informed medical decisions. **Second**, the healthcare-is-a-right folks ask why we should make important medical decisions when we're sick and probably frightened; we don't shop for other products under these circumstances. This is an inappropriate time to shop. **Third**, patients are generally poor self-diagnosticians. They are emotionally involved and lack the necessary medical training.

They may also disagree with Herzlinger and think that generating actual medical price and outcome data is extremely difficult, if not impossible. We don't, even today for example, have publically available prices for most treatments at most hospitals. The lack of federal requirement for this is only one reason. There are a host of others – confidentiality, anti-collusion laws, competitive business practices, data collection problems, etc.

Quantifying benefits from medical procedures, for example, is extremely difficult. Note the difficulty surrounding measuring the benefits of a specific therapy for a particular disease in a patient suffering from multiple chronic conditions, like scleroderma, Parkinson's Disease, diabetes, asthma and anxiety. Remember that some 75% of all healthcare spending goes to people with chronic diseases. We have not yet begun, in this country, to quantify benefits of most treatments – a necessary step for wise healthcare shopping.

Thus, the healthcare-is-a-right folks would argue, we cannot treat healthcare like other goods and services. We cannot generate sufficiently good cost and benefit data for people to make rational purchasing decisions. Even if we could, this is an inappropriate venue for comparison shopping.

People thinking that healthcare purchasing is essentially different from purchasing other goods and services tend to favor **managed care** or **single payer healthcare**.

There is no national consensus, and great minds differ on the answer to our Question #1.

## **Question #2: Is competition good or bad in healthcare?**

Some people think that competition among carriers, physicians and hospitals will improve our healthcare system – just as it improved our cars, computers etc.

Other people think that competition *per se* is not the critical variable, but that **certain kinds** of competition are necessary to improve our healthcare system.

In general, people who think that competition among carriers and providers will improve our system favor **consumer driven healthcare** or **managed care**.

Others disagree. They claim that physicians should focus exclusively on treating their patients, and should not think about marketing, business issues or competitive demands. Indeed, according to advocates of this position, competition may **harm** our healthcare system, by eroding professional values and standards and by forcing providers to think about inappropriate issues, like their business practices. This group would tend to favor **single payer healthcare**. Of course, there are variations within each system. I've tried, here, to outline the basic positions of single payer, managed care and consumer driven proponents.

### Comparisons

Here's the matrix defining the 3 basic forms of health insurance:

| <u>Consumer Driven</u>                                       | <u>Managed Care</u>                                                                                    | <u>Single Payer</u>                                  |
|--------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|------------------------------------------------------|
| Healthcare is like other goods and services                  | Healthcare is not like other goods and services                                                        | Healthcare is not like other goods and services;     |
| Competition among providers good and will improve our system | 'Managed Competition' Competition among Managed Care organizations is good and will improve our system | Provider competition is bad and will harm our system |

There's also a fourth type of healthcare system – the system we have today: fee-for-service financing based on billing code. The specific fees are based on negotiations between carriers and providers, and tend to reflect relative bargaining power more than any fundamental value structure or outcome goals.

Fee-for-service financing grew directly out of the Split described in Chapter 4, and has been around for 60+ years. Many think that fee-for-service is a fundamental problem with our healthcare system. Indeed, we articulated many of these reasons in Chapter 8.

We have no national consensus on which form of health insurance is best for us, and which will improve on our current fee-for-service mess.<sup>83</sup> If we had a national consensus, then healthcare reform would become significantly easier.

We'll describe, below, each form of health insurance. As we do this, try to focus on which form you think leads to the best cost control mechanisms, and which can provide the best patient outcomes.

### Understanding Consumer Driven Healthcare

People who think that purchasing healthcare services is the **same** as purchasing other services, and that **competition among carriers and providers is good**, tend to favor consumer driven healthcare.

Consumer driven proponents want less governmental regulation of our healthcare system so consumers can have more freedom of choice. The theory: when consumers shop among a wide variety of options, they will demand better quality at lower prices, thus improving the value of our

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<sup>83</sup> 'Mess' as in the title of Richmond and Fein's classic work, The Healthcare Mess.

healthcare system. Consumer choice and competition among providers are the keys to improving our healthcare system.

Since – according to these folks – healthcare purchasing is fundamentally the same as tennis racquet purchasing, then the same, relatively low level of government regulation should apply. More governmental involvement will reduce both **the ability of consumers to choose** and **the amount of competition among providers**. In sum, more government regulation will make the system worse in their view.

Consumer Driven Healthcare is defined by Herzlinger, perhaps its key academic proponent, as:

The restructuring of our healthcare delivery system around the needs of human beings, not around the needs of the status quo...high deductibles [don't] represent consumer driven healthcare. That's ridiculous. Consumer markets have lots of choice.<sup>84</sup>

When consumers apply pressure on an industry, whether it's retailing or banking, cars or computers, it invariably produces a surge of innovation that increases productivity, reduces prices, improves quality and expands choices.

The essential problem with the healthcare industry is that it has been shielded from consumer control – by employers, insurers and the government...

Entrepreneurs will respond to the unleashing of consumer demands with clearly differentiated products featuring various combinations of benefits, levels of insurance coverage, payment systems for providers, lengths of policies and sources of information. The competition among the new products, in turn, will control costs while improving the overall quality of coverage and care...

Under consumer driven healthcare, enrollees can tailor health insurance policies to their specific needs – e.g. insurance for long term care and drugs; easy access to integrated teams that specialize in treating chronic diseases and disability; pre-tax savings accounts for uninsured healthcare needs, such as hearing aids and support in modifying lifestyles; and 'bonus' long term policies that reward those who switch to healthy lifestyles.<sup>85</sup>

### Understanding Managed Care

People who think that purchasing healthcare services is **different** from purchasing other services, but that, among healthcare providers, **competition is good**, tend to favor managed care.

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<sup>84</sup> Sean Silverthorne, Is Healthcare Making You Better – or Dead?, Harvard Business School Working Knowledge, June 4, 2007

<sup>85</sup> Regina Herzlinger, Are Consumers the Cure for Broken Health Insurance?, Harvard Business School Working Knowledge, August 5, 2002

Managed care proponents think that individual consumers **cannot** choose wisely among healthcare professionals for several reasons:

1. Consumers cannot determine which specific physician or hospital is best for their particular medical needs;
2. Consumers generally purchase medical services when they are ill and upset or frightened. This is a poor time to comparison shop;
3. The appropriate unit of measure is not really the individual physician or hospital, but the **medical team** – consisting of diagnosticians, therapists, acute care specialists, rehab professionals and others who must work together to achieve the best patient outcomes. An outstanding surgeon working with a poor rehab team may generate poor results.

As a result, managed care proponents want to organize our healthcare system so that each physician, nurse and hospital belongs to only one managed care organization. This will foster good medical care integration within that organization.

According to the theory, managed care organizations include both the insurance function and healthcare treatment function in the same company – i.e. the Vertical Integration we discussed earlier.

In a true managed care society we would no longer have separate health insurance carriers, independent physicians, independent general hospitals and fee-for-service billing. Instead, we would have large organizations that integrate finance and treatment functions for the good of the subscriber / patient.

Consumers in a true managed care society would not purchase insurance from one company (Blue Cross, for example) and then get medical care from another (the Cleveland Clinic, for example). They would belong, rather, to a company that's hypothetically called *The Managed Care Organization that Integrates Finance and Medical Service Provision Together*.

Each physician and hospital would belong to only one such managed care company.

Each health insurer would affiliate with only a specific set of providers. Consumers could purchase insurance from only one company, and could get medical care only from the providers affiliated with that company.

Patients would also need a Primary Care Physician referral to access a specialist. The PCP sits at the center of information flows. He/she knows the patient, the available specialists and the best provider teams so can provide the best advice. Patients alone are unable to choose the best specialist and team for their particular needs.

In the ideal model, managed care organizations compete with each other to provide the best value to subscribers. Competition among managed care organizations is called 'managed competition'.

The goal of managed competition, according to Stanford Business School Professor Alain Enthoven, perhaps our foremost managed care proponent, is 'to divide providers in each community into competing economic units and to use market forces to motivate them to develop

efficient delivery systems.’<sup>86</sup> Only through competition can the health plans that do the best job of improving quality, cutting costs and satisfying patients be rewarded. Competition occurs at the level of integrated financing and delivery plans, not at the individual provider level.

Thus managed care advocates walk a fine line when answering our 2 fundamental questions.

They believe that purchasing healthcare differs from purchasing most goods and services in our society, so individuals should not buy their own medical services. But they also believe that competition is necessary to improve our healthcare systemic performance.

They walk that fine line, but not always very successfully.

### Understanding Single Payer Healthcare

People who believe that purchasing healthcare is **different** from purchasing other services and that among healthcare providers, **competition is bad**, tend to prefer single payer healthcare.

Some single payer folks think that healthcare is a right, not a product, so is not even appropriate for economic analysis. Thus it’s intrinsically different from other types of products and services in our economy. Arnold Relman of the Harvard School of Public Health seems to take this position, suggesting that ‘medical care is not really a ‘market’ at all in the classical economic sense and therefore ... the basic theories of economics are not relevant to the discussion of ... healthcare.’<sup>87</sup>

Others believe that individual consumers cannot shop wisely for healthcare, for roughly the same reasons as articulated by the Managed Care folks above:

- Patients cannot adequately diagnose their own medical problems – so cannot shop wisely for solutions;
- Patients cannot measure treatment costs or outcomes – especially for long term, chronic treatments – so cannot shop wisely.

Unlike the Managed Care advocates, however, Single Payer proponents do not generally believe that competition among providers is a good thing. Their reason: Physicians should focus entirely on their patients, and should not allow business considerations to cloud their thinking. Provider competition, they believe, decreases physician care quality.

Here’s Relman again, lamenting the impact of business competition and consumerism on our healthcare system:

To a degree greater than anywhere else in the world, our doctors think of themselves as competitive business people....a real solution to our problems will not be found until the public, the medical profession and the government reject the prevailing delusion

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<sup>86</sup> Enthoven, History and Principles of Managed Care, Health Affairs, 1993

<sup>87</sup> See Arnold Relman, Medicine and the Free Market, New Republic, March 7, 2005

that healthcare is best left to market forces...we need to depend on non-market mechanisms to make our healthcare system work properly.<sup>88</sup>

These 'non-market mechanisms' would include educational requirements and professional licensure standards, among others.

Thus Single Payer proponents believe that purchasing healthcare differs from purchasing other services and that competition among healthcare providers is bad for patients.

Single payer proponents further argue that having a national health insurance single payer will generate various other patient benefits. Among those benefits:

- Universal coverage;
- A more equitable healthcare system, which treats everyone alike;
- More uniform treatments, to avoid a situation where some Americans get access to excellent care, while others get only mediocre;
- Lower cost healthcare, since the single payer will not need to pay for marketing, underwriting or other expensive private insurance functions, and providers will not need to pay for expensive administration to manage their billing function.

Proponents of these 3 forms of health insurance – Consumer Driven, Managed Care and Single Payer – all believe that the other forms are inferior. They criticize each other enthusiastically.

Let's look next at the various standard criticisms.

### **What Consumer Driven folks say about the other forms of health insurance**

#### **Consumer driven healthcare proponents object to fee-for-service insurance.**

Fee-for-service financing pays for treatment inputs, not outcomes. This presents two major problems for our healthcare system:

**First**, fee-for-service financing is highly inflationary. It offers hospitals incentives to perform the most possible treatment, not the least. It further incents providers to perform the most expensive treatments, not the least. This is unlike any typical consumer product. Fee-for-service financing produces far more expensive than necessary medical care.

**Second**, fee-for-service financing offers little, if any, data collection resources to inform carriers or providers which treatments generate which results. Fee-for-service financing leads to fragmented services, with specialists rarely working as teams.

Yet good patient outcomes rely on all medical team members working together. If outcomes are good, which team members played the key roles? If outcomes are bad, which messed up – or did poor team coordination lead to poor outcomes? Only with this knowledge can we improve our healthcare system. The fee-for-service model does not generate the data to tell us.

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<sup>88</sup> Ibid.



As a result of this fragmentation, fee-for-service generates relatively mediocre results. It offers few incentives for providers to invest in prevention, safety or efficiency. It is inappropriate for chronic disease care.

Consumer driven proponents claim that allowing shoppers to choose medical services based on price and outcomes would simultaneously improve outcomes and reduce prices. This follows from the answers to our 2 questions above. They believe that purchasing healthcare is essentially like purchasing other goods and services, and that competition is a good thing.

### **Consumer driven folks object to single payer healthcare.**

Under single payer financing, one entity – often the government – defines the medical services to be covered and then pays for them.

Consumer driven opponents object to the ‘top down’ nature of government run programs. ‘Top down’ means that the government decides what types of coverage are available, what services are covered, and the terms and conditions of access. ‘Bottom up’ policies, favored by CDHC fans, are stimulated by consumer demand, and may come in a wide variety of types of policies, plans, services, terms and conditions.

CDHC proponents believe that bottom up policies most accurately reflect the demand for healthcare services, are more innovative, and respond more quickly to consumer demand and new treatment options. ‘Top down’ programs can too easily become politicized by special interests – to the potential harm of patients. Only consumers can save our healthcare system from special interest domination.

### **Consumer driven healthcare folks object to managed care.**

Consumer driven advocates claim that managed care is another ‘top down’ healthcare system with policies, programs, terms and conditions imposed on subscribers.

Harvard’s Herzlinger, for example, claims that managed care programs are designed by well-meaning but misguided academics who believe that they know more about your healthcare than you do. These academics do not trust consumers to make wise and informed healthcare decisions. They seek to reduce consumer healthcare choices through network or policy coverage limitations, and by various types of referral requirements.

CDHC fans reject these ideas.

Consumer driven proponents also claim that managed care’s requirement of integrated financial and medical service functions in the same company – i.e. vertical integration – is impossible to implement in the real world. They cite a large library of business school studies to support this.

### **What Managed Care folks say about the other forms of health insurance**

Managed Care theorists walk that fine line when they answer our Questions #1 and #2. They need to show why buying healthcare differs from buying other goods in our society, but that competition among providers will improve our system.

### **Managed care folks object to fee-for-service insurance**

Stanford's Enthoven sees 10 major problems with fee-for-service health insurance: <sup>89</sup>

- Fee-for-service creates an adversarial relationship between doctors and payers;
- Fee-for-service has little accountability – poor data collection and provider motivations for economy;
- Fee-for-service 'free choice of provider' leaves patients to make remarkably poorly informed choices;
- Fee-for-service generates excess hospital capacity, high tech equipment and open-heart surgeries;
- Fee-for-service generated an excess supply of specialists;
- Fee-for-service misallocates resources, as no incentive to use the least costly settings for treatment;
- Fee-for-service has no capacity to plan care processes from diagnosis to treatment to rehabilitation;
- Fee-for-service has led to a dangerous proliferation of facilities for complex and costly procedures without the volumes necessary to maintain good outcomes;
- Fee-for-service cannot practice total quality management due to lack of service integration;
- Fee-for-service cannot organize the rational use of technology

Only systems that manage healthcare can emphasize prevention, early diagnosis and effective chronic disease management.

### **Managed care folks object to single payer healthcare**

They claim that single payer financing eliminates competition from healthcare to the detriment of the entire system. Only through competition, they believe, can we simultaneously reduce healthcare costs and improve outcomes.

As evidence, managed care advocates might refer to this recent comparative cost data:

#### **Per Capita Healthcare Spending Increases, 2000 – 2007 <sup>90</sup>**

|           |     |     |
|-----------|-----|-----|
| Australia |     | 48% |
| Canada    |     | 54% |
| France    | 41% |     |
| Germany   |     | 34% |
| Greece    |     | 88% |
| Spain     |     | 73% |
| UK        |     | 63% |
| US        |     | 54% |

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<sup>89</sup> Alain C. Enthoven 'Why Managed Care Has Failed to Contain Health Costs' Health Affairs, Fall 1993.

<sup>90</sup> OECD Health Data

Absent appropriate competition, single payer systems were no better at containing healthcare spending than we were.

### **Managed Care Folks Object to Consumer Driven Healthcare**

Under CDHC, individual consumers make their own decisions about their healthcare.

Managed care theorists object to this idea. They believe that healthcare is fundamentally unlike other goods and services in our economy, and that consumers are unable to shop wisely for health services for reasons of information availability, risk and price.

Consumers, according to managed care advocates, cannot access good information about important aspects of our healthcare system. They cannot self-diagnose nor determine which specialists are 'better' than others. They can't determine which treatment is most appropriate, which hospital is best for a specific ailment, or which providers offer the best value.

Managed Care proponents think that consumers need a guide or gatekeeper to advise them how best to use our healthcare system. In the managed care vocabulary, the advisor is the Primary Care Physician.

The PCP knows both the patient and the available resources, so can design a treatment plan that uniquely fits each individual patient. This key component is lacking in Consumer Driven Healthcare plans, according to the Managed Care folks.

### **What Single Payer Folks Say about the Other Forms of Health Insurance**

**Single payer proponents object to consumer driven healthcare**, claiming that purchasing healthcare differs from purchasing other goods and services. Single payer advocates typically define healthcare as a right, much like primary education. As such, it fits outside our typical market based economy.

Market economics, in other words, are inappropriate in healthcare.

**Single payer proponents object to managed care**, though specific reasons vary according to the specific single payer advocate.

Some object to the narrow provider networks offered by managed carriers. Others object to payment of premiums based on some sort of risk analysis by the managed carrier. This follows from the 'healthcare is a right' argument.

Still others object to attempts to measure outcomes, fearing that any outcome measurement would negatively influence providers' behavior. Providers trying to maximize their outcome rankings might accept only healthier patients or specialize in certain types of treatments to make themselves look good on comparative scales. (By analogy, we hear stories about colleges that jockey their statistics to look good on comparative scales.)

Thus, single payer proponents typically think, competition among providers is a bad thing for our healthcare system.<sup>91</sup>

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### **Consensus is Key, Not Specific Form**

Who's right?

They all are!

Any of these 3 forms of health insurance – consumer driven, managed care or single payer – could work reasonably well...***if we had consensus.***

This is a radically different position from most healthcare commentators.

**I'm suggesting that the solution to our healthcare problems rests with our ability to generate consensus about the answers to Questions 1 and 2.**

This position contrasts with most commentators. Healthcare 'experts' typically define our healthcare system problems in some way or other, and then provide solutions based on their definition of the problem.

I take a different approach, suggesting that our lack of consensus is the real stumbling block to healthcare system improvement.

A typical commentator, for example, may claim that the fundamental problems with our healthcare system or any of the list below (choose as many as you like):

- Too many specialists;
- A financing system that rewards quantity of medical procedures rather than the quality of care provided;
- Inappropriate competition;
- Poor coordination of medical treatments;
- Over-use of general hospitals;
- Short term, rather than long term, insurance plans;
- Too much attention to the bottom line;
- Too much business focus;
- A lousy tort system;
- Too much carrier involvement;
- Too few real preventive services;
- Poor chronic disease care;
- Poor hospital safety;
- Etc, etc, etc

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<sup>91</sup> Single payer healthcare comes in various flavors. Some flavors, as those articulated by Professor Relman above, oppose competition. Others embrace some forms of competition. I tried to present a general summary here, fully acknowledging that the general does not fit every specific

While these – and other problems – may be real, I don't think they provide a basis for healthcare reforms.

Instead, it's the value and context within which we put that problem that's key.

Let's use 'poor hospital safety' as an example.

If we believe that purchasing healthcare is like purchasing other goods and services in our economy (more or less that healthcare is a privilege), then the solution to poor hospital safety comes from various market mechanisms. We could, for example, publish outcome data to shine a light on poor performers. Once this information becomes publicly known, then market will force the hospital to solve its safety problems, for fear of losing patients and going out of business.

The Consumer Driven and Managed Care folks would approve of this solution.

On the other hand, if we believe that purchasing healthcare is not like purchasing other goods and services (more or less that healthcare is a right), then simply publicizing outcome data is an inappropriate solution. We need something else – government regulations, more mandates, more investment or a different administrative structure. Healthcare regulations would be more like primary education regulations.

The Single Payer folks would applaud this.

Let's compare this situation to our primary education system. Occasionally a public school system is threatened by the state with a loss of accreditation. The school system rarely actually loses its accreditation. Teachers rarely get fired en masse. Administrators may get 'reassigned' but rarely lose their jobs. In other words, the school system doesn't go out of business. Instead, the state steps in to fix the problem.

So, apparently, would single payer folks address the problem of poor hospital safety. A very different approach from the market approach supported by managed care and consumer driven folks.

Thus, **the solution to our hospital safety problem depends on our answers to Questions 1 and 2:**

- #1: Is healthcare like or dislike other goods and services? And**
- #2: Is competition good or bad in healthcare?**

Either solution, above – market or regulatory - can improve hospital safety.

**But both, together, may cause more problems than they solve.** That's why we need consensus for any meaningful healthcare reform!

Let's expand on this example. If a clear majority of Americans answered our Questions 1 and 2 the same way, we could move forward with real healthcare reform – fairly easily. Any of these forms of health insurance would probably provide better outcomes at lower costs than today.

But all these forms together, conflicting with each other in our healthcare system, will probably not improve our system. These types of health insurance offer different provider incentives and set different treatment priorities. For example:

**Managed care systems**, working within tight budgets, emphasize preventive services but may reject some patients for certain types of acute care; but

**Consumer driven** systems may not emphasize prevention as much, but would give patients access to a wider range of acute services.

Or

**Managed care advocates** think that having a small network of providers who work together will generate the best patient outcomes at the lowest possible price; but

**Consumer driven advocates** want consumers to have the widest possible provider network, so people can have the most possible choices.

Or note the conflict between investing in the most efficient providers, and the least:

**Market based systems** (consumer driven or managed care) reward the most efficient providers the most, because they generate the best patient outcomes at the lowest cost; but

**Single payer systems** may invest disproportionately more in poorer quality providers so they raise their service levels, thus equalizing healthcare service quality to us all.

And note the conflict between consumer driven and single payer attempts to improve hospital efficiencies:

**Consumer driven folks** who think buying healthcare is like buying other goods and services want fewer hospital regulations. They see excessive regulations as hampering the hospital's ability to innovate, and thus improve efficiencies; but

**Single payer folks** who think buying healthcare is *not* like buying other goods and services and want more hospital regulations, to protect patients and to define efficiency.

**A piecemeal approach to healthcare reform – a bit of consumerism, a bit a managed care and a bit of single payer – will not work.** These different forms of health insurance rest on very different assumptions.

That's why our healthcare reforms over the past 40 years have all failed.

If we shared a consensus that healthcare is like other goods and services, and that competition is good, then we could design market based reforms to improve our system. We know how to design these – we've designed lots of market based regulatory systems in this country.

Alternatively, if we shared a consensus that healthcare is not like other goods and services, and that competition is bad, then we could design non-market reforms to improve our system. We know how to design these also.

But designing a combination of both market-based and non-market based reforms leads to mis-targeted regulations, confusion, contradiction and inefficiencies, like we see in our healthcare system today.

### **If We All Agreed... The Evidence That Any Form of Health Insurance Can Work**

My students often challenge this thesis - that any form of health insurance could work better than what we have now, provided we have consensus. 'No,' they sometimes say, 'consumer driven healthcare is much better than single payer.' And then they proceed, typically, to talk about Canadian or British waiting lists for certain types of medical procedures, or other restrictions.

Other students – particularly the left-leaning ones – claim the opposite, typically arguing 'Our private sector based healthcare system has huge administrative costs. Only a single payer system can save us' and then show Medicare's 2% overhead, compared to private carrier's 10%. The 8% difference in a \$2.5 trillion healthcare economy is about \$150 billion per year.

Or they claim that Britain and Canada – single payer systems – spend about 60% as much on healthcare as we do, while generating slightly better longevity and infant mortality statistics. A prima facie case, they claim, for single payer healthcare.

They're both right! That's why I think consensus is more important than actual policy type.

The evidence in favor of single payer healthcare is very strong, for example. The British or Canadian data from Chapter 1 show quite clearly that both generate better outcomes than we do, while spending far less on healthcare.

How do they do this? They have designed a regulatory environment around the concept that healthcare is different from other goods and services. They could do this because they share a national consensus, more or less, about this definition of health insurance.

Most surveys show that the British and Canadians (and French and Germans and other single payer systems) are generally satisfied with their healthcare systems. The interesting thing about these surveys - they have shown high levels of support for the national healthcare system in each country for many years. In essence, each system has evolved within its own national value structure. This is what I call consensus.

On the other hand, the evidence for managed care is also very strong, though presented differently. Stanford's Enthoven and his managed care buddies – a very bright and articulate crew – argue persuasively that the Kaiser Permanente experience, the Mayo Clinic experience and other such managed care organizations are the ideal that we should emulate nationally.

They typically present reams of data and analysis showing why Kaiser Permanente and the Mayo Clinic, among others, generate better outcomes than the US average – at a lower price.<sup>92</sup>

Hillary Clinton found these arguments sufficiently persuasive to attempt an entire national healthcare reform based on them in the 1990s. Clinton's reforms, of course, ultimately failed and have been ridiculed as HillaryCare ever since.

It is interesting to note, however, that most Americans actually liked her proposals – including the Wall Street Journal! Here's former Harvard University President Derek Bok explaining the results of a Wall Street Journal – NBC News poll that the Journal published in 1994. The Journal's article title: 'Many Don't Realize It's The Clinton Plan They Like':

The article reported the results of a Journal-NBC poll asking respondents their reaction to a health plan that contained all the features of the Clinton proposal without revealing that it was the President's plan. Respondents were also invited to evaluate the four other plans under consideration in Congress, again without identifying the sponsor of the plan to the readers. When the results were tabulated, 76 percent saw 'some' or 'a great deal' of appeal in the Clinton proposal, a much more favorable response than that given to any of the other plans.

**This result occurred at the very time that other polls were reporting a majority of Americans opposing the Clinton Plan.**<sup>93</sup>

At the time of the WSJ-NBC News poll, only about 37% of the American public actually supported the 'Clinton Plan'. But when the various contending healthcare plan options were presented to them – blindly, without identifying the sponsors – Hillary's plan emerged as most popular!

Our point: it was the Clinton's *lack of ability to build consensus*, rather than the actual managed care plan itself, that spelled defeat.

And our consumer driven friends also present a compelling case that they're right, though they generally argue this from the bottom – up. 'Look at all the evidence,' they say, 'of providers who respond to consumer demand' and then provide case studies of Shouldice Hernia Hospital, the Texas Heart Institute or similar, showing outstanding results at relatively low costs.<sup>94</sup>

'Just imagine,' they continue, 'how great our healthcare system could be if we harness the innovative and competitive energies of American entrepreneurs to fix our healthcare system. The problem is that regulators get in the way. Henry Ford couldn't have developed cars, or Bill Gates software, if regulators had been involved every step of the way.'

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<sup>92</sup> See, for example, Enthoven and Tollen, *Toward a 21<sup>st</sup> Century Health System*, Jossey-Bass, 2004. Jan Gregoire Coombs makes some similar points, though less stridently, in *The Rise and Fall of HMOs*, University of Wisconsin Press, 2005.

<sup>93</sup> Derek Bok, *The Great Health Care Debate of 1993 – 94*, [www.upenn.edu/pnc/ptbok/html](http://www.upenn.edu/pnc/ptbok/html)

<sup>94</sup> See for example, the Harvard Business School Case Study, Shouldice Ltd, or Cooley and Adams, *Package Pricing at the Texas Heart Institute*, in Herzlinger, *Consumer Driven Healthcare*, Jossey-Bass, 2004



They're right too! That's why I believe that any of these insurance types can work – provided we agree to use it.

But if we continue to lack consensus and engage in partial solutions, then our reform efforts will continue to fail.

### **Can We Generate Consensus About Whether Healthcare is a Right or a Product?**

Probably not, if the Great Healthcare Debate of 2009 /2010 is any indication. The proponents of each form are pretty entrenched. President Obama had to compromise, compromise and compromise to get anything passed in the Senate.

I think this lack of consensus flows directly from the different social values that underlie each health insurance position. Consumer driven proponents think that the additional government involvement necessary for single payer healthcare, will make our system worse. They believe that the best thing they can do for America is to stop movement toward single payer healthcare. Additional governmental involvement and regulations are anathema to them, because they believe that buying healthcare is **like** buying other goods and services.

Single payer proponents completely disagree. They think that deregulating health insurance, as proposed by the consumer driven folks, will generate harm to Americans. They fear attempts to treat healthcare like other goods and services, because they believe healthcare provision is a right.

There appears little room for compromise among these positions. That which consumer driven proponents see as 'good', single payer proponents see as 'bad'. And that which single payer proponents see as 'good', consumer driven proponents see as 'bad'. These are deeply held values.

Generating consensus among these virtual polar opposites is very difficult. Absent consensus, the chance of real healthcare cost reform seems slim.

## The Managed Care Movement and HMOs

Managed care is classically defined as:

large multispecialty group practices [that] provide a comprehensive set of healthcare services at a per capita price set in advance.<sup>1</sup>

These large practices include both a financial and service provision component. According to the theory, managed care organizations include both the insurance function and healthcare treatment function in the same company. Thus in a true managed care society we would no longer have separate health insurance carriers, independent physicians, independent general hospitals and fee-for-service billing. Instead, we would have large organizations that integrate finance and treatment functions for the good of the subscriber / patient.

In the ideal model managed care organizations compete with each other to provide the best value to subscribers.<sup>2</sup> Members of one organization could use all facilities owned by, or integrated into, that practice, but none of a competitor. Each local hospital, for example, would join only one managed care organization. Competition among these is called 'managed competition' and follows a set of prescribed rules. More on this below.

### **Managed healthcare differs from the three other forms of healthcare financing.**

**First, managed care differs from indemnity insurance.** The traditional US medical insurance until about 1990 was indemnity coverage. Insurers indemnify – or pay back - subscribers for medical treatment after-the-fact. The subscriber receives treatment, pays the provider, and then submits the bill to the carrier for indemnification. Carriers indemnify (pay) the subscriber according to coverage provisions. (Carriers might bill the hospital directly and then balance bill the subscriber.) Typically indemnification plans include a deductible and a co-insurance rate. For example, the subscriber might have an annual deductible of, say \$500 and 80% co-insurance - means the carrier pays 80% of all allowed costs above the deductible.

Carriers often pay 'usual and customary' or 'cost plus' fees to providers according to the carriers' fee schedule, and will generally pay any licensed healthcare provider. Under indemnity financing, there is no particular corporate or cultural relationship between any particular healthcare financing entity and provider. The relationship is entirely financial.

Indemnity health insurance plans only pay for medical services provided, creating a potentially powerful financial incentive for physicians and hospitals to perform tests and procedures. Indemnity plans typically pay very little (or nothing) for preventing medical treatments. With cost-plus reimbursement, providers have little financial incentive to offer low cost treatments, and a significant financial incentive to perform the most expensive available procedures. At the same time, indemnity carriers typically allow physicians and hospitals wide latitude to use their best judgements when designing medical treatments.

Indemnity insurance has three major drawbacks. **First**, it is very inflationary. Fee-for-service indemnification offers hospitals incentives to perform unnecessary or excessive treatment; it is a major contributor to Moral Hazard and the Medical Arms Race.

**Second**, indemnity results are often relatively poor, as we see above with Uneven Treatment Quality and Poor Safety Investments. It does not invest in prevention. Its' fee-for-service model is inappropriate for chronic disease care.

And **third**, indemnity insurance offers little, if any, data collection resources to inform carriers or providers which treatments generate which results. This makes results-based competition among carriers exceedingly difficult to implement.

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**Second, managed care differs from single payer healthcare.** Under single payer financing, one entity – often the government – pays for all healthcare for all citizens. Most advanced industrialized countries use some form of single payer healthcare financing as we do in the US with Medicare and the Veterans Administration Healthcare system.

Proponents of single payer financing argue that it is more equitable than any other form of healthcare financing, for all citizens are treated the same. Indeed, a key positive element of single payer financing compared to our current healthcare system is the universal nature of health coverage. In addition, supporters claim that single payer overhead is far less than private insurance, often citing Medicare's 2% overhead factor compared to private carriers 10 – 15%.

Interestingly, proponents of single payer systems sometimes use international outcome statistics to bolster their case. The British and Canadians for example, live longer than we do, exhibit lower infant mortality rates than us but spend less on healthcare. The conclusion offered by single payer advocates: the British or Canadian healthcare financing system is not only cheaper, but also better than ours. (We evaluate this argument in our course on Single Payer systems.)

Opponents of single payer financing claim that public financing leads to underfunding of healthcare. This in turn leads to less investment in medical technologies and long waits for medical services. Opponents of single payer systems often point to the relative dearth of the latest technologies available in the UK or Canada, or to the extensive waits for many services in these countries.

Opponents also claim that single payer financing eliminates competition from healthcare to the detriment of the entire system. Only through competition, many believe, can we simultaneously reduce healthcare costs and improve outcomes. Managed care proponents, as you will see below, subscribe to this position.

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**Third, managed care differs from consumer driven healthcare.** Under CDHC, consumers make their own decisions about their healthcare. CDHC proponents believe that healthcare is essentially like other goods and services in our economy and that consumers are perfectly able to shop among providers for the best value.

Consumer driven theorists believe that competitive shopping pressures from individuals will control healthcare costs and improve healthcare quality. Impediments to competition such as mandates, regulated term insurance policies and group-based policies reduce consumer

sovereignty thus harm our system. Consumer driven advocates want to treat health insurance like typical goods and services in our society such as automobiles, retirement funds or houses.

Managed care theorists disagree. They believe that healthcare is fundamentally unlike other goods and services in our economy, and that consumers by themselves are unable to shop wisely for health services for reasons of information availability, risk and price.

Consumers, according to managed care theory, cannot access good information about important aspects of our healthcare system. They cannot self-diagnose nor determine which specialists are 'better' than others. They can't determine which treatment is most appropriate, which hospital is best for a specific ailment, or which providers offer the best value. Consumers need advisors to navigate through our healthcare system. In the managed care vocabulary, the advisor is the Primary Care Physician.

**MANAGED CARE DESCRIBED:** As envisioned by perhaps its foremost proponent Alain Enthoven, Professor Emeritus at Stanford Business School, managed care organizations are integrated entities that include both healthcare delivery systems (providers, labs, etc) and an insurance (financing) function. The critical components are:

1. Multispecialty group practices, comprised of primary care physicians, nurses, specialists, etc;
2. A voluntarily enrolled population that understands the advantages (price and hopefully quality) and disadvantages (reduced provider choice) of membership;
3. Comprehensive care;
4. Per capita prepayment;
5. Accountability by the organization; and
6. A close relationship between the financial and healthcare service delivery arms. <sup>3</sup>

The goal of managed competition, according to Enthoven is 'to divide providers in each community into competing economic units and to use market forces to motivate them to develop efficient delivery systems.' Only through competition can the health plans that do the best job of improving quality, cutting costs and satisfying patients be rewarded. Competition occurs at the level of integrated financing and delivery plans, not at the individual provider level.

This environment will force competing prepaid group practices to innovate and improve care quality while reducing costs. As such it is far superior to single payer healthcare which has no such competition forcing innovation and cost control. For managed care / managed competition to work, perfect premium price competition among plans must be preserved. Any interference with price competition – including government practices, taxes, employer contributions, union demands or other artificial market imperfections – will modify the competition and reduce its positive effects.

Prepaid group practices originally developed through competition with the traditional fee-for-service / indemnity coverage. To survive, the flagships of the HMO movement had to outperform traditional medical practices. These original groups included Group Health Association in DC (founded in 1935), Group Health Cooperative of Puget Sound (founded in 1945) and Kaiser Permanente (founded in the 1930s) the largest of all. Kaiser is generally regarded as the prime model of a successful prepaid group practice or managed care organization.

**A LOOK AT KAISER PERMANENTE:** Kaiser Permanente was formed in the 1930s when industrialist Henry Kaiser contracted with physician / entrepreneur Sidney Garfield to provide healthcare to Kaiser employees. Garfield owned a small chain of health clinics. For \$.05 per employee per day he offered to cover industrial medical care (workers comp), and for an additional \$.05, non-industrial healthcare (major medical) for all Kaiser employees.

As this business grew, Garfield contracted with the Permanente medical group. Kaiser became Permanente's exclusive client, and Permanente, Kaiser's exclusive provider. The organization became known as Kaiser-Permanente.

KP integrated the financial and service provision functions into a single company. It owned its own hospitals to eliminate the conflict between hospitals wanting higher occupancy and carriers wanting lower. It hired physicians on salary to eliminate the potential for moral hazard excess testing and billing. KP emphasized prevention, for it had incentives to keep people healthy and out of the hospital. Remember that it received a fixed payment per subscriber from the Kaiser industrial business, today commonly called capitation. If KP could service its subscriber population for less than \$.05 per employee per day, it remained financially solvent. If not, it lost money.

As KP grew, it innovated to maintain quality while reducing costs:

1. Kaiser hospitals in the 1950s reported 25% shorter stays than the US hospital average;
2. Kaiser' ratio of outpatient visits to hospital admissions was 50% higher than the US average in 1969;
3. In the 1960s, Kaiser was among the first to offer home nursing services as a substitute to expensive lengthy hospitalizations;
4. Through the 1970s and 80s, Kaiser continued to emphasize outpatient care, becoming one of the first institutions to offer freestanding surgery and emergency care facilities.<sup>4</sup>

In 1971, Dr. Cecil Cutting, the executive director of the Kaiser Permanente Medical Group in northern California wrote that the 'direct relationship of prepayment to providers become an incentive for the physician to develop economies in spending the medical dollar while maintaining quality'.<sup>5</sup> This differentiated Kaiser Permanente from the more common indemnity form of insurance.

Kaiser Permanente developed a unique institutional culture emphasizing prevention, waste reduction and a constant search for the least expensive / best treatment option.<sup>6</sup> Much of this came from Sidney Garfield. His waste control fanaticism became legendary: employees could only get a new pencil if they turned in a pencil stub of less than 3 inches. 'This period of stringent economy established a pattern of frugal allocation of resources that persisted even into more prosperous years' suggests Harvard Business School's Regina Herzlinger.<sup>7</sup>

The Kaiser culture formed in opposition to – and under attacks from – organized medicine. Garfield established his medical operations in the Mojave Desert in the early 1930s. He battled Great Depression economics and organized medicine that viewed his physicians as an economic threat. (Independent medical practitioners worried that prepayment would motivate physicians to provide fewer services than needed, thus harming both the profession's reputation and pocketbook.)

Garfield hired only true believers in his model, people interested in making the plan work. He claimed that 'if you don't have the [people] who have it in their hearts to make it work and who believe in prepaid practice, it won't work.'<sup>8</sup> His physicians worked 6 days per week. They formed tight social groups. 'We picked people who liked each other – we felt like we were enjoying ourselves.' Garfield worked alongside staff physicians and continually sought their input and new ideas. His clinics were dynamic worksites.

This bonding experience was one factor in the development of KPs' culture. Other factors included its business structure that integrated physicians, hospitals and insurance with each other, long term relations with patients and prepayment / capitation. This set of factors was unique to KP among health insurance companies.

In business terms, KP successfully vertically integrated the provider and financial functions for the overall good of the organization – very difficult to do. (See discussion of vertical integration and transfer prices, below.) KP's evolution and economic incentives allowed financial controllers, for example, to make decisions for the patient's long-term benefit, rather than focus on short term cost control. In part this was because KP had subscribers for life theoretically – or at least as long as they worked for the Kaiser industrial enterprises. The subscribers' future health had a direct bearing on KP's future success. Also in part, this was because the KP management established a corporate culture that superceded specific division or functional loyalties.

Thus Kaiser Permanente had a very different economic and corporate approach to the business of patient care than did most of its competitors.

**NIXON'S HMO ACT OF 1973:** Richard Nixon used Kaiser Permanente as the basis of his HMO Act of 1973, because KP was the largest and most successful of the HMO models.

Nixon felt pressured to do something to control rising healthcare costs.<sup>9</sup> National healthcare expenditures almost tripled from \$27 billion in 1960 to \$73 billion in 1970, creating economic and political problems. Robert Finch, then Secretary of Health, Education and Welfare warned Congress in 1969 that 'the nation is faced with a breakdown in the delivery of health care unless immediate concerted action is taken by government and the private sector'.

Politicians and special interest groups lobbied the Nixon administration to overhaul our healthcare system, though from many different points of view. The Special Committee on Aging wanted Congress to extend Medicare and Medicaid programs to the entire population. The 1969 National Governor's Conference endorsed New York Governor Nelson Rockefeller's (one of Nixon's key rivals for the Republican nomination in 1968) plan for national health insurance. Massachusetts Senator Ted Kennedy and the United Auto Workers led the prestigious Committee of 100 for National Health Insurance in drafting it's own universal healthcare plan.

Even Nixon's own assistant Secretary of Health, Education and Welfare, Lewis Butler, wrote that 'ultimately some kind of national health insurance should be enacted.' And Dr. Vernon Wilson, Nixon's chief of Health Service and Mental Health Administration at HEW said that Kennedy's plan 'was a well-conceived, comprehensive approach to solving the nation's health delivery problems.'

Nixon's problem: he had to do something, but he couldn't support a Democratic healthcare plan sponsored by one of his chief rivals, Ted Kennedy. Nor could support a Republican plan sponsored by another political rival, Nelson Rockefeller – especially a plan that potentially harmed the physicians, hospitals and insurance carriers that supported Nixon politically. He had to develop his own plan.

Dr. Paul Ellwood Jr, sometimes called the father of the HMO came to Nixon's rescue in 1970. Ellwood recommended a prepaid healthcare system that would motivate doctors and hospitals to control costs and keep patients healthy. Assistant Secretary Butler (see above) supported Ellwood's ideas because they fit with the Republican philosophy of support for free markets and competition to reduce costs. Butler also believed that these HMOs would be inexpensive to implement, optional and self regulating. Many conservative politicians and organizations agreed with the HMO idea because it was flexible, inexpensive, encouraged private investment in profit-making organizations and imposed few mandates or regulations. Nixon's new HEW Secretary, Elliot Richardson predicted in 1970 some 450 HMOs by the end of fiscal 1973 and 1700 by end 1976.

The Republican HMO plan faced opposition from both the left and right between 1970 – 1973. Kennedy and the Left consistently fought for higher levels of guaranteed benefits, community rating, open enrollment periods and significant Federal grants and loans to help HMOs proliferate. Richardson, the AMA and the Right wanted only basic levels of guaranteed benefits, less government funding and individual underwriting. Richardson in particular, feared that community rating would put HMOs at a competitive disadvantage compared to indemnity coverage that routinely rejected people with significant medical needs.

The AMA in particular, lobbied enthusiastically against the HMO idea. Dr. Malcolm Todd, for example, chair of the Physician's Committee to Reelect the President claimed 'We used all the force we could bring to bear against this legislation. As a result, there has been some backtracking on the part of the White House, [which] directed the [HEW] Secretary to slow down this thing.'

As a result of these competing pressures and Nixon's determination to implement his own plan (i.e. not Kennedy's or Rockefeller's), the HMO Act of 1973 was not a particularly close copy of the Kaiser Permanente model. Indeed, the changes to KP's model doomed the entire effort for three main reasons:

**First**, under Nixon's law, HMO meant simply 'prepayment' – not vertical integration. Healthcare delivery and healthcare finance were separate functions handled by separate companies. This satisfied independent insurance carriers, physician groups and general hospitals - all parts of Nixon's political base. But the key integration feature that made Kaiser-Permanente so successful was lost in the legislation.

Why did carriers, physician groups and general hospitals dislike vertical integration? The short answer: they wanted to compete for revenues with each other.

Carriers hoped to dominate the marketplace and dictate economic terms to providers. The American Medical Association wanted its members to remain free from carrier or hospital meddling so they could protect their incomes. Hospitals wanted to determine patient lengths of stay to protect their own cash flow.

None of these groups trusted the others or the government to protect their interests.

**Second**, Nixon's law called for a loose physician structure, in which practitioners could opt in or out of any HMO. Again, this satisfied the insurance, physician and hospital groups. But it was the opposite of KPs tight structure in which physicians were fully integrated into both the hospital and financial system. The loose physician structure meant that providers had no particular loyalty to any specific HMO. Another key feature of KP was lost.

**Third**, Kaiser-Permanente used a capitated financial structure to motivate providers to control costs. Nixon's law allowed providers to bill insurance carriers on a fee-for-service basis. Absent capitation, much of the underlying financial advantage disappeared.

What were the results of Nixon's legislation? 'The HMO Act of 1973 clearly inhibited HMO development' claims Jan Coombs in *The Rise and Fall of HMOs*. Some 124 HMOs developed from 1970 – 1974, but only 40 developed from 1974 – 1978. Also, the enticement of public funding was insufficient to overcome federal legislative and regulatory requirements, so many HMOs turned to Wall Street financing and state approvals. In 1981, 88% of HMOs were nonprofit; by 1986 this had fallen to 41%.

Nixon's act legitimized HMOs and managed care, but so drastically altered the Kaiser Permanente model that insurers and providers had to develop new organizational forms. No longer did managed care equal Kaiser Permanente's closely integrated finance and service provision model. Instead three different types of managed care appeared in the marketplace.

**Staff model managed care** looked most like KP. Under a staff model, physicians were paid salaries by the integrated carrier/provider, which generally also owned its own hospitals. This allowed the carrier the greatest amount of cost and quality control over providers. Staff models are the most expensive to establish, take the longest time to get up and running, and offer subscribers the most limited networks of providers. They are generally the least attractive model to consumers for this reason.

**Group model HMOs** look like the original version of Kaiser Permanente. Here a carrier and provider group have mutually exclusive contracts. Carriers still exert cost and quality controls, through perhaps to a lesser degree. Quicker to establish than staff model HMOs, the limited network is still relatively unappealing to consumers.

**Independent Practice Associations or Network Models** offer the widest provider networks and the least carrier cost and quality control. The American Medical Association favored this form of managed care after Nixon's law – because it allowed AMA members the best opportunity for financial gain.

With IPAs, multiple carriers contract with any willing provider and carriers have the least amount of input and control. This managed care form also has the highest degree of consumer satisfaction as it generally offers the largest provider network and the least restrictions. Some commentators wonder if IPAs are really managed care at all, or instead simply fee-for-service / indemnity healthcare with a price list.

Post Nixon, HMOs grew because managed care premiums were lower than the alternative, indemnity coverage. As a result:



By 1980, 9 million Americans enrolled in HMOs;  
By 1990, 33 million enrolled;  
By 2000, 60 million enrolled.

However, the majority of subscribers entered IPA or network models:

Group and Staff Market Share <sup>10</sup>

| <u>Date</u> | <u># of subscribers</u> | <u>% of all HMO subs</u> |
|-------------|-------------------------|--------------------------|
| 1980        | 7.4 million             | 81%                      |
| 1990        | 13.1 million            | 39%                      |
| 2002        | 7.5 million             | 10%                      |

This raises a key question: Was the US moving toward true managed care or something else?

**COST AND QUALITY CONTROLS 1970 – 2000** Nixon's managed care legislation was supposed to use market forces to control healthcare costs and improve quality, just like Kaiser Permanente's experience. Unfortunately, the legislation differed so significantly from KP's model that various government agencies had to step in and devise new cost and quality control mechanisms. These were previously unseen at KP or other managed care organizations. Many of these controls became codified in our healthcare operations and still continue today; they institutionalized a non-Kaiser Permanente type of 'managed care.'

According to Northwestern Professor David Dranove, these cost and quality control programs 'utterly failed on all accounts.'<sup>11</sup> Bureaucrats and administrators – not physicians and medical practitioners – took over and sabotaged the managed care reform movement. They turned it into something that Sidney Garfield would not have recognized.

### **Hospital Cost Control Programs**

New York State had developed the first **rate setting program** in 1970. The New York legislature tried to cap Medicaid hospital payments and included private carriers in the program to avoid hospital cost shifting. This system was already in place when Nixon's HMO legislation passed. It continued since Nixon's plan allowed hospitals to bill carriers fee-for-service.

New York State was the first to try serious Medicaid cost controls since it had such a large Medicaid population. Medicaid costs are split between the federal and each state government. New York officials worried that continued Medicaid inflation might require politically unpopular tax increases. Hence their motivation to control costs.

The New York State Prospective Rate Setting System established a flat fee per patient per day. The fee was set at the beginning of each year so hospitals could budget and plan, and was approximately equal to the average cost per patient per day the previous year with an inflation factor and regional cost variations applied.

New York officials figured that the patient population would be about the same each year – about the same number of births, broken legs, heart attacks, etc - so on average hospitals would receive the same income year after year, adjusted for inflation. This assumption proved incorrect.

Hospitals quickly learned how to game the system. Since they received the same reimbursement from Medicaid for all patients, they earned more by admitting the healthy and denying care to the sick. Hospital competition quickly switched from providing excellent service to all patients, to denying service to expensive patients. Not a good solution.

New Jersey observed the experience in New York and sought to improve on New York's model by devising its own Prospective Payment System in the late 1970s – a few years after Nixon's HMO legislation. New Jersey modified New York's calculation of average cost/patient/day by introducing some 470 Diagnosis Related Groups (DRGs). This system, designed by Yale Medical School, divided patient costs into diagnostic groups. Cancer surgery now received a higher reimbursement than a simple overnight observation. New Jersey hoped to deny hospitals the ability to game the system as hospitals had in New York.

Under the New Jersey plan, hospitals would receive appropriate payment for medical treatment, but no more; patients would receive necessary care, but no more; and medical cost inflation would be controlled, at least in theory. Again this changed the KP model: there were no DRGs in Garfield's original system because there was no fee-for-service billing. Medicare took the New Jersey system national in the mid-1980s.

How did hospitals control their costs? Many shifted to more outpatient surgeries – not necessarily a bad thing. In 1984 some 28% of all community hospital surgeries were outpatient; by 1996 that percentage had increased to 59%, mirroring KPs' experience.

Other hospitals simply focused on DRG management. Some hired DRG experts to help 'up-classify' patients to receive higher reimbursements. Others began 'dumping' expensive patients who exceeded their DRG reimbursements by transferring them to other hospitals - presumably with less sophisticated admissions procedures. Some hospitals practiced 'skimming', by admitting only potentially profitable patients. Still others engaged in 'unbundling' services, or requiring patients to make more hospital visits at higher reimbursements, often with no additional health benefits. Hospitals, in other words, figured out how to game the DRG reimbursement system just as hospitals had in New York State.

Perhaps the biggest effect of DRG imposition, though, was a change in hospital culture. Hospitals previously were generally non-profits, funded by charitable contributions and cost-plus reimbursement. They were typically run by physicians who were more interested in providing service to the community than in maximizing revenues. They faced little financial risk. Perhaps they were more inclined to negotiate cooperative financial arrangements with carriers. As Northwestern's David Dranove says

Until the early 1980s, the managers of nonprofit health care organizations were under little financial pressure. Market conditions enabled even badly managed hospitals to survive. Private insurers either paid whatever price the hospital charged or paid the hospital for its costs plus a predetermined profit margin...(hospitals) that provided unprofitable services or cared for the uninsured covered the expenses by charging higher prices to everyone else.<sup>12</sup>

Physicians had traditionally run hospitals, leaving administrators to manage bookkeeping, purchasing and other defined line functions. These physicians could, perhaps, have worked in vertically integrated operations.

But DRGs changed this. By putting hospitals at financial risk, DRGs put hospitals and carriers on a competitive collision course. If the hospital managed its DRGs better than the carrier, then it received higher reimbursements – and earned more money - at the carrier's expense. Alternately, if the carrier out-managed the hospital, it made money at the hospital's expense. No longer was collaboration even possible – competition ruled.

Hospitals addressed this competition by hiring MBAs to put them on a level playing field against carrier financial expertise. Hospitals at first hoped to continue business as normal, with the MBA folks focusing on their specific DRG and financial areas of expertise. But this model disintegrated as the business school graduates began assuming true management responsibility.

This responsibility shift opened a Pandora's box. Once hospitals began hiring sophisticated MBAs - to fight the DRG battle - and giving them true responsibility, the MBAs learned how to manage hospitals...and then began buying them.

MBAs saw three particularly attractive reasons to own hospitals. First, hospitals had good long term cash flow provided by the government and private carriers. Second, implementing sound business practices could control hospital expenses – something previously insufficiently widespread in non-profit hospitals. And third, hospitals could design sophisticated accounting and billing systems to increase profits.

So attractive were these opportunities that investor-owned systems acquired over 100 hospitals by 1975; 273 hospitals by 1980 and nearly 500 hospitals (plus 200 more under management contract) by 1985.<sup>13</sup> By about 2000, investor-owned hospital networks dominated the landscape, and companies such as Partners Community Health Plan in Boston and the Sutter system in California were 'unabashed about flaunting their power, publicly stating their intention to use their leverage when negotiating rates with managed care purchasers.'<sup>14</sup>

The DRG subtle accounting change altered the mindset of hospital administrators and investors and began our national shift to investor-owned and professionally managed hospitals. Hospitals felt they had to maintain control over their billing function. Though carriers and regulators won some DRG battles, within 25 years hospitals won the DRG war.

The loser: true managed care. Rather than developing a national system of integrated financing / treatment operations like Sidney Garfield developed for the Kaiser industrial workers, we instead became an investor-owned, private hospital based healthcare system skilled at competing with financing organizations. The unintended consequence of Nixon's legislation became a stronger, more ingrained fee-for-service reimbursement system based on hospital vs. HMO competition. This was not at all what Sidney Garfield had originally developed.

### **Hospital Quality Control Programs**

Just as Diagnosis Related Groups were aimed at controlling hospital costs, so various measures were introduced in the 1970s to control hospital quality. These aimed primarily at ensuring that patients received appropriate, high quality hospitalization and care.

They fared no better than DRGs and none supported close cooperation between carriers and hospitals. None, in other words, supported the development of true managed care.

The first Professional Standard Review Organizations (PSROs) began in 1972. These were established by the Social Security Amendments of 1972 to 'promote the effective, efficient, and economical delivery of health care services of proper quality for which payments may be made.'<sup>15</sup> PSROs were local physician organizations designed to monitor the necessity, appropriateness and quality of hospital care. PSROs established standards of care for a wide range of diseases, with a goal of treatment practice uniformity – rather like guilds.

These organizations were quite ineffective. Local physicians, it turned out, were generally reluctant to judge or punish their colleagues. PSROs created dilemmas for physicians who observed questionable quality or potentially excessive treatment in others. Should they report on physicians who unnecessarily bring patients into the hospital - but increase everyone's income? Should they be team players? Or should they fight other physicians and hospital administrators and create political or professional problems for themselves?

Most physicians decided their interests – financial and professional - lay in getting along with their colleagues rather than reporting on them. Hence PSROs failed to have much impact on US medical quality.

Regulators grasped this problem and modified the PSRO concept when creating the next quality control mechanism, the Professional Review Organization (PRO) in 1983. These were private companies, initially contracted by Medicaid. PROs were designed to assure the necessity and appropriateness of Medicaid services by reviewing hospital records for evidence of upcoding, dumping or unbundling of services. PROs established elaborate guidelines and enforcement protocols, again focusing on physicians and hospitals working in a particular locale.

Unfortunately, the process of developing guidelines introduced an even bigger problem - startling variations in medical practice across seemingly similar communities.<sup>16</sup> A famous early study 'Are Hospital Services Rationed in New Haven or Over-Utilized in Boston' reported that rates of certain procedures including coronary artery bypass graft surgery were much higher in New Haven than Boston, but rates of other procedures such as carotid endarterectomy were higher in Boston than New Haven.<sup>17</sup> Studies such as this<sup>18</sup> suggested the PRO focus was too narrow and that the real hospital quality problem involved treatment variations. These put patients at risk, for some were under-treated while others were over-treated.

Once our medical community realized that treatment variation was a huge healthcare systemic problem, the question arose about how to address it. The medical community decided to continue measuring and controlling treatment inputs – costs, types of procedures, second opinions, etc. (It could, alternatively, have started to measure treatment outcomes – mortality and infection rates for example. The medical community apparently decided these outcome quality measurements were inappropriate, undesirable or too difficult to quantify.)

The exclusive focus on input measurement doomed future quality control programs to failure.

The first such post-PRO program was development of Treatment Guidelines. These had a goal of standardizing medical treatments to control both quality and costs. Treatment guidelines typically provide the medical staff with detailed day-by-day instructions for testing, nursing, surgery, rehabilitation and discharge planning. Guidelines also provide a systemized method of ordering tests.

Unfortunately, contradictory treatment guidelines proliferated. By 1994 the AMA reported over 1600 sets of guidelines designed by potentially competing special interests. Hospital guidelines sometimes said 'treat' (presumably to increase hospital occupancy) while carrier guidelines said 'don't treat' (presumably to control costs). Some guidelines were developed by pharmaceuticals and recommended drug therapy; others by surgical supply manufacturers and recommended surgery. Hospital bureaucracies and physicians often resisted the imposition of guidelines, which ultimately became voluntary and only marginally effective.

Regulators next turned to Utilization Review to overcome the narrow focus of PROs and ambiguity of Treatment Guidelines.

Utilization Review is a screening procedure to determine (a) if the patient should be admitted, (b) surgical second opinions and (c) on-going review of high cost cases.

Independent 'objective' companies perform Utilization Review. These companies have developed best practice criteria. Procedurally, the hospital admissions nurse reports clinical data and a treatment plan to the UR nurse who may agree to hospitalization, recommend outpatient treatment or even refuse the treatment plan. Typically there is also an appeal procedure.

Supporters claim Utilization Review achieves two goals. First, UR companies keep their screening procedures current with the medical literature, something no physician or hospital could possibly do given the hundreds of studies published annually. Second, they claim that UR reduces inpatient costs by reducing unnecessary hospitalizations and treatment.<sup>19</sup>

Detractors see UR as an unwanted intrusion in the physician-patient relationship, with some physicians even lying to get around UR restrictions.<sup>20</sup> Other detractors claim the UR companies have a financial bias to show cost reductions in order to get their contracts renewed. Interestingly this is the opposite of hospitals' financial bias to perform treatments.

Some commentators have concluded that UR has failed to provide the desired level of cost and quality control. The Journal of the American Medical Association reported a 'Retrospective Drug Utilization Review' study in 2003 that concluded 'we were unable to identify an effect of retrospective drug utilization review on...clinical outcomes'.<sup>21</sup> The New England Journal of Medicine reported that a studied utilization review program 'reduced the number of diagnostic and surgical procedures performed that required second opinions...(but) otherwise the program had little effect'.<sup>22</sup> The Canadian Medical Association Journal published a research study 'How valid are utilization review tools in assessing appropriate use of acute care beds?' and found that some UR companies underestimate – while others overestimate – appropriate hospital admission stays.<sup>23</sup> The CMAJ article concluded that

Although utilization review tools are widely accepted, these considerations...raise serious questions about the value of the tools...and whether they should be used at all.

### **Effects of Cost and Quality Control Programs on Managed Care Development**

Some carriers like Utilization Review while others do not. But that misses our point:

None, in other words, mitigate the conflict wrought by DRGs. But all became codified in US healthcare practices post-Nixon. All supported the deviation from true managed care. And all –

especially when combined with DRGs - make a return to real 'managed care' a la Kaiser-Permanente increasingly difficult. The reason: to implement true managed care now, we must first undo all the post-1973 healthcare systemic and bureaucratic evolution based largely on conflict between hospitals and carriers. No small task.

Our 1973 – 2000 experience with managed care did, however, superficially appear somewhat successful. Healthcare spending in 2000 was \$300 billion less than had been forecast by the Congressional Budget Office only 7 years earlier.<sup>24</sup> Unfortunately these savings were primarily the result of two features, neither of which appeared in the original managed care plan design:

1. Hospital overcapacity in the 1990s (resulting from overbuilding in the 1980s plus treatment constraints in the 1990s) allowed carriers to gain significant price concessions from providers;
2. Managed care insurance companies controlled costs by service denial: denial of provider payments, denial of specialist referrals, denial of hospital admissions. 'At the peak of managed care's sway, in 1999, far more physicians were financially rewarded for productivity [i.e. number of patients seen] by insurers than for patient satisfaction' claims Harvard Business School's Regina Herzlinger.<sup>25</sup>

Providers hated managed care. Carriers squeezed hospital revenue. Physicians lost control of their incomes and professional independence – in both cases to administrators – largely because of DRGs and Utilization Review. Subscribers hated it for they felt at the mercy of a heartless insurance carrier that denied necessary services for the sake of profit. The popular 2002 film John Q played on these concerns – a father whose insurance company wouldn't pay for his son's medical treatments takes an Emergency Room hostage until doctors agree to operate. John Q could be any American according to the film's marketing; it grossed over \$71 million in the first 2 months.

Meanwhile, the US Institute of Medicine in 2001, during the heyday of managed care, released its shattering study 'Crossing the Quality Chasm' claiming

The US healthcare system does not provide consistent, high quality medical care to all people...between the healthcare that we now have and the healthcare that we could have lies not just a gap, but a chasm...

The nation's healthcare delivery system has fallen far short in its ability to translate knowledge into practice...

This and other observations led ***The Economist*** to claim that managed care just 'treated the symptoms' – like every other healthcare control strategy.<sup>26</sup>

**THE MANAGED CARE PROPONENTS CALL FOUL:** The US healthcare system that developed post 1973 was not the healthcare system envisioned or designed by true managed care proponents. It strayed from their original concept and Kaiser Permanente's model, and thus failed to realize its true potential due to Nixon's political compromises and subsequent market evolution. The proponents called for a return to basics so managed care could finally replicate KP's financial and quality results nationally; they did not want to be blamed for managed care's failure.

Thus Stanford's Alain Enthoven wrote ***The History and Principles of Managed Competition*** and ***Why Managed Care Has Failed to Contain Health Costs*** both in 1993 <sup>27</sup> just as the Clinton administration began considering national healthcare reform...apparently hoping that this time a President would bring his ideas to life. In these back-to-basics pieces Enthoven reminded readers that Nixon had perverted his ideal, creating 'a system dominated by the cost-increasing incentive of fee-for-service payment combined with the cost-unconscious demand of insured patients' whose insurance was paid by employers and subsidized by taxpayers.

US HMOs developed provider networks, Enthoven claimed, simply by cobbling together independent physicians and paying them according to a fee schedule – in other words, IPAs. This was not the Kaiser Permanente model!

Enthoven went on to decry fee-for-service for 11 reasons:

1. Fee-for-service creates an adversarial relationship between doctors and payers;
2. Fee-for-service has little accountability – poor data collection and provider motivations for economy;
3. Fee-for-service 'free choice of provider' leaves patients to make remarkably poorly informed choices;
4. Fee-for-service generates excess hospital capacity, high tech equipment and open-heart surgeries;
5. Fee-for-service generated an excess supply of specialists;
6. Fee-for-service misallocates resources, as no incentive to use the least costly settings for treatment;
7. Fee-for-service has no capacity to plan care processes from diagnosis to treatment to rehabilitation;
8. Fee-for-service has led to a dangerous proliferation of facilities for complex and costly procedures without the volumes necessary to maintain good outcomes;
9. Fee-for-service cannot practice total quality management due to lack of service integration;
10. Fee-for-service cannot organize the rational use of technology
11. Organized systems, unlike fee-for-service, can emphasize prevention, early diagnosis and effective chronic disease management.

He further reiterated how to structure the market by a set of rules 'laid down once and for all.' These include appropriate types of plan sponsors, rules to ensure equity, rules to manage the enrollment process, rules for managing risk selection, rules for monitoring specialty care and quality, and lots more rules to make the system work. His goal: define a system involving

Intelligent, active collective purchasing agents contracting with healthcare plans on behalf of a large group of subscribers and continuously structuring and adjusting the market to overcome attempts to avoid price competition.

Any deviation from this ideal system reduces its effectiveness. Groups that dreamt up ways to get around the rules for their own advantage upset Enthoven. He lamented the self centered interests of many involved in healthcare: 'Whatever set of rules one proposes, critics could and did dream up ways for health plans to get around them to their advantage.'

Nixon's HMO Law of 1973 and subsequent healthcare evolution so perverted his managed care ideal that he wrote in *Why Managed Care Has Failed to Contain Health Costs* 'Some say that competition has failed. I say that competition has not yet been tried.'

He described Health Insurance Purchasing Cooperatives as the mechanism of implementing true managed care, just as Hilary Clinton was developing her healthcare plan. Enthoven's *History and Principles* seemed to serve as the intellectual basis to promote true managed care for all.

### **BILL AND HILARY CLINTON TAKE ON HEALTHCARE**

Bill Clinton had campaigned for President on four healthcare platforms:

1. To provide healthcare coverage for all Americans;
2. To slow runaway medical care cost inflation;
3. To minimize governmental intrusion; and
4. To avoid harming most special interest groups. <sup>28</sup>

He delegated responsibility for the specific healthcare plan design to his wife, Hilary. She introduced her plan in mid-September 1993.

The plan itself was broad, ambitious and founded in Enthoven's theories. It would set up one or more large 'healthcare purchasing alliances' in each region. These would restructure the health insurance market by serving as the group purchaser for people not on Medicare, including small and medium sized employers. Large companies with 5000+ employees could act as their own purchaser.

These alliances would manage competition among plans and carriers, along the lines that Enthoven envisioned. They would – theoretically – offer people their choice of health plans and would provide them with competitive information about costs, services and quality. As envisioned by the authors, consumers would have a minimum of 3 plan options, varying by cost-sharing, out of network restrictions and specific services covered (above the mandated minimums). The alliances' responsibilities would include maintaining competition among plan options so those that operated most efficiently would get rewarded in the marketplace.

The Clinton Plan would require carriers to offer a comprehensive minimum set of benefits including hospital and office care, clinical prevention services, hospice care and home health and long term care. By 2001 it would add mental health and substance abuse services.

The entire healthcare distribution operation would be run by a complex administration including a National Health Board responsible for oversight, budgets and national quality. States would also have responsibility for establishing risk-adjustment procedures, monitoring carrier fiscal stability and monitoring the quality of local care. This combined state and federal administrative effort was deemed necessary to ensure two things:

1. That our healthcare system would function well both during and after the transition to the Clinton Plan; and
2. That Enthoven's dual theories of managed care and managed competition would be made operational.



Hilary Clinton presented her 1000+ page healthcare plan in 1993. For about a year proponents and opponents discussed, debated, analyzed and considered her healthcare plan for America. Articles appeared in learned journals; interest groups spent over \$100 million lobbying and campaigning for or against it. Ultimately, in 1994, Congress voted the plan down.

The interesting question from this story is 'why'. Why did the American people – and ultimately Congress – reject Hilary's plan?

Public opinion polling during this period highlighted contradictory and confusing indicators. The American public apparently liked the ideas – while disliking the Clinton plan. Understanding how this can be helps explain the fundamental problem with establishing true managed care in the US.

The Wall Street Journal reported in 1994 that 'Many Don't Realize It's the Clinton Plan They Like'. The article summarized results of a WSJ-NBC news poll asking people their reaction to a health plan that contained the same features as the Clinton plan but without revealing that it actually was the President's. Some 76% found 'some' or 'a great deal' of appeal in Clinton's plan – even while indicating in other polls their opposition to 'the Clinton Healthcare Plan'.

How can people actually like the plans' features while opposing the plan itself? According to former Harvard University President Derek Bok, there are two answers: <sup>29</sup>

First, Americans distrust government imposed solutions to problems;  
Second, special interests (intentionally or otherwise) play on popular fears with targeted marketing campaigns.

Bok reports that polls taken during the 1993 – 1994 healthcare debate showed that 80% of the population believed healthcare costs would rise more than the Clintons claimed, including 54% who thought costs would rise 'much more'. Similarly although only 25% of Americans said that they understood what a health alliance actually was, 65% assumed that the President's plan would lead to more bureaucracy. Perhaps the Clintons marketed their plan poorly. But perhaps also, popular distrust of government made their marketing task impossible.

Plan opponents understood this popular sentiment and played on it. The over \$100 million spent to lobby the public for or against healthcare reform, according to Bok, 'seemed designed less to inform than to arouse latent fears and anxieties'. He reports on an infamous Harry and Louise TV commercial paid for by the Health Insurance Association of America:

This plan forces us to buy our insurance through those new mandatory government health alliances,' complained a prototypical wife, Louise... 'Run by tens of thousands of new bureaucrats,' added husband Harry. 'Having choices we don't like is not choice at all,' replied Louise. 'They choose, we lose,' both concluded with evident disapproval.

The University of Pennsylvania's Annenberg School of Communications found that 59% of all TV ads on healthcare reform were misleading, with most attacking rather than advocating one position or the other. Opponents said the Clinton plan was 'involuntary euthanasia' that deprived families of their choice of a doctor. Proponents claimed that 'unless the Clinton plan is passed, million of Americans will have no access to healthcare.' Fearmongering on both sides led less to education and compromise than to rejection amidst a climate of fear and mistrust.

This shows the fundamental problem with the Clinton healthcare plan – the same problem that has plagued every other government attempt to reform healthcare. Government designed, top-down solutions imposed on Americans fail due to the lack of buy-in by participants. Americans, it appears, do not want to be told what kind of healthcare to purchase.

Top-down solutions attempt to impose the values of some group – Stanford academics, Washington liberals, Texas conservatives or whomever – on the rest of Americans. It matters less that the healthcare plan is good or bad; what matters is that it is imposed. Americans need time to evolve solutions to our healthcare problems, to feel comfortable with and to embrace healthcare reform. This is not, as in the Clinton case, a 12 – 15 month process. It is a process in which Americans gain positive experiences necessary to ‘buy-in’. (Remember that it took years and years for Garfield to develop the Kaiser-Permanente operation.)

Absent this buy-in, we will, apparently, reject a health plan we like (according to the Wall Street Journal polling data) simply because it is imposed on us.

In short, any attempt to implement reform healthcare need focus at least as strongly on the acceptance process as on the plan itself. At least that appears the major lesson of this story. And popular acceptance is likely a multi-year, long term process.

The Clinton Administration ultimately failed to pass its huge healthcare reform plan. American culture and politics intervened, and for the second time in 20 years an attempt to take Kaiser Permanente national failed. That political debacle led to another 15+ years of fee-for-service healthcare that deviated from the ‘true’ managed care model, with economic and quality results that harmed Americans.

**MANAGED CARE PROPONENTS POST CLINTON REFORMS:** The true believers, though, weren’t finished yet. In 2002, Enthoven and Laura Tollen edited ‘Toward a 21<sup>st</sup> Century Health System’ which again extolled the virtues of Kaiser Permanente. In the Foreword, William Roper, Dean of the University of North Carolina School of Public Health, claimed

Prepaid group practices have remained the health reform prescription of choice of many in the health policy community...and I proudly put myself among them.

The problem with managed care in the 1980s-1990s, says Roper, was that it was forced on people, which planted the seeds of consumer backlash. Enthoven echoes this in his Preface by stating that ‘Patient satisfaction depends a great deal on whether or not the patient became an HMO member voluntarily or involuntarily.’ (He apparently had learned from the Clinton’s failure.) If only people would want to join prepaid group practices like Kaiser Permanente, then our healthcare system would improve. If only we could diffuse the model, then people would see its successes and want to join.

Chapter 1 of ‘Toward a 21st Century...’ discusses the two key barriers to diffusion of this model:

1. Lack of a group / corporate culture, and
2. Lack of financial incentives.<sup>30</sup>

Are these surmountable problems? Can the Kaiser Permanente model be successfully replicated? In other words, ***can managed care ever work?***

**The Corporate Culture Problem:** By the late 1990s, Kaiser Permanente began losing money – some \$270 million in 1997 alone. This was due to its rapid growth; some 50% of top managers were new to their positions by the late 1990s, and 20% of them were new to the organization. ‘The culture-imbued physicians, the hospitals managed directly by Kaiser, the seasoned insurance officials who worked with the providers to balance healthcare quality and cost, the tense interplay among the three elements of the system – all were diminished’ in this process, suggests Harvard’s Herzlinger. Kaiser’s membership soared, but it nearly lost its soul in the process.<sup>31</sup>

Remember Sidney Garfield who claimed you need true believers to make prepaid group practices work. He went on to state that ‘they aren’t going to work unless they get men [and women] who really believe in giving service to the people.’ In our market based economy, especially with our post-1973 experiences with DRGs and the like, it’s very difficult to hire seasoned, experienced managers, skilled in competition but with the right care-giving, philosophical orientation.

Absent culture, HMOs manage costs by denying claims – not nearly the same as managing health. Even Enthoven agrees that developing a corporate culture takes time, energy and effort – they are ‘difficult to develop and slow to grow’<sup>32</sup> - and then still may not succeed. Corporate culture grows from shared experiences and difficulties. You can’t recreate Kaiser’s culture without its evolutionary past. Absent soul and shared evolution, you’re doomed to fail.

This is apparently what happened to Kaiser Permanente during its failed attempt to expand into North Carolina.<sup>33</sup> KP entered North Carolina in 1984 and exited in 1999, where is operated mainly as a Group Model HMO. It peaked at 134,000 subscribers in 1997. According to the University of North Carolina researchers who studied this expansion, corporate culture problems plagued the enterprise from the beginning:

- KP struggled to find the right balance between giving the North Carolina operation the flexibility and autonomy necessary to respond to local market conditions while maintaining the overall corporate goals and policies. In other words, KP struggled to find the right mix of national corporate culture with local medical culture;
- The original KP – North Carolina leadership was supposed to replicate the California model, not innovate. Managers referred to the ‘cookbook formula’ imposed from KP headquarters;
- KP – North Carolina managers found it hard enough to build the familiar group model delivery system from scratch under less than hospitable market conditions (i.e. local medical cultural norms and specific state regs) – but found that creating a network model (as demanded by local conditions) so far removed from KP’s core competence was impossible;
- Managers reported that KP’s flirtation with network models nearly cost the company its soul;
- KP’s expansions into Texas, Kansas City, New York and New England also failed.

The University of North Carolina researchers concluded that this failed expansion case illustrates the difficulties of replicating the vertically integrated model in new geographic markets under different market conditions.

**Why Vertical Integration Fails** (or the Financial Incentive Problem): In Kaiser Permanente’s model the providers and financiers work together for the overall good of patients and the

organization. This is vertical integration: the financial and provider functions belong to the same corporation.

Merging these functions together is extraordinarily difficult, especially absent the shared values of a meaningful corporate culture. Hospitals, physicians and financiers have fundamental conflicts:

- Hospitals want high bed occupancy to generate income; carriers want low occupancy to reduce expenses;
- Hospitals want high reimbursements per patient; carriers want low;
- Physicians want high compensation / rewards from hospitals for referrals; hospitals want to pay less
- Hospitals want to make money; carriers want to control premium rates

The financial mechanism that links the insurance function to the provider function is called a transfer price. If the transfer price is too high, then the hospital makes money but the insurance carrier loses – a big problem if the insurance managers are compensated based on profits or if the insurance carrier is publicly traded.

If the transfer price is too low, then the carrier makes money but the hospital loses – and hospital managers face the same problems as carrier managers, above.

If the transfer price is set at market, then why integrate? Remember Enthoven's 11 problems with fee-for-service pricing. At market transfer pricing, there seems little advantage to owning both the financial and delivery systems as you just recreate the problems that you integrated to solve.

Vertical integration, according to McKinsey 'is notoriously difficult to set, easy to get wrong and – when a company does get it wrong – very costly to fix.'<sup>34</sup> Enthoven apparently agrees, claiming that managing true prepaid group practices requires 'wise, if not visionary, leadership, which has been relatively rare in American healthcare in recent years.'<sup>35</sup>

The examples of good vertical integration in Prepaid Group Practices – Kaiser Permanente until the 1980s, Group Health Cooperative in Seattle, HealthPartners in Minneapolis, the Mayo Clinic in Minnesota and others – were formed in a different era. That was before hospitals consolidated, before universities trained students in healthcare administration, before American consumers became accustomed to wide provider choice, before DRGs created billing conflicts between carriers and providers and before the myriad of state and federal healthcare regulations. Senior officials at existing Prepaid Group Practices think that 'without substantial changes to the US financial and regulatory systems, it would be difficult for new PGPs to develop and for many of the current ones to expand' due largely to the difficulty of exporting the entrenched group culture.<sup>36</sup> In this, they are probably correct.

Indeed, the UNC researchers who studied Kaiser Permanente's foray into North Carolina suggest several elements necessary for managed care success.

Key Idea: Elements necessary for managed care success today:

1. Broad choice of health plans, so HMOs can demonstrate their value advantages (financial savings and quality improvements vs. fee-for-service plans);

2. Risk adjustment to mitigate adverse selection;
3. Employer contributions that allow employees to retain any savings resulting from an economical choice;
4. A level playing field among HMOs, insurers and self-funded plans;
5. Reliable, comparable information about plan quality and customer satisfaction.

Unfortunately for managed care, if these are the necessary preconditions, the US healthcare market is far from an appropriate environment. Let's review some of these elements:

**First, broad choice of health plans.** Our current national trend is for fewer carriers to offer a broader choice of plans with broader provider networks. Many employers (mainly smaller) offer only a limited plan selection, often for reasons of administrative expediency. Subscribers demand wide provider choice, perhaps as reaction to managed care excesses of the 1990s. True managed care options with limited provider access in return for (theoretically) lower premiums and better quality run counter to this national trend.

**Second, risk adjustment among health plans.** In Enthoven's model carriers will use advanced statistical techniques to determine the likely future health costs of a subscriber, and the managed competition system will make financial arrangements (called risk adjustments) among plans to level the risk playing field. These statistical techniques are not yet available. As Enthoven wrote, not particularly comfortingly, in 1993:

It turns out to be much harder than one might think to turn available diagnostic information into 'risk adjusters'. For example, among patents diagnosed in one year to have breast cancer or HIV, there will be a very wide variation in medical costs the next year. **But it seems reasonable to suppose that diagnosis-based models eventually will be available** <sup>37</sup>

It may or may not be reasonable to make this supposition – but it is certainly a weak premise upon which to base our healthcare policy.

**Third, employer contributions should allow employees to retain savings from choosing a true HMO.** Unfortunately a number of factors currently mitigate against this. Employees generally pay half or less of their premiums on a pre-tax basis. Here's a typical scenario:

Total healthcare monthly premiums = \$1000  
 Employee contribution (33%) = \$ 333 to employee  
 Tax deductibility (at 40% combined state and fed) = \$199 net to employee

If the HMO cuts costs by 15% or \$150/month versus the competition (quite an outstanding achievement), the employee likely would only see a \$30 monthly after tax savings. To take advantage of this small savings, the employee may need to change primary care physician, change benefits and access a smaller provider network. Not very attractive to the employee.

But it creates a huge burden for the managed care organization. Since the employee only pays, effectively, about 20% of the premium after tax, the carrier must generate outstandingly good results to get employees to enroll.

Would the employer allow the employee to keep all the savings as managed care proponents desire? Unclear. Many employers want to reduce their own health insurance burden. One

rational response by employers: fix the employee contribution at \$199/month, regardless of plan. Then let employees choose among a true managed care option or fee-for-service coverage. The employer would keep any savings generated by the managed care organization.

In sum, our business environment is currently not structured as the managed care proponents require.

**Fourth, we need reliable, comparable information about plan quality.** This is often called transparency and requires both price and outcome data.

Unfortunately, our healthcare system is extremely poor at collecting and disseminating comprehensible outcome data. We don't, currently, know which providers have the best results, which hospitals have the lowest infection rates or which PCPs have the best diagnostic capabilities. Our healthcare system is evolving in this direction, but we're far from there today.

Thus, the pre-conditions outlined by the UNC researchers do not exist in our healthcare system. They agree by noting two real trends in US health insurance:

- More broad network insurance products divorced from provider systems;
- Policies that emphasize copayments and deductibles at time of purchase rather than cost-conscious choice at time of insurance policy purchase.

Their conclusion: true managed care has structural features – narrow networks and lower premiums – at variance with common employer policies and national trends.

**CAN MANAGED CARE WORK IN THE US TODAY?** The answer: No, managed care cannot work in the US today. Even supporters see this, as Northwestern's David Dranove wrote in 2002: 'my optimistic view of managed care's potential has wavered. I accept the possibility that managed care will never fulfill its promise.'<sup>37</sup>

We had two major attempts to develop the Kaiser Permanente model as our national healthcare. Nixon and Clinton – both brilliant politicians - failed. If neither of them could do it, then we wonder who could? It's time to move on.

Each attempt to replicate Kaiser Permanente – in North Carolina, for example – led either to failure or to such major changes in the model as to make it unrecognizable.

Furthermore, each political attempt to implement Enthoven's ideas nationally – by Nixon and Clinton – proved disastrous. Special interests force political compromises that drastically alter the ideal model. After 40 years of trying we have clear evidence that our society simply cannot implement true managed care.

Managed care's time has passed. It's now time to move on to other, more fruitful, healthcare reform options.

## Review Questions

Answers on next page

1. What is the classic definition of managed care?
  - a. Large multispecialty group practices that provide a comprehensive set of healthcare services at a per capita price set in advance
  - b. An HMO plan that requires referrals from a primary care provider
  - c. A PPO plan that does not require referrals to see a specialist
2. How does managed care differ from indemnity insurance?
  - a. Managed care differs from indemnity or fee-for-service health insurance, especially in terms of prevention, cost controls and outcome measurements.
  - b. Managed care is far more efficient than indemnity insurance
  - c. Indemnity insurance allows more access to specialists than managed care
3. How does managed care differ from single payer healthcare?
  - a. Managed care uses competition (i.e. managed competition) to keep prices low and quality high while single payer healthcare generally does not embrace competition.
  - b. Managed care is generally less expensive than single payer
  - c. Single payer is generally less expensive than managed care
4. How does managed care differ from consumer driven healthcare?
  - a. CDHC proponents believe that consumers can make their own healthcare choices. Managed care proponents disagree; they think healthcare is fundamentally unlike other consumer products. They think consumers need help navigating among diagnoses and specialists so require Primary Care Providers to act as advisors and gatekeepers.
  - b. Managed care is less expensive than CDHC
  - c. CDHC generally has higher deductibles than managed care
5. What is the classic example of a managed care organization?
  - a. Massachusetts General Hospital
  - b. Blue Cross and Blue Shield
  - c. Kaiser Permanente
6. How did Nixon change the Kaiser Permanente model in his HMO Law of 1973?
  - a. He did not require vertical integration between finance and service delivery
  - b. He required vertical integration between finance and service delivery
  - c. He restricted the number of HMOs that any given physician could join

## Answers to review questions

Correct answers in bold

1. What is the classic definition of managed care?
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## Health Risks That Drive Insurance Utilization

Chronic disease treatments consume about 85% of all healthcare spending with about half of Americans – that's roughly 160 million folks - having one or more chronic diseases. The number of chronic disease patients grows by 7 – 8 million every 5 years.<sup>95</sup>

The ten most common chronic conditions are arthritis, cancer, chronic obstructive pulmonary disease, coronary heart disease, asthma, diabetes, hepatitis, hypertension, stroke and weak or failing kidneys. These often – not always – have a lifestyle cause, a combination of excess body weight, suboptimal nutrition and insufficient exercise.

We have known about these chronic diseases, their costs and their causes for years, yet they continue and increase. Why? This chapter will suggest answers and focus on diabetes as a prime example of a lifestyle-caused chronic condition.

Diabetes occurs when your body produces too little insulin and results in you having too much sugar in your bloodstream. The disease comes in 2 basic forms: Type 1, an autoimmune disorder typically identified in kids for which there is no cure and Type 2, largely behaviorally based, in which your body doesn't use insulin well and can't regulate sugar in blood stream. About 95% of diabetic population has Type 2. It is largely preventable and potentially reversable. (Type 1 is neither.) We'll focus on Type 2 in this chapter.

Diabetes increases your risk of developing many of the chronic conditions listed above, perhaps most notably hypertension, failing kidney and heart disease. We might consider it a common cause of and link among America's epidemic of chronic diseases. That's admittedly an overstatement, though not a huge one.

Diabetes is defined by your number on one of 4 medical tests:

- Your A1C (aka hemoglobin A1C or HbA1c) above 6.5%
- Your fasting blood sugar above 126 mg/dL
- Your glucose tolerance above 200 mg/dL 2 hours after drinking a liquid. You need to fast the night before.
- Your random blood sugar above 200 mg/dL

About 37 million Americans have diabetes. It is the 7<sup>th</sup> leading cause of death and the #1 cause of kidney failure, lower limb amputations and blindness in the US. The number of diabetics has doubled in the past 20 years.

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<sup>95</sup> The Relation of the Chronic Disease Epidemic to the Healthcare Crisis, Holman, American College of Rheumatology, Feb 19, 2020

Two syndromes / conditions predict a patient becoming diagnosed with diabetes: 'prediabetes' and 'metabolic syndrome'. Though overlapping in some ways, these are distinct. Both provide a warning to patients about their likely diabetes diagnosis future.

**Prediabetes** is a narrowly defined condition in which you have too much sugar in your bloodstream though not enough to have full blown diabetes. By the CDC's definition, you have prediabetes if tests determine the following about your blood sugar:

- Your A1C or hemoglobin A1C or HbA1c test is 5.7 and 6.4%.
  - Full blown diabetes is defined 6.5% or greater.
- Your fasting blood sugar test is 100 – 125 mg/dL.
  - Full blown diabetes is defined as 126 mg/dL or greater.
- Your glucose tolerance test is 140 – 199 mg/dL.
  - Full blown diabetes is defined as above 200 mg/dL.

Here's a summary chart.<sup>96</sup>

| Result*     | A1C Test      | Fasting Blood Sugar Test | Glucose Tolerance Test | Random Blood Sugar Test |
|-------------|---------------|--------------------------|------------------------|-------------------------|
| Diabetes    | 6.5% or above | 126 mg/dL or above       | 200 mg/dL or above     | 200 mg/dL or above      |
| Prediabetes | 5.7 – 6.4%    | 100 – 125 mg/dL          | 140 – 199 mg/dL        | N/A                     |
| Normal      | Below 5.7%    | 99 mg/dL or below        | 140 mg/dL or below     | N/A                     |

About 96 million Americans have prediabetes including, according to Dr. Dariush Mozaffarian, dean of the Tufts Friedman School of Nutrition Science and Policy, about 1 in 4 American teenagers.<sup>97</sup> The condition increases your risk of developing Type 2 diabetes and suffering from all the problems associated with and resulting from it.

**Metabolic syndrome**, the other common precursor to full blown diabetes, is defined more broadly, again by the results of medical tests. It is a cluster of medical conditions occurring together, first identified in 1998. Though some researchers quibble about the exact numbers that define it, here is a generally accepted definition.<sup>98</sup>

- Obesity or having a BMI > 30.
  - Alternatively, males have a waist circumference >40 inches, females > 35.

<sup>96</sup> CDC Diabetes Basics <https://www.cdc.gov/diabetes/basics/getting-tested.html>

<sup>97</sup> Boston Globe, Nov 22, 2021 'The Obesity Pandemic Has Made Covid Much More Deadly'

<sup>98</sup> This definition comes from Harvard Health, Shmerling, Metabolic Syndrome is On the Rise, Oct 2, 2020 and AARP, Levine, Metabolic Syndrome

- Blood triglyceride levels above 150 mg/dL
- Low HDL (good) cholesterol, levels below 40 mg/dL in men or 50 in women
- High blood pressure, greater than 130/85 or on blood pressure medications.
  - For people over 60 years old, the American Heart Association suggests levels above 150/90
- Elevated blood sugar, having a fasting blood glucose level above 100 mg/dL, an A1C above 5.7 or taking diabetes medications.

Researchers seem to suggest that having 3 or more of these indicators defines someone as having metabolic syndrome.

Some 37% of Americans suffer from metabolic syndrome with the risk increasing as you age; some 50% of 60-year-olds have it including almost 60% of Hispanics over 60.<sup>99</sup>

People with metabolic syndrome are about 4x more likely to develop diabetes than healthy folks, 3x more likely to suffer a heart attack or have a stroke, and 55% more likely to develop kidney disease. In addition, according to the National Heart, Lung and Blood Institute<sup>100</sup>, the syndrome increases your risk of developing

- Coronary heart disease
- Erectile dysfunction
- Heart failure
- Inflammation and immune system problems – raise risks of complications from infections and Covid
- Organ damage esp pancreas, liver, gall bladder, kidneys
- Polycystic ovary syndrome (PCOS)
- Pregnancy complications such as preeclampsia, eclampsia, and gestational diabetes
- Problems with thinking and memory
- Sleep apnea and
- Certain cancers.

Metabolic syndrome, like prediabetes and diabetes itself, is largely preventable by maintaining a healthy weight, eating a healthy diet, exercising regularly and avoiding smoking.<sup>101</sup>

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<sup>99</sup> AARP, Metabolic Syndrome, Levine

<sup>100</sup> National Heart, Lung and Blood Institute <https://www.nhlbi.nih.gov/health/metabolic-syndrome/living-with>

<sup>101</sup> Ibid.

This link between obesity, defined as having a Body Mass Index greater than 30, and diabetes is so strong that some researchers invented a new word for it: diabetesity.<sup>102</sup> As the Cleveland Clinic put it in 2021:

The pancreas creates insulin, which is a hormone that moves glucose out of your blood. Normally, insulin transports glucose to your muscles to use right away for energy or to the liver, where it's stored for later.

But when you have diabetesity, your cells resist letting insulin move glucose into them. To make matters worse, the area of your liver where excess glucose is usually stored is filled with fat. It's like trying to put furniture in a room that's already packed. With nowhere to be stored, the glucose remains in the bloodstream.

Your pancreas becomes overworked, and as a result, it wears out. It starts producing less insulin. Diabetes develops and then quickly worsens if the fat resistance remains

The CDC calls diabetes the most expensive medical condition in the US, though no one knows for sure how much it costs because it affects so many other medical conditions. Should we include leg amputations as diabetes costs? The associated prosthetics? Unclear.

The CDC estimated direct diabetes costs and related reduced productivity at the lower end, \$327 billion in 2017. That's about \$500 billion today give a take a few dozen billion, about 14% of healthcare spending. That's the low estimate.

On the higher end, the American Diabetes Association claims that 25% of all US healthcare spending goes to diabetes and related treatments.<sup>103</sup> I don't know who's right here, but under either estimate, diabetes is a big deal and very expensive.

We know a lot about it, understand its causes and estimate its costs as high under any reasonable assumptions. Why can't we prevent it?

### Why We Don't Prevent Diabetes and cut healthcare spending while improving American's health

The classic advice for treating metabolic syndrome or pre-diabetes, the two typical precursors of full blown diabetes, is lifestyle modification. This traditionally has 2 components: dietary improvement and exercise increase. In short, eat a bit less of primarily healthier foods, and exercise a bit more.

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<sup>102</sup> Cleveland Clinic, November 2021 'Diabetesity: How Obesity is Related to Diabetes', slightly edited in the following quote.

<sup>103</sup> American Diabetes Association. Economic costs of diabetes in the US in 2017. *Diabetes Care*. 2018;41:917–928.

Easier said than done.

Let's put some numbers and costs into this advice. We'll use American males as our case study here simply to present an analytic framework. This will help us understand our dismal failure to prevent diabetes.

We could have used American females instead of males – same methodology, just different numbers. Ditto for other socio-economic groups: Latino women, Appalachian residents, Appalachian single parent families, elderly urban men, etc. Same methodology, different numbers.

We'll first address the dietary part of that old 'diet and exercise' mantra and consider calorie **quantity** and **quality**.

In 2022, the average American male – we'll call him Joe - was 5 foot 9 inches tall, 38 years old, exercised 1 – 3 times per week and weighed 198 lbs.<sup>104</sup> He had a BMI of 29.2, almost obese. He gained about 1.5 pounds per year. According to online calorie consumption estimates<sup>105</sup>, he needs to eat about 2650 calories per day; that's the amount necessary to maintain his 1.5 pound / year weight increase.

We'll assume that Joe is single for analytic ease.

Joe needs to reduce his daily calorie intake to 2237 to lose ½ a pound per week. That would get him down to 172 pounds in a year for a BMI of 25.4, slightly overweight but not nearly obese. It would probably get him out of the prediabetic or metabolic syndrome condition and help him avoid diabetes.

I choose the ½ pound per week weight loss as a moderate amount; I didn't want to bias this analysis with a more aggressive number. Some research suggests that a faster weight loss, with the associated greater degree of daily discomfort /

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<sup>104</sup> Average weight American male adult from healthline.com <https://www.healthline.com/health/mens-health/average-weight-for-men>

Average height American male adult from World Population Review  
<https://worldpopulationreview.com/state-rankings/average-height-by-state>

Average age Americans in 2022 from World Population Review <https://worldpopulationreview.com/state-rankings/median-age-by-state>

How Much Do Americans Exercise, Romero, Washingtonian, May 12, 2012

Daily calories to lose ½ lb / week from [www.Calculator.net](http://www.Calculator.net)

Daily calories to gain 1.5 lbs / year from [www.Calculators.net](http://www.Calculators.net)

Average American annual weight gain from Washington Post, 'Look How Much Weight You're Going to Gain' 1/29/2016

<sup>105</sup> In this case I used [www.calculator.net](http://www.calculator.net).

hunger, leads to a quicker termination of this dietary program with the associated relatively fast rebound back to the original weight.

In other words, I want to stack the odds in Joe's favor.

We'll assume here that Joe spends 10% of his income on food. That comes from the US Department of Agriculture's 2021 estimate.<sup>106</sup>

We know that Joe earns \$1,144 / week – that's \$59,488 per year - thanks to various Bureau of Labor Statistics studies.<sup>107</sup> That means he has \$16.34 available for food each day, 7 days / week, a combination of eating in and eating out. The BLS says we split this about 50/50.

If Joe was a Black or Hispanic male – an example of some specific socio-economic groups – he would only earn \$820 / week (\$42,640 per year)<sup>108</sup> meaning \$11.71 available for food.

Or if Joe were a woman, a different socio-economic group, he would earn, on average, about 15% less and need about 10% fewer calories, than an average American male.<sup>109</sup>

Quick quantitative summary:

- Joe currently eats about 2650 calories per day. He gains about 1.5 pounds per year.
- He needs to reduce his daily caloric intake to 2237 to lose ½ pound per week or 26 pounds / year. That's 13% of his body weight.
- He has \$16.34 available for food daily.

Let's turn now from calorie quantity to calorie **quality**. The most recent government recommendation is that our food plate consist of 50% fruits and vegetables, 25% grains – mainly whole grains – and 25% protein and dairy. That's a rough approximation of the

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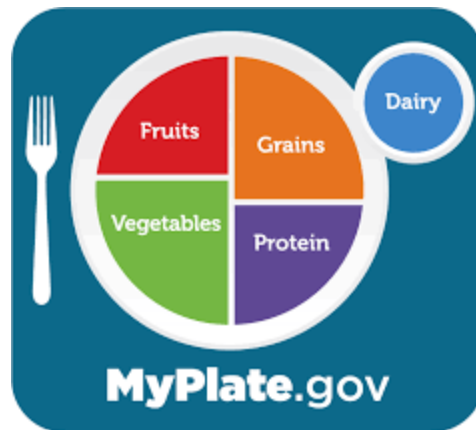
<sup>106</sup> US Dept of Agriculture estimate 2021, [https://www.ers.usda.gov/data-products/chart-gallery/gallery/chart-detail/?chartId=76967#:~:text=In%202021%2C%20U.S.%20consumers%20spent,from%20home%20\(5.1%20percent\).](https://www.ers.usda.gov/data-products/chart-gallery/gallery/chart-detail/?chartId=76967#:~:text=In%202021%2C%20U.S.%20consumers%20spent,from%20home%20(5.1%20percent).)

<sup>107</sup> Overall Median weekly earnings from BLS, [wkyeng \(5\).pdf](#), July 29, 2022, 'Usual Weekly Earnings of Wage and Salary Workers Second Quarter 2022'

<sup>108</sup> Black and Hispanic male earnings from BLS, 'TED, The Economics Daily', Oct 25, 2021, <https://www.bls.gov/opub/ted/2021/median-weekly-earnings-were-916-for-women-in-third-quarter-2021-83-3-percent-of-mens-earnings.htm#:~:text=Source%3A%20U.S.%20Bureau%20of%20Labor,End%20of%20interactive%20chart.&text=In%20the%20third%20quarter%20of%202021%2C%20median%20weekly%20earnings%20for,th e%20median%20for%20White%20men.>

<sup>109</sup> Earning estimates from various BLS studies. Calorie estimates from calculator.net; I simply substituted 'female' for 'male' using Joe's numbers. The calculator estimated 2008 calories / day for a woman instead of 2237 for Joe.

US Department of Agriculture's MyPlate, image below. You can google MyPlate.gov for more.



I don't like this graphic though. It's too cartoonish in my opinion and not detailed enough as a guide. I prefer the Canadian version, below. It's essentially the same – see the small dairy dish in the protein section as opposed to the small dairy circle in the American MyPlate version - but with more impactful graphics in my opinion. The Canadian version shows specific foods in each category. We'll use it in this chapter rather than the MyPlate image, again, only for presentation reasons. Feel free to disagree with my artistic taste.

### **The Canadian Food Plate**

Water is the recommended drink.



You can quickly see the breadth and types of foods in each category and the approximate serving size of each.

Proteins, for example, include nuts, beans, legumes and eggs, not just chicken, beef, pork, and fish and take up a quarter of your meal plate.

Fruits and vegetables come in lots of different colors and flavors, with that variety apparently providing nutritional benefits.

This version seems to suggest that we eat lots of different vegetables, not just potatoes and tomatoes, the most commonly consumed vegetables in the US, which together dwarf all the others combined.<sup>110</sup>

Ditto lots of different fruits, not just apples and oranges, the most commonly consumed fruits in the US, which, along with bananas, dwarf the others.<sup>111</sup>

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<sup>110</sup> Potatoes and tomatoes most commonly consumed vegetables, US Economic Research Service, Department of Agriculture, 2019 <https://www.ers.usda.gov/data-products/chart-gallery/gallery/chart-detail/?chartId=58340>

<sup>111</sup> Apples and oranges are top US fruit choices, US Economic Research Service, Department of Agriculture, 2019 <https://www.ers.usda.gov/data-products/chart-gallery/gallery/chart-detail/?chartId=58322>



That's why I like this graphic: it's impactful and suggests what to eat simply and comprehensibly.

It also tells you what to avoid. Look at what's not on this plate:

- Corn
- Sugar
- Sweeteners
- Oils, salad dressing
- Refined, bleached flour
- Processed foods and snacks like chips, cookies & baked goods
- Sugary drinks
- Beer, wine & alcohol

We eat lots of these foods. Consider these summaries from a 2016 Pew study of American food and nutrition practices:<sup>112</sup>

Baked goods, a \$35 billion / year market segment not on the Food Plate, includes refined flour and sugar.

Sweeteners, about 15% of daily calories for the average American, include sugar and corn based products (in addition to non-caloric options like aspartame). A can of regular Coke contains 140 calories for example. Americans consume about 40 gallons of soft drinks per person annually, 72% non-diet.<sup>113</sup> Soft drink sales run about \$318 billion per year. Not on the Food Plate.

Snacks, about 27% of children's daily caloric intake (remember Tufts School of Nutrition Dean Dr. Mozaffarian's estimate that 1 in 4 American teenagers is pre-diabetic?), mainly salty snacks, candy, cookies, and sugary drinks. Salty snacks, ice cream, candy and cookies are a \$70 billion / year industry segment. Not on the Food Plate.

Oils for cooking, flavoring, and salad dressing, about 23% of our daily calories. On average. Americans eat about 36 pounds of these per year. Not on the Food Plate.

Processed foods including hydrogenated oils, HFCS, flavoring agents and emulsifiers used in foods like potato chips, sugary drinks & processed meat, not on the Food Plate. Processed foods tend to lead to higher weight gain than unprocessed.<sup>114</sup>

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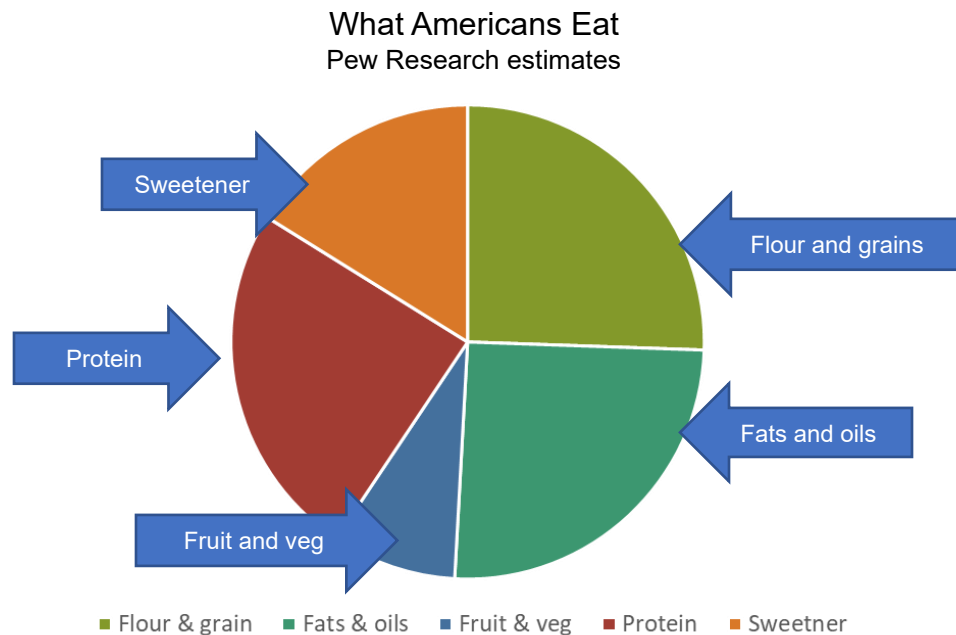
<sup>112</sup> What's On Your Table: How America's Diet Has Changed Over the Decades, Drew Desilver, Dec 13, 2016

<sup>113</sup> Diet vs regular soda percent estimates from statistica.com

<https://www.statista.com/statistics/1133019/carbonated-soft-drinks-regular-vs-diet-volume-us/>

<sup>114</sup> First randomized, controlled study finds ultra processed diet leads to weight gain, Clinical Center News from NIH, 2019 <https://clinicalcenter.nih.gov/about/news/newsletter/2019/summer/story-01.html>

Instead of eating the high quality calories shown on the Food Plate above, here, according to the Pew Research folks, is what we really eat:



I find this estimate credible based on supermarket shelf space allocations and restaurant menus.

Supermarkets allocate shelf space according to food sales, more to foods that sell the best. See, for example, the space allocated to salad dressing, cookies and sweetened breakfast cereal.

Restaurants offer meals that people request the most. See, for example, in moderate priced, popular restaurants - the large chains for example – the frequency of ‘burger and fries’ or ‘chicken, potato and small vegetable of the day’ or ‘salad’ generally consisting only of lettuce, tomato and carrot shavings doused in dressing (many restaurants offer more dressing options than vegetable variety). Compare to the frequency of fruit offerings.

Joe, our typical American male, thus faces 3 tasks in the attempt to improve his diet and thus avoid diabetes.

- Eat fewer calories.
- Eat higher quality calories.
- Stay within his \$16.34/day food budget.

How might he accomplish all this?

### Composite Daily Menus

Let's compare the daily costs of Joe's current diet and a healthier one designed to prevent diabetes. I've developed two sample day's meals – one called Food Plate based on the Canadian Food Plate above and the other called Typical based on the Pew analysis. I used food prices at my local Shaw's supermarket in Easton, Massachusetts in October 2022.

These diets are composites of what people *should* eat and what they often *in fact* eat. In designing these menus – particularly the typical one - I considered supermarket shelf space. I choose popular items meaning lots of people buy and eat them.

We have, of course, endless food options and combinations in this country. I present this analysis in part to show calorie and cost data and in part to show a methodology. Do a similar analysis yourself and see your own results. I suspect they will be close to mine below.

The healthier diet below comes to 2239 calories for a day (very close to our theoretical goal of 2237); the typical diet comes to 2648 calories (very close to our daily estimate of 2650). Some minor rounding issues, a calorie or penny here or there. But look at the cost difference.

#### Breakfast, Food Plate

- 2 jumbo eggs @ 90 calories each = 180 calories, \$1.33
- 2 pieces multigrain toast @ 100 calories each = 220 calories, \$.66
- Butter @ 50 calories / serving = 50 calories, \$.16
- 1 banana = 100 calories, \$.23
- Black coffee = 2 calories, \$.20
- 552 calories
- \$2.58 at Shaw's, Easton

#### Breakfast, typical diet

- Shaw's honey bran muffin = 420 calories, \$1.25
- Coffee = 2 calories, \$.20
- Cream @ 35 calories per serving of Coffeemate = 35 calories, \$.07
- Sugar @ 30 calories per serving of granular sugar = 30 calories, \$.04
- 487 calories
- \$1.56 at Shaw's, Easton

#### Lunch, Food Plate

- Spinach salad w/ tomato, carrots, yellow pepper, beets (130 cal total, \$5.02)
  - 1 serving of fresh spinach = 20 calories, \$1.71
  - Half a tomato = 45 calories, \$1.50
  - Half a serving of carrots = 15 calories, \$.16
  - Half a yellow pepper = 25 calories, \$.85
  - Half a serving of beets = 25 calories, \$.80
- Oil & vinegar dressing = 84 calories, \$.22

- .3 lb chicken breast @ 748 calories per pound = 224 calories, \$1.20
- 1 pita = 90 calories, \$.37
- Apple = 95 calories, \$.66
- 623 calories
- \$7.47 at Shaw's, Easton

#### Lunch, typical diet

- Ham & cheese on sub roll with mustard & iceberg lettuce (538 cal total, \$3.20)
  - Ham, .25 pound @ 885 calories per pound = 221 calories, \$2.00
  - Cheese, 1 slice = 100 calories, \$.30
  - Sub roll = 200 calories, \$.50
  - French's mustard, 1 serving = 1 calorie, \$.03
  - Iceberg lettuce .15 of a head = 16 calories, \$.37
- Bag of chips from multi-bag box = 150 calories, \$.52
- 3 Oreos = 160 calories, \$.26
- Apple = 95 calories, \$.66
- Coca Cola, can = 140 calories, \$.23
- 1083 calories
- \$4.88 at Shaw's, Easton

#### Dinner, Food Plate

- Basmati rice bowl with broccoli, summer squash, snap peas, green beans, .4 lb salmon, soy (872 calorie total, \$8.48)
  - 2 cups Basmati rice @ 170 calories per cup = 340 calories, \$.38
  - 1/3 pound of broccoli = 51 calories, \$.66
  - 1/3 pound of summer squash = 24 calories, \$.66
  - 1 serving of sugar snap peas = 35 calories, \$1.00
  - 1/4 pound of green beans = 25 calories, \$.82
  - .4 pounds of salmon = 378 calories, \$4.80
  - 1 tablespoon low salt soy sauce = 20 calories, \$.16
- Blueberries (.5 pint) = 115 calories, \$1.00
- Strawberries (.5 lb.) = 74 calories, \$2.50
- 1061 calories
- \$11.97 at Shaw's, Easton

#### Dinner, typical diet

- Pasta with sauce, ground beef, grated cheese (578 calories, \$2.55 total)
  - Barilla pasta, 1 serving = 200 calories, \$.37
  - Prego traditional pasta sauce, 1 serving = 70 calories, \$.80
  - 80% ground beef, .25 pounds = 288 calories, \$1.25
  - Grated Kraft parmesan cheese, 1 serving = 20 calories, \$.13
- Green salad with dressing (150 calories)
  - Dole American salad bag, 2 servings = 30 calories, \$1.50
  - Ken's House Italian dressing, 1 serving = 120 calories, \$.25
- Canned peaches, 1 serving = 100 calories, \$.50
- Friendly's vanilla ice cream, 1/2 serving = 105 calories, \$.28

- Bottle of Budweiser beer = 145 calories, \$1.38
- 1078 calories
- \$6.46 total, food from Shaw's, Easton, beer from Walmart

You can see my spreadsheets at the end of this chapter for additional details.

I encourage you to use this methodology with your dietary decisions. You can adjust the daily calorie targets to fit your own needs, then insert your foods of choice.

We learn from this process that 2237 healthier Canadian Food Plate calories cost \$22.02 / day. Those are the foods Joe is supposed to eat, with meals designed to lose ½ pound per week. If Joe spends 10% of his salary on food as the Bureau of Labor Statistics suggests, then he needs to earn at least \$80,000 per year to afford this menu.

But Joe only earns \$59,488 per year. We learned that earlier in this chapter. He can't afford the healthy Food Plate!

Imagine that Joe is a Black or Hispanic male. He'd only earn \$42,640 per year making the Food Plate even more unaffordable.

Try this with your socio-economic demographic of interest and see what you learn.

Now let's consider the 2648 calorie typical diet. It only costs \$12.90 / day, making it affordable to people earning at least \$47,000 per year. Joe earns that much. It is tasty and satisfying.

But he gains 1.5 pounds per year on it and risks prediabetes, metabolic syndrome and diabetes.

We're beginning to learn why we don't prevent diabetes by following the 'eat more fruits, vegetables and whole grains, less processed food, fat and sugar' mantra. It's too expensive.

This analysis only addressed foods prepared at home using one particular supermarket's prices. I ran a similar analysis on restaurants, comparing healthier and typical meals at Cheesecake Factory and D'Angelo's. It's methodologically easy; simply look up your items of choice on the restaurant's menu and nutritional guide – sometimes they're listed together on the menu - then divide.

Here's what I found, again all in October 2022.

At the Cheesecake Factory, 'The Club' sandwich with turkey, bacon, bread, French Fries, lettuce, tomato and mayonnaise contains 1740 calories and costs \$17.95. That's 1.0¢ per calorie.

The Cheesecake Factory's Skinnylicious Factory Chopped Salad including dressing contains 530 calories and costs \$15.95. That's 3.0¢ per calorie, 3x more per calorie than the Club sandwich.

At D'Angelo's, the medium Italian sub contains 790 calories and costs \$10.29. That's 1.3¢ per calorie.

The D'Angelo's Garden Salad with small Pokket (pita bread) but without dressing contains 180 calories and costs 4.6¢ per calorie, about 3.5x more per calorie than the Italian sub.

As with our supermarket example above, eating the Food Plate healthier calories costs more. The oft-recommended 'fruits, vegetables and whole grains, not processed food, fat and sugar' diet is still too expensive.

How much more expensive? According to my supermarket food data above, eating healthier – meaning eating according to the Food Plate – costs about \$9.12 more per person per day. That's \$3320 per year or, for the US average 2.6-person household, over \$8300.

*A single person* would need to earn \$33,000 more annually to afford the Food Plate meals above. That's using the US Department of Agriculture's '10% of your income on food' estimate discussed above.

*An average American household* would need to earn \$83,000 more.

That's not the cost of eating but the *additional* cost of eating a healthy diet, the one designed to avoid or exit from, metabolic syndrome.

That's a significant economic disincentive to eat healthy foods and a significant economic incentive to stay the course.

### Why do healthier foods cost more?

This chapter is not a discussion of food subsidies but the question often arises from astute readers. Here's a very short explanation:

Congress and various states subsidize food production.<sup>115</sup> In 2016, for example, the feds provided \$13.9 billion in crop subsidies and insurance payments, equivalent to 25% of farmers income. Those subsidies generally went to the largest and best organized farm groups like huge companies that produce commodities - corn and soybeans for example. About 90 million acres – half our farmland – goes to those types of (heavily subsidized) products.

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<sup>115</sup> This analysis comes from Barth, Congress Finally Passed a New Farm Bill, January 7, 2019, Modern Farmer

Food producers, in turn, then use those products in processed foods. That helps explain why corn sugar (a.k.a High Fructose Corn Sugar, HFCS and corn syrup) is included in so many of our processed foods. Just check the ingredients of your favorite jars or cans of food. We'll discuss this more in the section on food tastes, below.

Subsidized corn sugar helps control the cost of real sugar, thus expanding the market for sweeteners, about 15% of American's typical daily calories.

Meanwhile, only about 10 million acres, or 3% of our cropland, goes to fruits, nuts and vegetables, products not typically included in the farm subsidy programs. They're more expensive for 2 reasons:

- Consumers pay the full price for their production since production costs are not subsidized
- There is no excess supply since their acreage is constrained by market forces, not supplemented by subsidies. Tighter acreage means less supply. The standard economics of price being determined by supply and demand factors then takes over.

We subsidize the foods we're not supposed to eat much of, and fail to subsidize the foods we're supposed to eat in abundance.

But wait, there's more

Let's now discuss some additional, non-cost problems of switching from our typical to a Food Plate diet. The problems fit into 3 groups: hunger, taste, and convenience. How much of a financial incentive would be required to induce people to overcome these problems? That's over and above the \$3320 per person food cost difference.

**Hunger:** as people eat fewer calories, they feel hungry. That's the prime behavioral reason so many diets fail: people want that satisfying full feeling.

I sometimes hear people claim, 'I lost 25 pounds and never felt hungry.'

I rarely see these dietary results replicated on a large group of people over a long time period, making me dubious. Indeed, studies suggest that the vast majority of dieters regain all their weight within 2 years. I suspect hunger or related food cravings is a primary culprit.

But when people claim to have lost weight without feeling hungry, I often respond 'Why doesn't everyone do that?'. That generally ends the conversation.

I can identify only 2 large groups of people who successfully lose weight by dieting and keep it off for a long time period: actors and athletes. (Apologies if I unintentionally missed a group.) Actors and athletes often / always have body weight requirements included in their employment contracts. That's a tremendous economic incentive, far exceeding anything that employers, insurance companies or the medical establishment can provide to employees or patients.

A word about the long term issue facing of dietary incentives. Good food habits – eating certain foods, losing your taste for others, acclimating yourself to a certain ‘appropriate’ hunger – takes months if not years to develop. By ‘appropriate’ hunger, I mean accustoming yourself to feeling somewhat hungry much of the time and feeling only somewhat full immediately after meals. Most people, according to studies, need at least a few months to develop new food habits; other folks need much longer.<sup>116</sup> I needed a year when I lost 40 pounds in 2021 but that story comes later in this chapter.

How much of an economic incentive does Joe need to switch from his traditional 2650 calories per day to the Food Plate’s 2237? Probably less than the \$200,000 Matthew McConaughey earned for his 50 pound weight loss in Dallas Buyer’s Club but I don’t know how much less. Perhaps 3% of Joe’s annual income? 5%? While I don’t know the exact amount, I’m pretty sure that a calorie-restricted dietary program needs to address this issue.

**Taste.** Our Food Plate lacks many tastes common to the typical American diet – sugar, salt, salad dressings, mayonnaise, etc. People sometimes complain that healthy foods taste bland. They also sometimes describe food cravings, missing various tastes and sensations.

Food producers know this and have identified the ‘bliss point’, a combination of sweetness, saltiness and richness (generally some sort of fat) that people find satisfying. The right combination of these sends a jolt of endorphins to your brain causing a pleasure sensation and desire to do it again. That’s why people like mayonnaise on sandwiches, salad dressing on their salads and cream and sugar in their coffee. It makes food more satisfying. How often have you heard ‘I just couldn’t drink black coffee’?

The combination of sweetness, saltiness and richness works better together than any one ingredient on its own. That’s why a standard sized Hershey Bar contains 35 milligrams of sodium<sup>117</sup> and a Nestle Crunch Bar 66 milligrams<sup>118</sup> and why Jif peanut butter contains 2 grams of sugar per serving<sup>119</sup> and Barilla pasta 7 grams<sup>120</sup>.

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<sup>116</sup> Grohol, Need to Form a New Habit? Give Yourself At Least 66 Days, PsychCentral, October 7, 2018 <https://psychcentral.com/blog/need-to-form-a-new-habit-66-days> ; UCL News August 9, 2009 Interview with Phillippa Lally <https://www.ucl.ac.uk/news/2009/aug/how-long-does-it-take-form-habit>

<sup>117</sup> <https://www.hersheyland.com/products/hersheys-milk-chocolate-candy-bar-1-55-oz.html>

<sup>118</sup> <https://www.heb.com/product-detail/nestle-crunch-candy-bar/98268>

<sup>119</sup> <https://www.jif.com/peanut-butter/creamy/simply-jif>

<sup>120</sup> <https://www.heb.com/product-detail/barilla-traditional-sauce/1637428>



Fruits and vegetables lack the bliss point. There's infinitesimal salt in an apple or yellow pepper, infinitesimal sugar in spinach or kale. And no fat.

The good news is that people can adjust their tastes to become satisfied with non-bliss point foods. The bad news is that it takes time to develop the habit, likely that same as to adjust to the new 'slightly hungry' or 'no longer totally full' eating feeling. Again, programs aiming to help people eat fewer-but-healthier calories need to maintain their incentives for this lengthy time period.

**Convenience.** Joe's typical meals included a store baked honey bran muffin as opposed to the Food Plate home cooked eggs and toast. His ham-and-cheese sandwich lunch with a bag of chips and Oreos was quicker to make than the Food Plate made-from-scratch spinach salad with chicken breast. Not only quicker to make, but also quicker and easier to eat.

And his industrially produced dinner Prego pasta sauce with canned peaches and ice cream for dessert was easier to prepare than the Food Plate home-made rice bowl.

Accessing these convenient foods is easy and relatively stress free – just open the can or package. Meanwhile, shopping for, cutting and preparing the less-convenient-but-healthier Food Plate meals is more difficult and time consuming, and therefore more stressful in our time compressed daily lives.

As one indication of convenience importance in our daily food decisions, consider the number of take-out food options now available. (I'm not sure if take-out counts as eating at home or out, but it doesn't much matter what we call it as long as people stay within their '10% of salary on food' parameter.) We had, for example, 71,856 pizza restaurants in 2012 but 78,092 in 2020.<sup>121</sup> That's almost a 9% increase in 8 years, not including other competitive take out options. All this suggests that increasing numbers of us order out to eat in, the definition of convenience.

How much should designers of wellness or diet programs incentivize people to eat more labor intensive / healthier foods as opposed to more convenient-but-less healthy? I don't know – sorry, not a program designer – but food convenience is one factor that such programs need to address. 'Address' here means 'provide economic incentives to do'.

#### Summary of the diet part of 'diet and exercise'

We have established so far that eating fewer-but-healthier calories costs more than eating more-but-unhealthier ones. The cost difference is about \$9.12 per person per day or \$3320 per year. Those are, of course, just estimates – take them with a grain of salt. (Bad pun.)

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<sup>121</sup> Number of pizza restaurants in the US, Statistics <https://www.statista.com/statistics/377597/number-of-pizza-restaurants-us/>

We have also discussed

- how eating fewer calories makes people feel hungry
- how eating non-bliss point foods diminishes taste satisfaction, and
- how consuming less convenient foods is more difficult and time consuming.

Overcoming those behavioral obstacles requires additional financial incentives for the 6-to-8 months – or more – necessary for the new dietary habits to get formed.

Remember our discussion so far: we want to help people avoid prediabetes, metabolic syndrome and diabetes. We have explored the ‘diet’ part of that standard ‘diet and exercise’ recommendation. We learned that eating healthier foods is more expensive, less tasty, less convenient and less comfortable. The dietary goal is, therefore, difficult to achieve.

Tons of real world evidence shows this, including increasing rates of obesity and diabetes in the past 20 years.

Let’s switch focus and turn to the exercise side now, to see if that holds more promise for success.

### Exercise

The April – May 2004 issue of Harvard Magazine summarized some then-current research at Harvard University and Medical School as follows (lightly edited for context):

[Researchers are developing] a pill, a marvel of modern medicine that will regulate gene transcription throughout your body, helping prevent heart disease, stroke, diabetes, obesity, and 12 kinds of cancer—plus gallstones and diverticulitis.

Expect the pill to improve your strength and balance as well as your blood lipid profile. Your bones will become stronger. You’ll grow new capillaries in your heart, your skeletal muscles, and your brain, improving blood flow and the delivery of oxygen and nutrients.

Your attention span will increase. If you have arthritis, your symptoms will improve.

The pill will help you regulate your appetite, and you’ll probably find you prefer healthier foods. You’ll feel better, younger even, and you will test younger according to a variety of physiologic measures.

Your blood volume will increase, and you’ll burn fats better. Even your immune system will be stimulated.<sup>122</sup>

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<sup>122</sup> The Deadliest Sin, Harvard Magazine, April – May 2004

There is just one catch. There's no such pill.

The prescription instead is exercise.

Everyone knows that exercise is good for you. The Harvard quote makes the point poignantly. But touting the overall benefits of exercise is not our aim here. Instead, our focus is diabetes prevention and, more specifically, the impact of exercise on people with prediabetes or metabolic syndrome. How does exercise impact these groups?

Several papers address this, mainly metabolic syndrome patients. I'll quote 3 below.

One study by the Norwegian University of Science and Technology Faculty of Medicine in 2008 found that 36% of patients with metabolic syndrome reversed the condition with 4 months of exercise.<sup>123</sup> "The study shows that exercise in general, but especially interval training, is able to partially or completely reverse metabolic syndrome," according to lead author Arnt Erik Tjønnå.

Second, a 2017 meta-review of 16 studies was, according to the authors, the "first to compare the effects of aerobic, and combined aerobic and resistance, exercise on clinical outcome measures in people with metabolic syndrome".<sup>124</sup>

The authors concluded that

- BMI was significantly reduced in exercise versus control groups.
- Fasting blood glucose was significantly reduced in exercise compared to control groups.
- Triglycerides were significantly improved, and LDL cholesterol was significantly improved in exercise versus control participants.
- HDL cholesterol was unchanged in exercise versus control participants.

Third, a 2019 metastudy, published in *Nutrients* suggested that "physical activity as a treatment for metabolic disease remains underutilized."<sup>125</sup> Among their findings

In one component study "exercise training resulted in marked improvements in the metabolic profile of the participants, including triglycerides, HDL cholesterol, blood pressure, fasting plasma glucose, and waist circumference. Of the 105 participants with the metabolic syndrome at baseline, 30.5% (32 participants) were no longer classified as having the metabolic syndrome after training."

A different component study found "strong support the use of aerobic exercise for patients with the metabolic syndrome who have not yet developed diabetes."

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<sup>123</sup> <https://norwegianscitechnews.com/2016/08/exercise-to-combat-metabolic-syndrome/>

<sup>124</sup> Ostman et al, The effect of exercise training on clinical outcomes in patients with the metabolic syndrome: a systematic review and meta-analysis, *Cardiovascular Diabetology*, 2017

<sup>125</sup> Myers et al, Physical Activity, Cardiorespiratory Fitness, and the Metabolic Syndrome, *Nutrients*, July 19, 2019

A third component study totaling 77,000 patient hours of exercise for folks with metabolic syndrome found “In analyses comparing aerobic exercise training versus control groups, there were reductions in BMI, waist circumference, systolic blood pressure and diastolic blood pressure, fasting blood glucose, triglycerides and low-density lipoprotein.”

The authors concluded that “achieving the minimal physical activity guidelines (at least 150 minutes per week of moderate-intensity activity or 75 minutes per week of vigorous intensity activity) has been consistently demonstrated to have significant benefits on metabolic risk” and “Among subjects who meet the criteria for the metabolic syndrome, health outcomes are significantly improved by aerobic or resistance training, or their combination.”

Terrific benefits to people suffering from metabolic syndrome. Unfortunately, Americans don’t exercise much or enough.

The CDC recommends that adults get 2.5 to 5 hours of moderate cardio exercise per week and 30 minutes of muscle strengthening exercise. Only 23% of us meet these targets, skewed toward higher income folks.<sup>126</sup> Lower income folks, those most likely to find switching to the Food Plate diet more economically difficult, tend to exercise the least.

How much might it cost to incentivize people to exercise? An old economic rule-of-thumb suggests that people value their free time at 1/3 the amount they normally earn. Our hero Joe, earning the US male average of \$1,144 / week, gets \$28.60/hour and would therefore value his free time at \$9.44/hour. He would, according to this economic theory, exercise in his free time if someone paid him \$9.44 / hour or more.

Joe probably should exercise about 4 hours / week – that’s conservative, the mid-point of the CDC’s weekly recommendation. I exercised about 7 hours / week during my own weight loss period, mainly brisk walking, but again, that discussion comes later in this chapter. Joe’s 4 hours / week would cost \$37.76, or \$1964 in annual incentives. I don’t know who pays this – an employer, insurance company, hospital, TPA or other. At this point, I only want to suggest what the incentive would be. I focus here on why we fail to prevent diabetes and invite others to figure out the rest.

### The Context of our Failure to Treat Metabolic Syndrome and Prevent Diabetes

Two socio-medical factors underly our failure to treat patients suffering from metabolic syndrome and to prevent diabetes. I’ll briefly address each in turn.

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<sup>126</sup> Only 23% of adults meet guidelines, Time Magazine, Ducharme, June 28, 2018.

**Television.** Americans watch, on average, about 3 hours of TV each day.<sup>127</sup> The states in which people watched the most TV correlate closely with states having the highest percent of obese people – West Virginia, Alabama, Arkansas and Mississippi. Obesity often leads to diabetes. We begin to see the television link

“The best single behavioral predictor of obesity in children and adults is the amount of television viewing,” according to Harvard School of Public Health’s Professor Steven Gortmaker.<sup>128</sup> “The relationship is nearly as strong as what you see between smoking and lung cancer.” Wow.

Unpack this:

TV watching is non-weight bearing, non-aerobic, entirely sedentary activity that generates no metabolic system benefit or weight loss.

TV watching exposes viewers to (generally less healthy) food products. That advertising leads to sales, otherwise companies wouldn’t continue. Products advertised rarely include the fruits and vegetables that are supposed to account for half our food plate.

The average American child sees over 40,000 TV commercials per year according to estimates by the American Psychological Association.<sup>129</sup>  
That’s a lot of low-quality food message reinforcement!

TV watching, according to anecdotal evidence, is associated with munching less healthy foods. People report eating salty snacks, buttery popcorn, sugary baked goods and similar while watching TV; fewer (none?) report over-indulging in broccoli or kale.

The take-away about television watching: if you want to create an obese, diabetic population, get them to watch a lot of TV. Our bountiful viewing options including streaming services, seem ideally suited to this task.

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<sup>127</sup> Hubbard, Outside of Sleeping, Americans Spend Most of Their Time Watching TV, US News, July 22, 2021. Also Statista, Average Daily Time Spent Watching TV, <https://www.statista.com/statistics/186833/average-television-use-per-person-in-the-us-since-2002/#:~:text=Estimates%20suggest%20that%20in%202022,hours%20watching%20TV%20each%20day>

<sup>128</sup> The Way We Eat Now, Craig Lambert, Harvard Magazine, May-June 2004

<sup>129</sup> Protecting Children From Advertising, American Psychological Association, June 2004  
<https://www.apa.org/monitor/jun04/protecting#:~:text=The%20average%20child%20is%20exposed,a%20year%2C%20according%20to%20studies>.

**Cholesterol treatments.** Our typical diet, referenced in the meal case study above, leads to high blood cholesterol, with statin prescriptions a primary treatment. About 1/3 of American adults currently take a statin.<sup>130</sup>

Statins, it turns out, may *increase* your risk of developing type 2 diabetes.

Statins prevent the buildup of fatty deposits in blood vessels and reduce the inflammation that occurs when arteries are blocked. This lessens your risk of having a heart attack, but it may also make cells more resistant to insulin, the hormone that helps regulate glucose levels in blood. The net effect according to various studies:<sup>131</sup>

- Statins increase your risk of developing diabetes by about 9% on average, but
- The higher the statin dose, the higher the diabetes risk, and
- The higher your blood sugar levels when you start taking the statin, the more likely you are to develop diabetes.

That means sicker people, taking higher statin doses, are more likely to develop diabetes, exactly the people most at risk.

One study found that, on average again, 1 in every 255 people who take a statin for 4 years will develop diabetes<sup>132</sup> but older patients especially those suffering from multiple health problems are at higher risk than younger, healthier people.<sup>133</sup>

Note the caveat here: though changes in blood sugar caused by statins are ‘pretty modest’ according to Dr. Jill Crandall, an endocrinologist at the Albert Einstein College of Medicine in New York, they may be enough to tip someone from prediabetes to full blown diabetes.<sup>134</sup>

Let’s tie all this together:

- Diabetes and related medical costs account for up to 25% of all healthcare spending, with diabetes rates rising
- About 90% of diabetes is type 2, caused by lifestyle behavior
- The standard ‘lose weight and exercise to avoid diabetes’ prescription is both unaffordable and unpalatable to most of us; diets generally fail within 2 years
- The economic incentives required to keep people on their diet and exercise programs are unaffordable to employers, insurance carriers or similar

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<sup>130</sup> The 1/3 estimate is extrapolated from the trend. <https://consumer.healthday.com/general-health-information-16/misc-drugs-news-218/number-of-americans-taking-statin-keeps-rising-cdc-694895.html> or <https://www.ahrq.gov/data/infographics/statin-use.html>

<sup>131</sup> This analysis comes from Madhusoodanan, NY Times, October 25, 2022 Ask Well ‘Do statins increase the risk of type 2 diabetes?’

<sup>132</sup> Sattar, Statins and risk of incident diabetes, <https://www.ncbi.nlm.nih.gov/books/NBK78906/>

<sup>133</sup> Madhusoodanan, op cit

<sup>134</sup> Ibid.

- One common behavioral response to our high stress lifestyles – TV watching – may exacerbate the diabetes problem
- Medical treatments for other behaviorally related health problems, i.e. statins to lower cholesterol, may also exacerbate the diabetes problem.

Is there a medical solution?

### Semaglutide

Semaglutide developed by Novo Nordisk, apparently treats obesity and diabetes quite well.

In one large random controlled study, for example, patients taking 2.4 milligrams of semaglutide lost an average of 6% of their body weight by week 12 and 12% of their body weight by week 28. That's impressive.

Other studies have suggested similar successes.<sup>135</sup>

In February 2022, the British National Institute for Clinical Excellence (NICE), the UK's medical rationing agency, approved Wegovy, Novo Nordisk's brand name for semaglutide to treat obesity. In the vernacular, NICE approval means the drug works; it has a higher approval bar than the US Food and Drug Administration.

Eli Lilly has developed a competitor weight loss drug called tirzepatide, not yet approved as of time of writing. I assume other companies have already, or will, similarly design competition to semaglutide.

NICE's stringent use guidelines for semaglutide illustrate some underlying issues with the drug.<sup>136</sup>

- It is approved for people with at least 1 weight related medical issue and a BMI of 35 or more, or, only exceptionally, for people with a BMI between 30 – 34.9
- It can only be prescribed as part of a specialist weight management program including supervised weight loss coaching. This has implications for the US where only 1% of physicians are trained in obesity medicine.<sup>137</sup>
- Semaglutide can be prescribed for 2 years, maximum.

Novo Nordisk also sells semaglutide it for diabetes treatment under the brand named Ozempic.

But the pricing:

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<sup>135</sup> Weghuber et al, One-Weekly Semaglutide in Adolescents with Obesity, NEJM, Nov 2, 2022

<sup>136</sup> Much of this discussion comes from 'NICE approves Wegovy for obesity', European Pharmaceutical Review, February 10, 2022 <https://www.europeanpharmaceuticalreview.com/news/168431/nice-approves-wegovy-semaglutide-for-obesity/>

<sup>137</sup> Kolata, The Doctor Prescribed and Obesity Drug; the insurance company called it vanity, NY Times, May 31, 2022. Much of the following discussion comes from this source.

- Ozempic, semaglutide for diabetes, lists for \$894 for 4 weeks in the US. Insurance companies normally cover it for diagnosed diabetics.
- Wegovy, semaglutide for weight loss, lists for about \$1,350 per month. Insurance companies normally don't cover it, at least not without a fight.
- Saxenda, basically Wegovy lite also by Novo Nordisk, also lists for \$1,350 per month. Ditto on the insurance coverage front.

This creates confusing incentives. In the US, having a high BMI does not necessarily qualify a patient for Wegovy or Saxenda as in the UK. American doctors must wait until their patient becomes diabetic. Patients 'only' suffering from obesity and metabolic syndrome don't have access so must settle for less robust, older medications, often with unpleasant side effects. As the New York Times reported, one doctor 'finds herself rejoicing when patients have high blood sugar levels'<sup>138</sup>, i.e., becomes diabetic and therefore eligible for treatment.

We don't yet know the long term effects of semaglutide because it's too new:

- Does a patient who loses 12% of their body weight in 7 months then keep it off?
- What happens when, in the UK situation, semaglutide's prescription runs its full 2-year course: does the patient regain the weight or not?
- Is 2 years long enough for the patient to develop good eating habits?
- Can the patient afford to stay on the healthier diet?
- What is the medical cost difference between staying on Wegovy for life and returning to obesity and diabetes?

We also can't yet answer the most important economic question: how do semaglutide treatment costs compare with medical treatment costs over time? We can only, today, guess at the answer.

Semaglutide and, perhaps, Novo Nordisk's competitor's drugs, may be the light at the end of the obesity-to-metabolic syndrome-to-diabetes tunnel. Or they may be the proverbial headlight of an oncoming train. I certainly don't know which, but the future looks murky to me. At best.

### Case study

#### My own experience with metabolic syndrome

My doctor diagnosed me with metabolic syndrome in August 2020 based on various numbers from my annual physical.

A quick word on numbers and annual physicals. I consider these equivalent to a half-semester report card in high school, a rough indication of your academic health and direction. You might be a good student having a bad semester for some ephemeral reason. You might have a serious intellectual disease. Or you

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<sup>138</sup> Ibid.



might be going in a bad academic direction, through lack of effort for example. Your half semester report card doesn't tell which.

A series of report cards over time might though. Consider a student with an A average in 8<sup>th</sup> grade, an A- average in 9<sup>th</sup> grade, a B average in 10<sup>th</sup> grade and a C- average on the first half semester report card in 11<sup>th</sup> grade. We see a trend. The report card suggests need for an intervention by the school, parents, community, or others to identify and address some issue or other.

Similarly, my 2020 annual physical numbers suggested an issue. What it was – lifestyle, individual biology or something else – remained to be determined.

Add to that my own idiosyncratic personality: I don't like to receive failing grades. I found myself annoyed more than concerned and determined to do something about it. I self diagnosed – always a bad idea – my problem as lifestyle and decided to lose weight, exercise more and see what happened.

My August 2020 numbers compared to the metabolic syndrome guidelines:

| Before (Physical 8/2020) | Guidelines                                  |
|--------------------------|---------------------------------------------|
| Weight 225               |                                             |
| • BMI 30.5               | • Should be < 25; obesity = 30+             |
| • BP 168/104             | • Should be < 150/90 (over 60 yrs old, AHA) |
| • Total Cholesterol 203  | • Should be < 200                           |
| • Triglycerides 269      | • Should be < 200                           |
| • HDL 29                 | • Should be > 45                            |
| • LDL 120                | • Should be < 130                           |
| • TC – HDL ratio 6.9     | • Should be < 4.9                           |
| • A1C 5.3                | • Should be < 5.7                           |
| • Heart Rate 91          | • Should be 60 - 100                        |

I put myself on diet-and-exercise program and lost about 40 pounds in a year. See the addendum to this chapter for details.

But the big question facing me: would the healthy habits, developed over a year, maintain themselves and keep me at a healthy weight at the 2 year anniversary? I know the 2 year failure rate of weight loss programs, well over 80% with some estimates as high as 97%.

Also, what would that metabolic profile look like 2 years later?

Here are the results from my August 2022 physical:

| After (Physical 8/2022) |                                        |
|-------------------------|----------------------------------------|
| Weight 189              |                                        |
| • BMI 24.9              | • Should be < 25; obesity = 30+        |
| • BP 142/80             | • Should be < 150/90 (over 60 yrs old) |
| • Total Cholesterol 172 | • Should be < 200                      |
| • Triglycerides 83      | • Should be < 200                      |
| • HDL 44                | • Should be > 45                       |
| • LDL 112               | • Should be < 130                      |
| • TC – HDL ratio 3.9    | • Should be < 4.9                      |
| • A1C 5.3               | • Should be < 5.7                      |
| • Heart rate 61         | • Should be 60 - 100                   |

And here's the side-by-side comparison of all those numbers two years apart to show the remarkable impact of weight loss and exercise increase in one relatively easy-to-read chart.

| Before (8/2020)         | After (8/2022)          |
|-------------------------|-------------------------|
| Weight 225              |                         |
| • BMI 30.5              | • BMI 24.9              |
| • BP 168/104            | • BP 142/80             |
| • Total Cholesterol 203 | • Total Cholesterol 172 |
| • Triglycerides 269     | • Triglycerides 83      |
| • HDL 29                | • HDL 44                |
| • LDL 120               | • LDL 112               |
| • TC – HDL ratio 6.9    | • TC – HDL ratio 3.9    |
| • A1C 5.3               | • A1C 5.3               |
| • Heart rate 91         | • Heart rate 61         |

Diet and exercise worked well to get me out of the metabolic syndrome.

It's a shame that cost, convenience, and other factors keep so many others from enjoying this success and the related good health / low healthcare costs.

## Chapter summary

Diabetes accounts for up to 25% of all healthcare spending. Its incidence grows over time, along with the underlying causes: obesity, low quality caloric food consumption and insufficient exercise afflict many of us, perhaps a majority of Americans, perhaps a large majority.

Many afflicted folks progress through metabolic syndrome and / or prediabetes to full blown diabetes. Efforts to intervene behaviorally - typically referred to as lifestyle changes involving dietary improvements and exercise increases - generally fail, by some estimates up to 97% of the time.<sup>139</sup> They're

- Too expensive for average income Americans
- Too uncomfortable to maintain for years
- Too inconvenient
- Too dissonant with our normal lifestyles, TV watching for example.

New, promising medications are too expensive for widespread use, with 'widespread' meaning the 70 million currently obese Americans. Insurance companies balk at the cost.

I don't see a hopeful path forward. Instead, I see our diabetic population growing along with the associated healthcare costs.

A pessimistic end to a pessimistic chapter.

### My calorie and cost spreadsheets

All data from Shaw's, Easton Massachusetts, October 2022. I made several trips to gather data.

In case you have trouble reading the spreadsheets below, the column headings are

- Item name
- Cost / package. The store publishes this.
- Servings / package. This is on the nutritional label of all packaged foods, or you can google it for fruits and vegetables.
- Calories / serving. Again, on the nutritional label. Google provides this information about other foods - calories / pound of apples for example, or calories in a medium apple.
- Cost / calorie. This is a simple division: cost / package divided by number of servings / package divided by number of calories / serving.
- # servings per meal. That's how much you put on your plate. You may choose 2 servings of spinach for example, or ½ serving of ice cream.
- Total calories = Again a simple calculation: the number of calories / serving times the number of servings on your plate.

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<sup>139</sup> The Weight of the Evidence, Harriet Brown, Slate, March 24, 2015

<https://slate.com/technology/2015/03/diets-do-not-work-the-thin-evidence-that-losing-weight-makes-you-healthier.html>.

- Total cost = the cost / calorie for each food times the number of calories on your plate.

| Item                                   | Cost / package (\$) | Servings / package | Calories / serving | Cost / calorie | # servings | Total # calories | Total cost (\$) |
|----------------------------------------|---------------------|--------------------|--------------------|----------------|------------|------------------|-----------------|
| <b>Healthy breakfast</b>               |                     |                    |                    |                |            |                  |                 |
| 2 jumbo eggs - range free              | 7.99                | 12                 | 90                 | 0.007398148    | 2          | 180              | \$ 1.33         |
| 2 pieces Arnold Multigrain toast       | 5.29                | 16                 | 110                | 0.003005682    | 2          | 220              | \$ 0.66         |
| Butter (Land o Lakes)                  | 4.79                | 30                 | 50                 | 0.003193333    | 1          | 50               | \$ 0.16         |
| 1 banana                               | 0.69                | 3                  | 100                | 0.0023         | 1          | 100              | \$ 0.23         |
| Black coffee                           | 19.99               | 100                | 2                  | 0.09995        | 1          | 2                | \$ 0.20         |
| <b>Total</b>                           |                     |                    |                    |                |            | <b>552</b>       | <b>\$ 2.58</b>  |
| <b>Healthy lunch</b>                   |                     |                    |                    |                |            |                  |                 |
| Spinach salad                          | 5.99                | 3.5                | 20                 | 0.085571429    | 1          | 20               | \$ 1.71         |
| Tomato                                 | 2.99                | 1                  | 90                 | 0.033222222    | 0.5        | 45               | \$ 1.50         |
| Carrot                                 | 3.49                | 11                 | 30                 | 0.010575758    | 0.5        | 15               | \$ 0.16         |
| Yellow Pepper                          | 1.7                 | 1                  | 50                 | 0.034          | 0.5        | 25               | \$ 0.85         |
| Beets                                  | 3.99                | 2.5                | 50                 | 0.03192        | 0.5        | 25               | \$ 0.80         |
| Olive oil - Bertolli                   | 7.49                | 33                 | 120                | 0.001891414    | 0.67       | 80.4             | \$ 0.15         |
| Balsamic vinegar - Filippo Berio       | 6.99                | 33                 | 11                 | 0.019256198    | 0.33       | 3.63             | \$ 0.07         |
| .3 lb of chicken breast                | 3.99                | 1                  | 748                | 0.005334225    | 0.3        | 224.4            | \$ 1.20         |
| 1 pita                                 | 2.99                | 8                  | 90                 | 0.004152778    | 1          | 90               | \$ 0.37         |
| Apple                                  | 1.99                | 3                  | 95                 | 0.006982456    | 1          | 95               | \$ 0.66         |
| <b>Total</b>                           |                     |                    |                    |                |            | <b>623.43</b>    | <b>\$ 7.47</b>  |
| <b>Healthy dinner (Rice Bowl)</b>      |                     |                    |                    |                |            |                  |                 |
| 2 cups brown rice                      | 20.99               | 111                | 170                | 0.001112348    | 2          | 340              | \$ 0.38         |
| Broccoli                               | 1.99                | 1                  | 154                | 0.012922078    | 0.33       | 50.82            | \$ 0.66         |
| Summer squash                          | 1.99                | 1                  | 74                 | 0.026891892    | 0.33       | 24.42            | \$ 0.66         |
| Snap peas                              | 2.99                | 3                  | 35                 | 0.02847619     | 1          | 35               | \$ 1.00         |
| Green beans                            | 3.29                | 4                  | 25                 | 0.0329         | 1          | 25               | \$ 0.82         |
| Salmon                                 | 11.99               | 1                  | 944                | 0.012701271    | 0.4        | 377.6            | \$ 4.80         |
| Low salt soy sauce                     | 3.29                | 20                 | 20                 | 0.008225       | 1          | 20               | \$ 0.16         |
| Blueberries                            | 2                   | 1                  | 229                | 0.008733624    | 0.5        | 114.5            | \$ 1.00         |
| Strawberries                           | 4.99                | 1                  | 149                | 0.033489933    | 0.5        | 74.5             | \$ 2.50         |
| <b>Total</b>                           |                     |                    |                    |                |            | <b>1061.84</b>   | <b>\$ 11.97</b> |
| <b>Total Daily Calories &amp; Cost</b> |                     |                    |                    |                |            | <b>2237.27</b>   | <b>\$ 22.02</b> |

| Item                                   | Cost / package (\$) | Servings / package | Calories / serving | Cost / calorie | # servings | Total # calories | Total cost (\$) |
|----------------------------------------|---------------------|--------------------|--------------------|----------------|------------|------------------|-----------------|
| <b>Typical breakfast</b>               |                     |                    |                    |                |            |                  |                 |
| Honey bran muffin (Shaw's)             | \$5.00              | 4                  | 420                | 0.00297619     | 1          | 420              | \$ 1.25         |
| Coffee                                 | 19.99               | 100                | 2                  | 0.09995        | 1          | 2                | \$ 0.20         |
| Cream (Coffeemate)                     | 4.49                | 63                 | 35                 | 0.002036281    | 1          | 35               | \$ 0.07         |
| Sugar (Domino's granular)              | 1.99                | 54                 | 30                 | 0.001228395    | 1          | 30               | \$ 0.04         |
| <b>Total</b>                           |                     |                    |                    |                |            | <b>487</b>       | <b>\$ 1.56</b>  |
| <b>Typical lunch</b>                   |                     |                    |                    |                |            |                  |                 |
| Ham                                    | 7.99                | 1                  | 885                | 0.009028249    | 0.25       | 221.25           | \$ 2.00         |
| Cheese (20 slices / lb)                | 5.99                | 20                 | 100                | 0.002995       | 1          | 100              | \$ 0.30         |
| Sub roll                               | 2.99                | 6                  | 200                | 0.002491667    | 1          | 200              | \$ 0.50         |
| Mustard (French's)                     | 2.49                | 79                 | 1                  | 0.031518987    | 1          | 1                | \$ 0.03         |
| Lettuce - ice berg                     | 2.49                | 1                  | 105                | 0.023714286    | 0.15       | 15.75            | \$ 0.37         |
| Bag of chips                           | 21.99               | 42                 | 150                | 0.003490476    | 1          | 150              | \$ 0.52         |
| 3 Oreos                                | 5.49                | 21                 | 160                | 0.001633929    | 1          | 160              | \$ 0.26         |
| Apple                                  | 1.99                | 3                  | 95                 | 0.006982456    | 1          | 95               | \$ 0.66         |
| Coca cola                              | 2.79                | 12                 | 140                | 0.001660714    | 1          | 140              | \$ 0.23         |
| <b>Total</b>                           |                     |                    |                    |                |            | <b>1083</b>      | <b>\$ 4.88</b>  |
| <b>Typical dinner</b>                  |                     |                    |                    |                |            |                  |                 |
| Regular pasta (Barilla)                | 2.99                | 8                  | 200                | 0.00186875     | 1          | 200              | \$ 0.37         |
| Pasta sauce (Prego traditional)        | 3.99                | 5                  | 70                 | 0.0114         | 1          | 70               | \$ 0.80         |
| Ground beef - 80%                      | 4.99                | 1                  | 1152               | 0.004331597    | 0.25       | 288              | \$ 1.25         |
| Grated cheese (Kraft parm)             | 5.99                | 45                 | 20                 | 0.006655556    | 1          | 20               | \$ 0.13         |
| Green salad - Dole American            | 3                   | 4                  | 15                 | 0.05           | 2          | 30               | \$ 1.50         |
| Italian dressing (Ken's house)         | 3.99                | 16                 | 120                | 0.002078125    | 1          | 120              | \$ 0.25         |
| Canned peaches                         | 3.49                | 7                  | 100                | 0.004985714    | 1          | 100              | \$ 0.50         |
| Ice cream (Friendly's)                 | 4.99                | 9                  | 210                | 0.002640212    | 0.5        | 105              | \$ 0.28         |
| Beer (Bud) Walmart                     | 8.27                | 6                  | 145                | 0.009505747    | 1          | 145              | \$ 1.38         |
| <b>Total</b>                           |                     |                    |                    |                |            | <b>1078</b>      | <b>\$ 6.46</b>  |
| <b>Total Daily Calories &amp; Cost</b> |                     |                    |                    |                |            | <b>2648</b>      | <b>\$ 12.90</b> |

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## Addendum: My battle with metabolic syndrome

A version of this is available from [www.lulu.com](http://www.lulu.com) as Gary's Guide to Weight Loss.

### Foreword

Dr. David Mudd

Gary asked me to write a forward to his book while we were kayaking together. I told him I would be honored to do so.

I have worked for 30 years as a primary care physician in a mixed urban / suburban environment. Over these years obesity rates have skyrocketed. I have seen it in my own practice: young and old patients, blue and white collar, it doesn't matter. Far too many of my patients are heavier these days causing other health conditions to become more prevalent including diabetes, hypertension and heart disease.

I have had countless people come to me complaining of their inability to lose weight. The complaints are the same and the accounts of their food intake and exercise eerily similar. "I hardly eat anything" or "I eat the same amount I always have." Lacking hard data, I wonder about this.

When I ask about their activity level, they usually respond “I try to walk.”

They typically want to have their thyroid checked, assuming that there is a medical explanation for their weight gain and fatigue.

My message to them is always the same: “you need to cut back on your calories and become more active”. Unfortunately, we never have enough time together for me to understand their lifestyles, dietary norms and physical activity habits in enough detail. Invariably they return frustrated and unsuccessful.

Fewer than 1/10 patients actually make the changes necessary to lose weight and keep it off.

Patients such as Gary Fradin are few and far between but a joy to work with. Gary is the rare patient who understands nutrition and exercise and actively takes control of his own health. He formulated a plan to cut his calories and increase his activity level and enjoyed spectacular results, losing over 40 pounds and getting himself into good physical shape as well.

Gary summarized the process in this readable and informative book. His recommendations are science based, useful and appropriate. I heartily recommend it.

In fact, I plan to give this book to my own patients. Enjoy it and good luck!

Dr. David Mudd  
Easton, Massachusetts  
May, 2021

## Preface

After Covid struck, after our lives turned upside down, after my business revenues fell by 50%, after all normal routines disappeared, my doctor told me I had metabolic syndrome and to lose weight.

I told him I was fit and healthy.

He repeated his order.

How to lose weight? Diet options ranged from A (Atkins) to Z (Zone). All claimed dramatic successes.

But all almost certainly fail over time. Research suggests that 97% of people regain their weight within about 3 years.<sup>140</sup> Here, for example, is Traci Mann from UCLA summarizing her group's study:

"You can initially lose 5 to 10 percent of your weight on any number of diets, but then the weight comes back. We found that the majority of people regained all the weight, plus more."<sup>141</sup>

I didn't want to be one of the failures.

My doctor offered a nutritionist referral, which I postponed; I didn't like the odds, hate scheduling medical appointments and feared entering the modern diet culture even under the guise of organized medicine.

Instead, I decided to try on my own. I figured I could achieve at least the same dismal long-term weight loss result myself, and possibly do even better.

This chapter describes how.

The program isn't a unique, novel or brilliant but it's straightforward, practical and honest. You can easily adapt it to your own situation.

Just follow the steps, modify it to your own needs and give yourself time.

**The Camera Adds 20 Pounds**  
Me, fit-and-healthy pre-weight loss

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<sup>140</sup> The Weight of the Evidence, Harriet Brown, Slate, March 24, 2015  
<https://slate.com/technology/2015/03/diets-do-not-work-the-thin-evidence-that-losing-weight-makes-you-healthier.html>.

<sup>141</sup> Dieting Does Not Work, Stuart Wolpert, UCLA Newsroom, April 3, 2007  
<https://newsroom.ucla.edu/releases/Dieting-Does-Not-Work-UCLA-Researchers-7832>





## Introduction

I'm not a doctor, nutritionist, dietician or exercise physiologist. I have no medical training.

Instead, I'm an economist. I measure things. Weight loss strikes me as a measurement problem:

- If you eat more calories than you burn, you gain weight.
- If you eat fewer calories than you burn, you lose weight.
- As you eat less, your metabolism slows so you need to exercise more.

Sustained, long term weight loss also incorporates a fourth, behavioral consideration:

- Do this all slowly enough to develop new habits. That increases your chance of long-term success.

This program incorporates all those issues.

As background, I'm a 68-year-old, 72-inch-tall man. I weighed 225 pounds in my doctor's office on August 13, 2020.

I followed this program for 9 months and weighed 185 at my Sunday morning weigh-in April 4, 2021. I had lost 40 pounds over 36 weeks, about a pound per week on average.



It wasn't very difficult – more a task to accomplish than a mountain to climb - but I was hungry much of the time, especially at the beginning. That feeling dissipated as my new eating habits became ingrained and my body adjusted to its new setpoint. Dissipated but didn't disappear.

I'm optimistic about long-term success, optimistic that my habits have changed enough to maintain my new weight for years to come. Cautiously optimistic that is, not blindly. After all, 97% of people who lose weight ultimately put that weight back on.

We'll see. The future is a long time.

### **Step 1: Calculate your daily calorie needs.**

There's a weight loss mantra 'eat 500 calories less each day and lose a pound a week'.

Maybe true – I don't know - but I needed a starting point. 500 calories less *than what?* No idea. I hadn't tracked my previous consumption.

I initially tried cutting cream from my morning coffee and dessert from lunch and dinner. But I didn't use the same amount of cream every day. Nor did I eat dessert every day but when I did, the type and size varied. Did that cut 500 calories? No idea.

I tried eating smaller portions. Small enough? Too small? Again, no idea. I only knew that I felt hungry. I worried that if I felt hungry without seeing results, I'd get frustrated and stop.

I needed a plan.

So instead of eating 500 calories *less* than some unknown number, I decided to calculate how many calories I *should* eat each day to lose a pound a week, an absolute number.

I googled 'calories per day to lose weight' and found lots of websites that base their estimates on age, height, weight, gender and daily activity level. Most suggested roughly the same amount – 2300 calories per day to lose a pound a week from that 225 pound starting point. (Your own amount will vary.)

The agreement among websites gave me a reasonable degree of confidence.

I aimed for 2200 calories per day, slightly below the 2300 estimate to allow for measurement errors.

Interestingly, 2200 calories per day isn't a starvation diet. Far from it. In fact, the US Department of Agriculture estimates that the average American consumed 2234

calories per day in 1970.<sup>142</sup> My 2200 calorie target simply mimicked America's pre-obesity food consumption level.

Three thoughts on eating according to your daily calorie estimates and watching the impact on your weight:

1. Remember to recalculate as you lose weight. Your calorie needs drop.
2. Set reasonable weight loss goals – neither too fast nor too much – to avoid frustration.
3. Weigh yourself on the same scale, at the same time, every week. This generates the most consistent data, necessary to keep you on track. I choose Sunday mornings, first thing. Those are the weights I show in the **Results and Lessons** chapter.

I started thinking 'if I can get down to 215, I'll be successful'. Then, upon reaching 215, I wondered about losing another 5 pounds. Then I aimed for 200, a nice round number. Then 195, a 30-pound loss and enough to write a book. Maybe others could benefit from this program?

But losing 40 pounds sounded better than 30, so I aimed for 185 and made it. Low enough! My doc said to stop here.

Remember that my initial goal wasn't 185. It was 215. Try to define success for yourself as a goal you can reasonably reach in a relatively short period, something that will make you feel proud. Then let the future take care of itself as you gain confidence through success.

### **Step 2: Divide your daily calorie target into 3 meals and a snack.**

I used this rule-of-thumb for my initial 2200 calorie per day program.

Breakfast - 400 calories (18% of total daily calories)

Lunch - 600 calories (27%)

Dinner - 800 calories (36%)

Snacks or dessert - 400 calories. You can add these to your breakfast, lunch or dinner.

Your own calorie target and meal amounts may differ.

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<sup>142</sup> Wells and Buzby, US Food Consumption Up 16% Since 1970, Economic Research Service US Department of Agriculture, November 1, 2005 <https://www.ers.usda.gov/amber-waves/2005/november/us-food-consumption-up-16-percent-since-1970/>

You'll find calorie estimates for specific foods on packages or online. Simply google 'calories in a medium potato' or 'calories in a cup of blueberries' or whatever. It's easy and close enough for our purposes.

**Meal timing:** I ate according to the clock throughout this program and expect to in the future:

- Breakfast at 9:00
- Lunch at 1:30
- Dinner at 6:30. Regular as clockwork.

Try not to eat whenever you feel hungry because those feelings come and go. Stick to the clock. It's honest, reliable and will keep you on track.

See the discussion of hunger below, for more on this.

**Food choices:** I learned several things through trial and error about my own reaction to food groups. You probably will too, though perhaps different lessons.

First, I feel fuller, longer eating vegetables probably because of their high fiber and water contents. I eat lots of vegetables these days.

Second, I prefer healthy food tastes. I look forward today to my English muffin, peanut butter and banana breakfast as enthusiastically as I had previously anticipated pancakes with syrup or eggs with bacon, sausage and toast.

In fact, I no longer want those overly-sweet, overly-salty, overly-filling, low-fiber meals, not because they're so high in calories but because they make me feel lousy afterward. They sit like a rock in my stomach and leave me stuffed and thirsty, then surprisingly hungry relatively quickly.

Third, I don't miss those previously routine, calorie-rich tastes, things like cream in my morning coffee, cheese and crackers between meals or rich desserts after dinner. I now prefer blueberries, raspberries or strawberries for dessert, sometimes with a drop of honey on top. Berries are sweet and delicious, and I feel good after eating them.

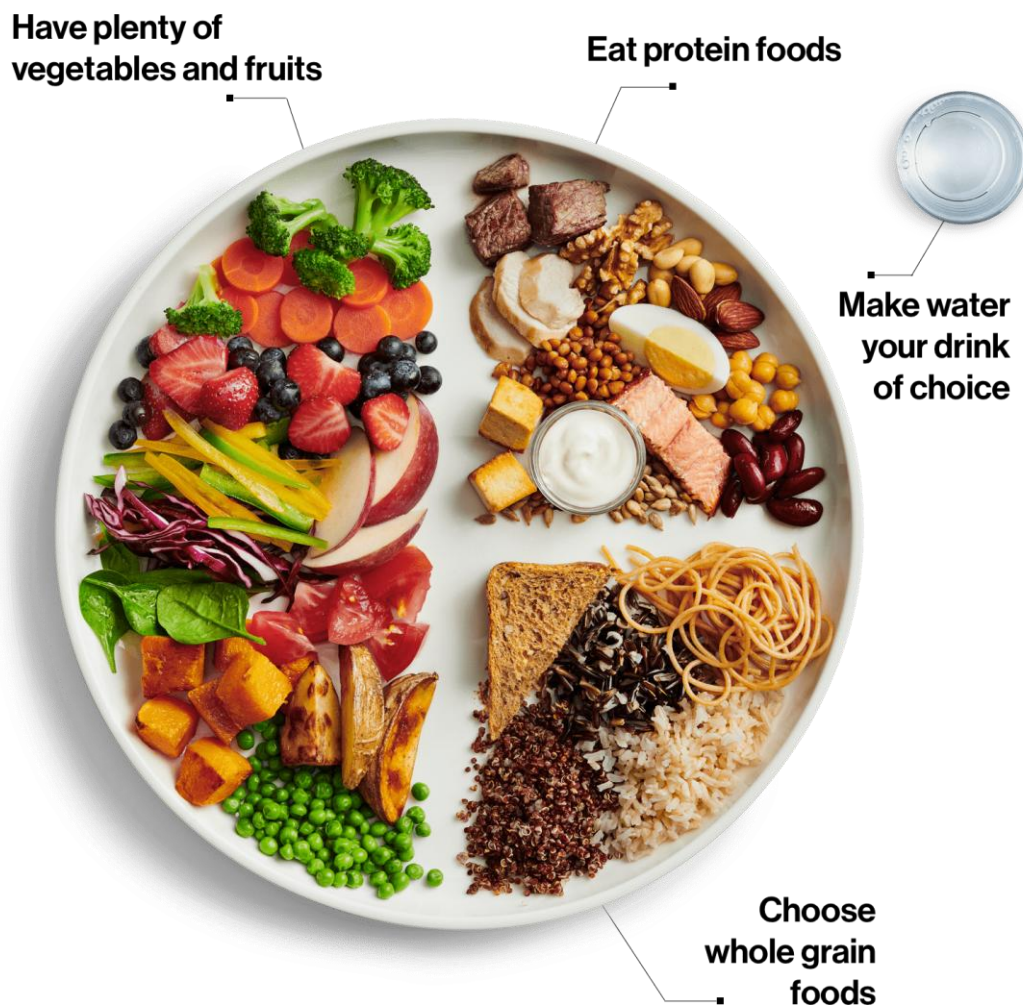
Plus I don't have that sugary thirst like I used to after eating cookies or cake.

My experiences mirror recommendations from 2 thoughtful sources. Michael Pollan, New York Times contributor, best-selling author, and Berkeley professor famously advises people to "Eat food. Not too much. Mostly plants." Consider each phrase.

- **"Eat food"** means eat real, identifiable farm products like fruits, vegetables, whole grains, meat and fish. Avoid ingredients you can't pronounce and foods your grandmother wouldn't recognize.
- **"Not too much"** means stick to your daily calorie limit.
- **"Mostly plants"** means lots of fruit and vegetables.

The Canadian Food Plate, photo below, suggests the proportion of each food group – plants, grains and proteins – to eat daily. Remember that nuts, beans and legumes count as proteins.

About half your plate should be fruits and veggies – aim for lots of different colors - a quarter protein and another quarter whole grains.



**Eat food. Not too much. Mostly plants.**

**Tastes and habits:** When people say, 'I can't drink coffee without sugar' or 'I can't eat an egg without salt', I wonder if they remember what got them into their overweight situation in the first place.

Changing eating habits is a process, both challenging and rewarding. The good news is that you really can change.

The bad news is that it takes time. Most people require at least 2 months for a new taste preference to become fully automatic though some people take up to 8 months

according to research.<sup>143</sup> Understand and accept this. Give yourself time to change your habits.

This habit development process may suggest why our modern diet industry so often fails people. It operates within two mutually exclusive constraints.

- First, it has to deliver weight loss results quickly enough that people don't drop out and post negative reviews online.
- But second, long term sustained weight loss and new habit creation takes a long time.

You can't generate fast results slowly! That's why I didn't want to get involved with it. I wanted a program without commercial or time pressure.

**Hunger.** Eating fewer calories per day makes you hungry. That's simply reality. I learned to differentiate three types of hunger.

\* **Hunger as not feeling completely full.** I had previously enjoyed eating until I was 'pleasantly satisfied'. I don't get that feeling anymore.

Instead, I feel 'full enough' these days, not exactly hungry but not completely full either. I could happily eat an additional muffin at breakfast, a bigger sandwich at lunch, an extra helping at dinner or a second bowl of fruit in the evening. But I don't.

I've learned to embrace feeling 'full enough' when I reach my calorie limit per meal. It's my new normal, my new habit. Today it feels right.

You can adapt to this new feeling too. Just give yourself time. And remember your goal.

\* **Hunger as deprivation**, actual physical need. This is sometimes called 'belly hunger' as opposed to 'head hunger', below.

I wasn't worried about physical deprivation as long as I ate every 4 – 5 hours. I knew that my 2200 calorie per day program was sufficient for good health; the 1970 era US food experience proved that. Two hundred million Americans ate that way every day. End of story.

Some people, of course, might have special nutrition or health issues. I can't speak to those. Still not a doctor.

\* Head hunger differs from **belly hunger**. Head hunger goes away when you think about something else. Belly hunger does not.

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<sup>143</sup> Grohol, Need to Form a New Habit? Give Yourself At Least 66 Days, PsychCentral, October 7, 2018 <https://psychcentral.com/blog/need-to-form-a-new-habit-66-days> ; UCL News August 9, 2009 Interview with Phillippa Lally <https://www.ucl.ac.uk/news/2009/aug/how-long-does-it-take-form-habit>

Try this thought experiment to understand the difference: visualize a delicious burger or juicy steak or moist chocolate cake or juicy mango. Imagine the taste. Picture it. Anticipate the sensation as you bite in.

Hold that thought.

Feel hungry? It's head hunger.

Now think of an IRS audit or root canal surgery. Visualize it. Hold onto it. Lose the hungry feeling?



Causes head hunger



Removes head hunger

Head hunger is a mental state. You can feel it equally few hours after either a big or small meal. When you feel it, think about something else. Easier said than done of course.

**Food costs.** Vegetables, per calorie, cost more than most other food groups due to various food subsidy and tax programs. Understand this and be prepared for a food budget increase.

**Restaurants** pose a problem for calorie restricted diets. Here are four suggestions that might help:

- Split a main course with someone and complement each portion with a side salad.
- Ask the restaurant to bring a doggie-bag containing half of your meal **when they serve it**. I find this works better than attempting to estimate and eat half first, then asking for a doggie bag later.
- Stick with salads and protein toppings. Careful with the dressing. This option might make the restaurant experience less special, but it will make your calorie intake more predictable.
- Pay attention to drinks, both alcoholic and non. Wine has about 120 calories per glass, beer 150, gin and tonic 170, Long Island iced tea 280 and Margaritas up to

450.<sup>144</sup> Coca-Cola classic has 140 calories per 12 ounces, orange juice about 110 per cup and chocolate milk about 200. Those all count toward your daily total.

**Cheating:** Try not to. You'll only sabotage your progress and depress yourself at your next weekly weigh in. Be honest with your measurements and anticipate that you'll be on this program for several months at least, maybe for life (maintenance period).

**Summary:** Eat according to the clock and follow your grandmother's advice: eat the foods she would approve, don't eat foods she wouldn't recognize and control your portions.

Allow yourself time to develop new habits.

\*\*\*\*\*

I invented some recipes, unexpected food combinations that satisfied me. Several became my new habits. If you like any, use them. Feel free to invent your own!

### **Breakfasts**

**Toasted English muffin with peanut butter plus a banana with almond butter.** I eat this most frequently, perhaps 5 times per week. Cut a whole wheat English muffin (100 calories) in half and toast both halves. Then spread one tablespoon of salt-free peanut butter – about 100 calories – onto the 2 halves, about half a tablespoon per half. I don't add jam because I don't like very sweet tastes for breakfast, but that's just me.

Then cut a ripe banana, about 100 calories, in half and spread one tablespoon of almond butter – about 100 calories - onto it, again half a tablespoon per half. I prefer almond butter to peanut butter with bananas but again, my own preference.

**Poached eggs on oatmeal.** Instead of 2 scrambled eggs and 2 pieces of toast for breakfast, I substituted 2 poached eggs over oatmeal with a splash of ketchup, again my own taste preference. Oatmeal instead of wheat, one grain for another. Make it thick. One-third cup of steel cut oats is 170 calories, two jumbo eggs total 180.

Sometimes I add tomato slices or steamed broccoli. Tasty. Other times I melt Swiss cheese into the oatmeal, then put one egg on top. Delicious!

Plenty of other breakfast options exist within that original 400 calorie constraint. You're only limited by your imagination.

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<sup>144</sup> Best and Worst Booze While Dieting, Carolyn Williams on [cookinglight.com](https://www.cookinglight.com/healthy-living/weight-loss/best-alcohol-drink-on-diet)  
<https://www.cookinglight.com/healthy-living/weight-loss/best-alcohol-drink-on-diet>



## Lunch

I often eat leftovers for lunch, generally vegetables with some protein and fruit for dessert. Sometimes I add peanuts, cashews or butter beans - I really like butter beans - depending on our refrigerator's contents. Remember to estimate your calories honestly when you do this.

Here are some creative combinations that I enjoyed.

**Tuna fish sandwich with pickles and a chocolate banana smoothie.** I use chunk light tuna, only 90 calories per can, oilier than solid white so requiring less mayonnaise; add about ½ tablespoon, 50 calories. Then 2 slices of bread @ 100 calories each, a tomato slice and lettuce with a side of pickles for a 360 calorie, filling sandwich. Maybe add a splash of mustard (!) for flavor.

Then, assuming your taste buds require (mine generally do), make a frozen banana smoothie. One cup of skim milk (100 calories), a banana (another 100) and 2 tablespoons of Ovaltine (40 calories). I prefer Ovaltine to other chocolate syrups, but again, that's just me. Total about 240 calories, making your tuna sandwich plus smoothie a tasty 600 calorie lunch.

**Beans or mussels in tomato sauce over steamed vegetables.** One 8-ounce packet of frozen mussels (I use PanaPesca) contains 175 calories; 3 cups of broad beans about 150 calories. One cup of tomato or marinara sauce has about 120 calories depending on the brand. Put this modified bolognese sauce over steamed zucchini, broccoli or cauliflower and sprinkle with parmesan cheese for a delicious and filling 300 calorie lunch. Enjoy a couple pieces of fruit for dessert.

I sometimes substitute chicken, garbanzo beans or left-over steak.

And I sometimes, though rarely, put this over a cup of pasta, about 200 calories.

Plenty of options to try.

**A word about vegetables and salad.** Per volume, vegetables contain fewer calories than most other foods. It's hard to overeat spinach or broccoli!

Try mixing three cups of raw spinach (25 calories) with a cup of raw beets (45 calories), a large tomato (25 calories), left over veggies from your refrigerator and any other vegetables you have on-hand. Then top with your favorite cheese, nuts or protein.

Careful with the dressing though. I limit myself to 1 tablespoon, generally of Italian or Greek dressing, 50 - 75 calories depending on the brand. Sometimes I make my own, mixing olive oil, vinegar and mustard or horseradish.

**A word about fruit.** I normally eat at least 3 pieces of fruit every day in addition to my frequent morning banana. I'm partial to apples, oranges, clementines, strawberries,



raspberries and blueberries. We're not, in my family, big melon, pineapple or mango people but if we were, I'd include those too. It's a matter of taste again.

## Dinner

We enjoy broiled vegetables at almost every dinner during the winter and grilled veg in the summer, generally broccoli, cauliflower, green beans, Brussels sprouts or eggplant. I char them slightly and sometimes sprinkle lightly with salad dressing. ('Lightly' means about a tablespoon per pound of veg.)

We typically eat this as a side dish with grilled meat, chicken or fish, most often fish. Sometimes my wife and I split a sweet potato too, about 80 calories per half. That adds natural sweetness to the meal.

Remember to control your portions! Steak has more calories per pound than chicken; salmon more than white fish.

We also try more creative dinners too.

**Tomato sauce with turkey or beans and vegetables.** This becomes a stand-alone stew; no pasta required. We use low fat ground turkey, a low calorie / low salt pasta sauce (read the labels) and add broccoli, cauliflower, peas, onions, mushrooms, peppers or fresh tomatoes. Then flavor with red wine.

We sometimes substitute butter beans for the turkey.

One issue with this meal: estimating calories accurately, especially leftovers. I generally add up all the calories in the entire batch, then estimate portion size – a quarter, a third, etc. Close enough for our purposes. Overestimating your portion today leads to underestimating it tomorrow or vice versa.

I then label the leftover calories in the fridge because I forget otherwise.

**Baked feta and vegetables.** Cut a block of feta cheese into 300 calorie chunks then bake or broil with red onions and cherry tomatoes. Sprinkle lightly with Greek salad dressing. Add a glass of chilled white wine, about 100 calories.

We sometimes add or substitute tofu for feta. Same idea but a different flavor.

**Homemade oatmeal muesli,** a sweet, Swiss-themed change from veggies and protein. Mix together 1/2 cup of steel cut oatmeal (255 calories), 1/2 cup of unsalted cashews or peanuts (320 cal.) or almonds (414 cal), a cup of blueberries (85 cal.), a cup of strawberries (50 cal.) and a banana (100 cal.). Total about 800 calories depending on your specific ingredients. Top with yogurt or honey, another 70 calories or sprinkled coconut. Eat hot or cold.

## Snacks and Deserts

Some of my favorite quick-and-easy snacks include:

- Baked apples with cinnamon
- Blueberries or raspberries. 85 cal. per cup each + 1 tablespoon honey, 70 cal. equals 155 calories total
- Yogurt with Ovaltine. ½ cup fat free, sugar free yogurt, 60 cal. + 2 tablespoons of Ovaltine, 40 cal. = 100 calorie version of chocolate mousse. OK, not *exactly* mousse but it's pretty good. I sometimes double this if I'm ahead on my daily calories. (Haven't tripled it yet.)

You'll invent your own recipes. Write everything down so you remember which worked best for you.

**Step 3: Go for a daily brisk walk.**  
or get some other form of daily exercise

Our metabolisms slow down as we eat fewer calories. To counter this, exercise every day. I normally enjoy a brisk daily walk, equal emphasis on **brisk** and **daily**. 'Brisk' means you can *just barely* keep a conversation going. Walk with a friend to find your own speed using this metric. (Check with your doctor to make sure you're healthy enough first.)

**Our frighteningly unfashionable hero in his  
winter walking outfit, 2021**



I average about 420 minutes – 7 hours – of brisk walking per week. I measure minutes of exercise per day instead of steps or total walking distance to allow for variety - swimming, bike riding, exercise classes, weight-lifting, cross country skiing or similar activities.

Interestingly, both the CDC and British National Health Service recommend at least 150 minutes per week of brisk exercise for everyone. More is better. That weekly 420 minutes of brisk walking helped keep my metabolism from slowing down as I ate fewer calories. The simple form at the end of this book helped me stay on track. Try it yourself.

Daily exercise – walking in my case - like everything else in this book, becomes a habit. You miss it on days you don't go. Allow yourself time for this habit to develop.

I like to measure both my daily exercise time and walking distance. The goal is to maintain at least, and hopefully increase, both. Various smart phone apps can help.

One day, early in this program, I walked 4 miles in 70 minutes, about 17.5 minutes per mile, finishing tired and certain I couldn't go farther or faster. Six months later, on a mid-February walk, I averaged 15:30 per mile for 5 miles, equally certain that I couldn't go faster ... but pretty sure, this time, that I could go farther. (I actually went 7 miles a week later though at a slower 16:30 pace.)

Some people prefer to track total daily mileage or total daily steps. These are different ways to measure the same thing. I prefer exercise minutes since I can plan and control these, but again, just my preference. As long as you walk briskly during your exercise minutes, any measure can work.

One trick that keeps me motivated, even enthusiastic about walking every day: I listen to novels, generally long ones that keep me engaged. I prefer historical fiction and mysteries but again, personal preference.

I've walked with Winston Churchill during the Blitz of London, young Nigerian intellectuals as they navigate life, Sherlock Holmes, seafaring merchants, unscrupulous criminals, clever detectives and many others. I look forward each day to reconnecting with my audio friends and often – oddly – feel sad when each book ends. Listening while walking has become another habit, one that I increasingly enjoy.

Confessionary addendum: I know that I should add strength training to my exercise regime. I keep meaning to start but, truth be told, I never enjoyed lifting weights or doing sit-ups. Maybe I'll start tomorrow.

Probably not.

#### **Step 4: Write *everything* down.**

Write down your food consumption after every meal and snack, and your exercise time (or whichever exercise metric you choose) every day. That keeps you on track to achieve your goals.

The forms below can help. Completing them becomes another habit. It takes a minute or so. I expect to continue this for years since I plan to stay in the 185 pound weight range for a long time.

Writing down your food consumption each meal also makes you think twice about what you eat. It acts as a speed bump, forcing you to ask 'Do I really want to use this many calories on this food?' I found it a useful exercise.

**Weight** I weigh myself first thing every Sunday morning, always on the same scale. That's my 'official' weight though I confess to checking more frequently. I worry, slightly, that daily weigh-ins will drive me crazy, or, more likely, my wife. I'm already obsessive enough!

Beware of salt and water retention at your weigh-ins. Eating a salty evening meal – feta cheese or pasta sauce for example – can increase my weight by 2 to 3 pounds the next morning. Factor this into your calculations and, perhaps more importantly, watch your daily salt consumption. Harder to do than say unfortunately.

**Meals** You can use the attached simple form to track your daily calories. You'll see patterns emerge pretty quickly. Plus this will keep you from overeating in response to head-hunger. I've inserted a week of meals simply as an example. You can set up these forms very easily in Excel and design your own meals.

| Date | Breakfast                                                                                     | Lunch                                                                                                                             | Dinner                                                                                                                 | Snack(s)                                                                                  | Total |
|------|-----------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|-------|
| Sun  | Eng Muffin (100)<br>Pnut butter (100)<br>Banana (100)<br>Almond butter (100)<br><br>Total 400 | Salad bag (50)<br>Tomato (30)<br>Chicken left overs (300)<br>Italian dressing (75)<br>Apple (100)<br><br>Total 555                | Turkey stew (ground turkey, pasta sauce and veg) (750)<br>Salad and dressing (100)<br>Pineapple (120)<br><br>Total 970 | 3 Clementine (105)<br>Yogurt & Ovaltine (100)<br>Blueberry + honey (150)<br><br>Total 355 | 2280  |
| Mon  | Oatmeal (170)<br>2 jumbo eggs (180)<br>Ketchup (20)<br><br>Total 370                          | Cauliflower left overs (75)<br>Butter beans (150)<br>Dressing (75)<br>Chicken (150)<br>Apple & cashew butr (190)<br><br>Total 640 | Salmon (300)<br>Broccoli (100)<br>Salad (50) & Dressing (75)<br>Wine (100)<br>3 clementines (105)<br><br>Total 730     | Bana & Alm butr (100)<br>Blueber & honey (150)<br>Yogurt & ovaltine (200)                 | 2190  |

|              |                                                                                               |                                                                                                                           |                                                                                                          |                                                                              |      |
|--------------|-----------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|------|
| <b>Tues</b>  | Eng Muffin (100)<br>Pnut butter (100)<br>Banana (100)<br>Almond butter (100)<br><br>Total 400 | Broad beans (200)<br>Steamed veg (150)<br>Dressing (75)<br>2 sm oranges (180)<br><br>Total 605                            | Cod & panko (450)<br>Salad & beans (200)<br>Dressing (75)<br>1 slice bread (100)<br><br>Total 825        | Blueberries & Activia (220)<br>Orange (100)<br>Apple (100)<br><br>Total 420  | 2250 |
| <b>Wed</b>   | Eng Muffin (100)<br>Pnut butter (100)<br>Banana (100)<br>Almond butter (100)<br><br>Total 400 | Impossible burger (270)<br>2 x Bread (200)<br>L & T, mustard, pickle (30)<br>Apple (100)<br><br>Total 600                 | Oatmeal (170)<br>Cashews (320)<br>2 cups frozen fruit (140)<br>Honey (70)<br><br>Total 700               | Baked apple & cinn (200)<br>Yogurt & Ovaltine (200)<br>Total 400             | 2100 |
| <b>Thurs</b> | Eng Muffin (100)<br>Pnut butter (100)<br>Banana (100)<br>Almond butter (100)<br><br>Total 400 | Tuna (90), mayo (50)<br>2 x Bread (200)<br>Pickles, L & T (40)<br>Skim milk & banana (200)<br>Ovaltine (40)<br>Total 640  | Swordfish (400)<br>Broccoli (200)<br>Green beans (100)<br>Dressing (75)<br>Blueberries (85)<br>Total 860 | Apple (100)<br>Orange (100)<br>2 x Clem (70)<br><br>Total 270                | 2170 |
| <b>Fri</b>   | Oatmeal (170)<br>2 jumbo eggs (180)<br>Ketchup (20)<br>Tomato (30)<br><br>Total 400           | Broccoli (100)<br>Green means (50)<br>Swordfish (200)<br>Dressing (50)<br>Pear & orange (200)<br>Total 600                | Baked feta (300)<br>Tomatoes, onions (50)<br>Broccoli (100)<br>Potato (200)<br>Wine (100)<br>Total 750   | Blueberries & honey (180)<br>Yogurt & Oval (200)<br>Clem (100)<br>Total 480  | 2230 |
| <b>Sat</b>   | Oatmeal (170)<br>Swiss cheese (100)<br>1 egg (90)<br>Ketchup (20)<br><br>Total 380            | Tuna (90), mayo (50)<br>Eng muffin (100)<br>Pickles, L & T (40)<br>Skim milk & banana (200)<br>Ovaltine (40), Apple (100) | Beans (200)<br>Rice (200)<br>1/3 cup cashews (250)<br>Salad and dressing (150)<br>Blueberries (100)      | Baked apple & cinn (200)<br>Yogurt & Oval (100)<br>Orange (100)<br>Total 400 | 2260 |

|  |  |           |           |  |  |
|--|--|-----------|-----------|--|--|
|  |  | Total 580 | Total 900 |  |  |
|--|--|-----------|-----------|--|--|

**Exercise** Use this form to track your daily exercise, total mileage or steps. If you track exercise minutes, focus on brisk walking minutes, the time your heart beats more quickly than normal so you can just barely keep a conversation going.

Exercise minutes per day, mileage or steps

|      | Sun | Mon | Tues | Wed | Thurs | Fri | Sat | Total |
|------|-----|-----|------|-----|-------|-----|-----|-------|
| date |     |     |      |     |       |     |     |       |
| date |     |     |      |     |       |     |     |       |
| date |     |     |      |     |       |     |     |       |

### Results and Lessons

This program worked for me. It may also work for you. No promises but I hope so.

If you decide to try, give it an honest effort. Stick with it for at least 6 months, long enough to develop new food habits.

You'll likely be pleased with the results.

Below, a sample of my own experience over 3 months, enough to make the point.

### Weekly Food Consumption, Exercise and Weight Change 4<sup>th</sup> quarter, 2020

| Week Ending Date | Average Calories Consumed per Day | Total Minutes Walked per Week | Sunday Morning Weight | Weight change, pounds, rounded |
|------------------|-----------------------------------|-------------------------------|-----------------------|--------------------------------|
| Oct 4            | 2120                              | 465                           | 207                   |                                |
| Oct 11           | 2020                              | 535                           | 206                   | -1                             |
| Oct 18           | 2230                              | 465                           | 204                   | -2                             |
| Oct 25           | 2110                              | 550                           | 203                   | -1                             |
| Nov 1            | 2300                              | 360                           | 202                   | -1                             |
| Nov 8            | 2019                              | 475                           | 201                   | -1                             |

|                           |                        |     |     |                         |
|---------------------------|------------------------|-----|-----|-------------------------|
| Nov 15                    | 2087                   | 455 | 200 | -1                      |
| Nov 22                    | 2657<br>(Thanksgiving) | 580 | 198 | -2                      |
| Nov 29                    | 2069                   | 540 | 199 | +1                      |
| Dec 6                     | 2157                   | 320 | 196 | -3                      |
| Dec 13                    | 2452                   | 485 | 195 | -1                      |
| Dec 20                    | 1999                   | 340 | 197 | +2                      |
| Dec 27                    | 2400                   | 410 | 196 | -1                      |
| Jan 3, 2021               | 2332                   | 600 | 195 | -1                      |
| Averages over<br>14 weeks | 2210                   | 470 |     | <b>-.9 lb. per week</b> |

## Plan Design Issues

Let's start with an analogy.

Clayton Christensen, a professor at Harvard Business School best known for studying business innovation - and particularly disruptive innovation - wrote an insightful article about the US educational system in the May 11, 2014 Boston Globe.<sup>145</sup> As you read some highlights from that article, consider the analogy to our healthcare system.

- *Tuition costs have been ballooning faster than general inflation...and what do we get in return?*
- *Nearly half of all bachelor's degree holders do not find employment or are underemployed upon graduation. At the same time, employers have not been satisfied with degree candidates.*
- *Two recent Gallup polls showed that although 96% of chief academic officers believe they're doing a good job of preparing students for employment, only 11 percent of business leaders agree that graduates have the requisite skills for success in the workforce.*
- *And this is all occurring while higher education leaders were convinced that they were innovating all along.*

Now let's substitute 'healthcare' for 'education' and rewrite:

- *Premiums have been ballooning faster than general inflation...and what do we get in return?*
- *Lower life expectancies, higher infant mortality and poorer access than other countries.*
- *At the same time, employers have not been satisfied with broker services.*
- *A recent poll showed that although most brokers believe they're doing a good job of developing benefit strategies and communications, only about half of business leaders agree that brokers do a good job implementing and executing desired programs.*
- *And this is all occurring while brokers are convinced that they were innovating all along.*

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<sup>145</sup> Clayton Christensen et al, Thank You MOOCS, Boston Globe, May 11, 2014



The poll in question was Zywave's 2013 study of customer satisfaction with broker services that received 5500 responses. Some highlights: <sup>146</sup>

- Creates strategic plan that aligns with company goals: **43% unsatisfied**
- Offers employee benefits and consumerism communication / education: **41% unsatisfied**
- Assists with creating or maintaining a workplace wellness program: **66% unsatisfied**

Part of the problem comes from our employer based health insurance distribution system. We are the only major advanced, industrialized country that uses employer based health insurance as the primary mechanism of financing healthcare. Other countries use employer based coverage – if they allow it at all – to supplement the national health insurance system.

We, in the US, use public programs like Medicaid and Medicare to supplement employer based coverage, exactly the reverse of everyone else. If you can get health coverage through your employer, you (generally) cannot get public coverage. How does employer based primacy impact our overall healthcare system?

Princeton economic professor Uwe Reinhardt answered that question in his New York Times piece 'The Culprit Behind High US Health Costs' in 2013. <sup>147</sup> Here are some direct quotes:

- *Most health-policy analysts I know regret that employers appointed themselves their employees' agents in the markets for health insurance and health care*
- *[Employers are] the sloppiest purchasers of health care anywhere in the world. For more than half a century, employers have passively paid just about every health care bill that has been put before them, with few questions asked.*
- *One reason for the employers' passivity in paying health care bills may be that they know, or should know, that the fringe benefits they purchase for their employees ultimately come out of the employees' total pay package.*
- *In a sense, employers behave like pickpockets who take from their employees' wallets and with the money lifted purchase goodies for their employees*
- *[Carriers] are merely the conduits for the employers' wishes.*

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<sup>146</sup> This study was summarized at the Massachusetts Association of Health Underwriters annual 'Benefest' in a presentation by Sarah Lucas of Marshberry entitled 'Trends and Best Practices in Employee Benefits Agencies'.

<sup>147</sup> Uwe Reinhardt, The Culprit Behind High US Health Costs, NY Times, June 7, 2013

- *When agents perform poorly, one should look first for the root cause at the principals' instructions.*
- *a decade of health care cost growth under employment-based health insurance has wiped out the real income gains for an average family with employment-based health insurance.*

Reinhardt then provided his data. In 2013, for an average family of 4, employer based health insurance cost \$22,000, up \$10,000 since 2003, compared to median family income of \$55,000. He then suggests

- *One must wonder how any employer as agent for employees can take pride in that outcome*

I would extend that query to brokers, echoing the Christensen and Zywave points above.

Over time we developed more and more 'fill in' programs to cover people excluded from the employer based system – old people, unemployed people, veterans, children and others. Combining and coordinating these various programs leads to confusion, inefficiencies and costs.

One confusing consequence of employer based primacy and myriad fill in / supplementary programs, for example, is that our system treats people differently based on non-health factors, like who they are or where they work. Unlike other advanced countries, we have different systems and rules for

- Full time employed people
- Part time or low income people
- Very poor people, provided they are also either **i** children, **ii** blind or disabled, **iii** elderly, **iv** mentally ill, **v** pregnant women or **vi** mothers (if they don't fit into one of these six categories, they are treated like 'part time or low income people'. Understand?)
- People over 65 years old
- Young people who don't otherwise qualify for health insurance
- Military veterans provided their medical problems are 'combat related' and
- People with kidney disease, among others.

As you move from group to group – in other words, as your economic conditions change (generally) - you face different medical access rules, different financing rules and tons of paperwork. This does nothing to improve health and adds no efficiencies to our system.

We, in other words, base our healthcare financing and access systems on non-health related categories of people. Since the groupings are arbitrary, much more a function of interest group lobbying than healthcare distribution efficiency, compliance becomes extraordinarily difficult: compliance experts can't apply logic or reason to regulations. Instead, they must memorize or continuously consult the regs. This makes absolutely no medical or economic sense except, perhaps, to the favored business interest groups.

It only adds overhead, inefficiencies and costs to the system.

### **Complexity and confusion add costs more in the US than in other countries**

Consider the relative inflation rates in the US and some other advanced countries. Inflation, of course, is driven by many factors, only one of which is systemic complexity. But it's difficult to design rational, cost-cutting, efficiency-promoting reform on top of an inefficient, irrational structure.

I use 2003 as my comparison basis because that was the year we introduced tax advantaged deductibles, designed to reduce unnecessary utilization and costs. Policy makers in the W. Bush administration figured that if patients pay with their own money they'll be more frugal and less wasteful. That was a big change from the traditional first-dollar-coverage in managed care that many saw as promoting unnecessary care.

|                | 2003 healthcare spending |                         |
|----------------|--------------------------|-------------------------|
| US             | \$3788 per capita        |                         |
| Canada         | \$2054 per capita        | US spends 1.84x as much |
| United Kingdom | \$1344 per capita        | US spends 2.82x as much |
| France         | \$2093 per capita        | US spends 1.81x as much |
| Germany        | \$2943 per capita        | US spends 1.29x as much |

|                | 2011 healthcare spending |                         |
|----------------|--------------------------|-------------------------|
| US             | \$8508 per capita        |                         |
| Canada         | \$4522 per capita        | US spends 1.88x as much |
| United Kingdom | \$3405 per capita        | US spends 2.50x as much |
| France         | \$4118 per capita        | US spends 2.07x as much |
| Germany        | \$4495 per capita        | US spends 1.89x as much |

From passage of the Medicare Modernization Act in 2003 at least under passage of the Affordable Care Act in 2010, our relative healthcare spending position has worsened vis-à-vis other countries. We not only spend *more* than these countries but, on average over time, we spend *more more*.

An underlying problem, at least from the broker or ‘benefits advisor’ perspective is that the enormous complexity of our healthcare system leads brokers to become expert at compliance, not at healthcare or healthcare systemic efficiency. In fact, ‘health’ insurance brokers today need understand nothing about ‘health’, only about compliance, to have successful, financially lucrative careers.

But compliance, as I suggested above in the discussion of Christensen and Reinhardt, does nothing to control costs or improve systemic value. Benefits advisors who *only* advise about compliance provide far less value to their clients than they could.

This was made poignantly clear to me one day in a lecture. I asked an experienced broker why she attended, as her agency normally didn’t contract with me. Her response:

*I sell CDH plans, understand HSAs, HRAs, deductibles, FSAs, networks and all the rest.*

*But I recently switched employer, and I now have a high deductible plan...*

*And I don’t know how to use it!*

### **Consumer engagement to the rescue ... or not**

My somewhat depressing response to her comment: if the pros don’t know how to navigate our healthcare system for themselves – don’t know which services to use, which are wasteful and harmful – how much can they help their clients? Too often, their compliance advice only helps their clients access unnecessary, inappropriate or wasteful services, with up to some 40 or 50% of all healthcare spending going to services that do nothing to promote health.<sup>148</sup> The compliance focus only promotes easier access to care, much of which is unnecessary.

Brokers, and far too often also their clients, lack the tools to differentiate necessary from unnecessary interventions. That’s the real impact of the broker comments quoted above.

Indeed, today’s ‘consumer engagement’ emphasis falls into the same quagmire as the rest of our system. ‘Consumer engagement’ to health insurance brokers means knowing deductibles, plan design details, tax implications and the like. Knowing these things does not decrease costs, waste, unnecessary care or improve patient outcomes.

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<sup>148</sup> Several scholars at Dartmouth Medical School, notably Elliott Fisher and John Wennberg, have written extensively about this. Shannon Brownlee’s excellent *Overtreated* provides plenty of detail. I’ll belabor this point myself later in this book. The ‘up to 50%’ estimate is mine, not theirs.

But better outcomes are (almost) always cheaper than poorer outcomes!

Healthier people cost our healthcare system less, and the more efficiently our system turns people from unhealthy to healthy, the less we spend on them. Poorer outcomes – infections, returns to operating tables, ineffective medications, high false positive test rates etc – always cost more. (Yes, I know that MRI costs vary significantly. But no one wants the cheapest unnecessary MRI.)

That's why the medical community, as opposed to the brokerage community, defines consumer engagement as knowing **how well** medical care works, not how to access it financially or where to get the cheapest. The well informed consumer, to the medical community, knows about the 'health' part of health insurance.

Note the discrepancy between the insurance and medical definitions. The insurance definition does nothing to improve outcomes or reduce waste and thus can't have much cost control impact.

But the medical definition directly attacks waste and improves outcomes so **can** significantly reduce costs. In fact scholars like Dr. Michael Barry of the Informed Medical Decisions Foundation and Dr. Albert Mulley of Dartmouth Medical School, suggest that well informed (medical definition) patients cost roughly 20% less than poorly informed patients. Much more on this coming up.

Unfortunately, our medical consumer engagement process falls trap to yet *another* definitional problem. Here's Dr. Suzanne Koven, summarizing it in the Boston Globe: <sup>149</sup>

- I appreciate patients informing and advocating for themselves
- I don't appreciate patients arguing with me about anatomy and physiology

In the 10 or so minutes patients typically spend with doctors, they can either question their doctor's competence ('arguing about anatomy and physiology') or discuss treatment options. They probably don't have time to do both.

And they'll probably lose the anatomy and physiology argument. Doctors know much more about medical care and technology than the typical patient ever will. Four years of medical school really do provide a solid technical foundation. Your doctor can out-fact you many times over. (Yes, your doctor may have misdiagnosed your problem. But that's best remedied by a second opinion, not an argument about physiology.)

You, however, know much more about your own treatment preferences than your doctor does. That's the real goal of consumer engagement: aligning treatment processes with patient preferences. That process – having doctors and patients explore treatment

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<sup>149</sup> Suzanne Koven MD, Is physician burnout really a problem? Boston Globe, May 26, 2014

options to choose the best for each patient – can have a huge impact on utilization and costs.<sup>150</sup>

We have not, in this country, developed a standard definition of ‘consumer engagement’ or ‘well informed patient’ because, I suggest, of the ‘mess’<sup>151</sup> that our system has become, largely due to the irrational employer based financing model upon which it rests. Compliance issues have become so overwhelming that brokers, and often their clients, simply don’t have the time or energy to discuss more impactful issues.

As brokers struggle with compliance and plan designs, physicians with appropriate consumer information and advocacy, and the internet explodes with medical factoids and information, consumers get overwhelmed. Who gives them direction for their own research? What do they need to know? Which information is correct? Which is valid and appropriate?

### **Six faulty assumptions**

Too often patients make assumptions and medical decisions that are, simply, wrong. I’ll give some examples. How many of these resonate with you?

#### **Faulty assumption #1: Good medical care leads to good health**

Many people believe that good medical care leads to good health. As one thoughtful and articulate broker once said to me over an informal lunch, describing his young family, ‘I have great healthcare for my kids. They’re doing really well.’

Nonsense, I responded. ‘Your kids are doing well because they’re intellectually and emotionally within the normal range, have a mother and father who love them, live in a safe neighborhood, get plenty of good food and fresh air, have friends, and are warm in the winter and cool in the summer. The quality of their physicians and hospitals has virtually nothing to do with their health.’

Indeed, overwhelming evidence shows that good health comes from, in no particular order, good nutrition, exercise, emotional security, environment, public safety, socio-economic status *and* medical care, but that medical care is a relatively small component of good health.

How small a component? About 10%, according to the Massachusetts Health Policy Commission’s 2013 cost trends report. Here are direct quotes from page 22:

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<sup>150</sup> We’ll discuss preference sensitive decision making in detail later in this book

<sup>151</sup> “Mess’ comes from the title of Dr. Julius Richmond and Rashi Fein’s 2005 book ‘The Healthcare Mess’. Both authors were professors at Harvard Medical School.

- Massachusetts residents have better overall health than the United States average, with an additional 1.6 years of life expectancy and 0.9 fewer physically or mentally unhealthy days per month.

*but*

- Research shows that such outcomes are driven largely by social and behavioral factors, along with public health policies, while health care services delivered account for only 10 percent of general variation in health status.

Richmond and Fein, the two highly respected Harvard Medical School professors, echoed this in their 2005 book *The Healthcare Mess*:<sup>152</sup>

Health gains since World War II were largely the consequence of progress in applying our knowledge of health promotion and disease prevention rather than improved clinical care.

Dr. William Frist, cardiologist and former US Senate Majority Leader, estimates medical care's impact slightly higher than the Massachusetts Health Policy folks, at 15 – 20%, saying

Health is not health services. Health is behavior, it's genetics, it's socio-economic status, it's disparity, it's environment. Health services has about a 15 – 20% impact.<sup>153</sup>

We all know this but we forget it when we, ourselves, get sick or frightened. One reason, I submit, is that we have not been taught how best to use our medical care system. (Now *that's* an interesting value added role for brokers. Don't worry – I'll go into it in detail later.)

Here are some numbers to bolster my argument that 'more medical care isn't better for you'. Compare average medical spending per capita in various states with average longevity in those states. The assumption, of course: if more medical spending had a big impact, people who live in high spending states would live longer than people in low spending. That is not nearly the case.<sup>154</sup>

| State         | \$/capita 2009 | Longevity at birth 2013 |
|---------------|----------------|-------------------------|
| Massachusetts | \$9,278        | 80.5                    |
| Minnesota     | \$7,409        | 80.9                    |

<sup>152</sup> Richmond and Fein, *The Health Care Mess*, pages 92 and 94

<sup>153</sup> CNBC Meeting of the Minds: The Future of Healthcare, broadcast in July 2009.

<sup>154</sup> Spending data from Kaiser Family Foundation. Longevity data from Measure of Americans. I used longevity data 4 years in the future to account for any potential health benefits of high 2009 spending.

|                  |         |      |
|------------------|---------|------|
| Washington state | \$6,782 | 79.9 |
| Utah             | \$5,031 | 80.2 |
| Mississippi      | \$6,571 | 75.0 |
| Oklahoma         | \$6,532 | 75.9 |
| West Virginia    | \$7,667 | 75.4 |

Good medical care doesn't necessarily lead to good health. Lots of other things are far more important.

By the way, based on the state data presented above, should a broker provide the same benefits advice in Minnesota and West Virginia? Or Massachusetts and Utah?

### **Faulty assumption #2: Lower deductibles and wider networks = better health insurance**

Brokers and consumers too often equate better health insurance policies with lower deductibles and wider provider networks. Poorer policies have the opposite.

Unfortunately, there's no evidence - none that I've seen, at least, and I've looked - that lower deductibles or wider networks lead to better patient outcomes.

One reason for the faulty equation of wider networks with better policies: we have very poor outcome data by provider in this country. Lacking such data, consumers apparently prefer easier access to lots of (potentially mediocre) physicians and hospitals, figuring that one of them should be good in a crisis I guess.

Though we lack evidence that lower deductibles and wider networks lead to better patient outcomes, we have some evidence that lower deductibles and generous benefits can lead to patient harm. Here's Bernard Rosof, Chairman of Huntington Hospital in New York:

Often people with generous insurance plans can run up large bills and face life threatening complications from unnecessary care. <sup>155</sup>

We also have extensive evidence that *better decision making* leads to better outcomes.

### **Faulty assumption #3: Newer technologies and medications are better**

This is almost a mantra in this country: newer technologies / newer meds / robotic surgeons etc are better, so, when in doubt, get the newest.

This overlooks the fact that 'newer' is a very poor proxy for 'better'. Extensive evidence shows that *outcome based decision making*, not the newest shinny object, leads to better outcomes.

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<sup>155</sup> More care is not necessarily better care, Connolly, Washington Post, 9/29/09



Consider Pradaxa, a newer blood thinner than warfarin, heavily advertised on TV and designed to overcome warfarin patient's need for excessive testing. Pradaxa's annual sales hover around \$800 million. Its TV ads claim

*In a clinical trial, Pradaxa was proven superior to warfarin at reducing the risk of stroke in patients with Afib not caused by a heart valve problem*

suggesting to the poorly informed, who don't know the right questions to ask or how to make outcome based decisions, that the newer drug was better. However...

In their legal settlement announced in May of 2014, Pradaxa paid **\$650 million** to settle **4,000 claims** that company didn't adequately warn of risks including severe or fatal bleeding. (If death is a side effect, what's the main effect?) Unlike warfarin, there is no known reversal agent or antidote for Pradaxa.

Or consider robotic surgeries for hysterectomy patients. The da Vinci robot, approved by the FDA in 2005, is designed to generate better results and an easier recovery than traditional laparoscopic surgery, meaning less pain and fewer complications <sup>156</sup> all of which sounds great to the uninformed.

But a massive study of 264,000 women who had either laparoscopic or robotically assisted hysterectomies at 441 hospitals between 2007 and 2010 showed no benefits from robotic surgery when benefits are measured as complication rates or blood transfusion rates. The robotic procedures, however, cost about \$2000 more. That's roughly 1/3 more.

Again an interest group, the robot manufacturers, benefited by making more money, while patients did not, at least in terms of enjoying better outcomes. Just higher costs.

The morale of these stories, and there are many more: *newer* isn't necessarily better in medicine. *More heavily advertised* isn't necessarily better. Instead *better* is better, based on outcomes from comparative studies. Well informed patients learn the right questions to ask and types of information to consider when evaluating their treatment options.

#### **Faulty assumption #4: Publishing price lists will save money**

Today, almost as an article of faith, brokers, carriers and healthcare consumers claim that knowing prices will save money. This is commonly called 'transparency' and the theory runs rampant among health insurance thinkers.

While I agree that a wise consumer should compare prices of similar quality products, then choose the least expensive to get the best value, I *don't agree* that simply publishing price lists will lead to any benefit, either systemic or individual. Remember:

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<sup>156</sup> Rabin, Questions about Robotic Hysterectomy, New York Times, Feb 25, 2013

- You don't want the cheapest *unnecessary* care
- You also don't want the cheapest *poor quality* care
- You don't want cheap *inappropriate* care when slightly more expensive care might be preferable.

Let's consider tonsillectomies in northern New England. Here are tonsillectomy rates per 1000 children in various pediatric service areas during the period 2007 – 2010.<sup>157</sup>

|                     |      |                   |     |
|---------------------|------|-------------------|-----|
| Middlebury, Vt      | 5.6  | Burlington, Vt    | 2.9 |
| Berlin, NH          | 10.4 | Lewiston, Maine   | 5.2 |
| York, Maine         | 7.3  | Portland, Maine   | 4.0 |
| Presque Isle, Maine | 5.8  | Bangor, Maine     | 2.7 |
| Dover, NH           | 8.1  | Waterville, Maine | 3.6 |
| Manchester, NH      | 8.1  | Ellsworth, Maine  | 3.8 |
| Exeter, NH          | 8.4  |                   |     |

We know from these data that having about 3 tonsillectomies per 1000 children is appropriate, since there are no reports of kids in Burlington Vermont, Bangor Maine, Waterville Maine or Ellsworth Maine suffering poor health due to an insufficient number of tonsillectomies.

We also know that about 2/3 of tonsillectomies in Berlin New Hampshire, and half the tonsillectomies in York Maine are unnecessary since their tonsillectomy rates are so high.

Shopping for the least expensive tonsillectomy in Berlin or York leads to a bad medical care decision over half the time: people doing that get the cheapest unnecessary care. Imagine that your child has a bad reaction or needs a surgical re-do from an unnecessary tonsillectomy!

A far better approach is to learn the service quality and necessity first, and then, for two equally necessary services of similar quality, choose the least expensive. Don't put the cart before the proverbial horse.

Perhaps a better way to understand transparency is to consider the many types necessary to enhance good medical decisions. A wise patient would want access to transparency data addressing:

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<sup>157</sup> These data come from the Dartmouth Atlas of Healthcare, Tonsillectomies per 1000 Children by Pediatric Surgery Area, 2007 – 2010. 'Pediatric service areas' are the geographical regions served by a specific pediatrician office. Kids in Burlington Vermont, for example, typically use Burlington pediatricians, not Berlin New Hampshire docs.

- Prices
- Treatment intensity as, for example, our tonsillectomy example above, or C-section rates by hospital, mastectomy rates by region or similar
- Clinical quality/ infection rates by provider and by treatment
- Treatment benefits
- Provider conflicts of interest

Providing only 1 may distort the message and lead patients away from making wise decisions rather than toward systemic efficiencies.

Another way to express this: homeowners who hire the cheapest plumber, framer, roofer, electrician and painter end up with the most expensive house that leaks. We tend to forget this when we consider healthcare prices.

#### **Faulty assumption #5: Getting the least expensive care saves money**

This variation on ‘publishing price lists will save money’ ignores a key factor in physician compensation: that doctors want to maintain their incomes and that time is their main inventory. When they receive less money per patient, they respond by seeing more patients.

This has negative, foreseeable but generally unforeseen consequences.

Dr. Sandeep Jauhar MD, PhD, and director of the heart failure program at Long Island Jewish Hospital, claims that ‘there is no more wasteful entity in medicine than a rushed doctor’. <sup>158</sup> Because we’re so rushed, he says, ‘we order tests, prescribe drugs, hospitalize patients and — one of the costliest decisions a doctor can make today — call specialists for help’ rather than explain to patients why some tests are unnecessary and specialist referrals inappropriate. ‘Specialists in turn,’ he says, ‘order more tests, scans and the like.’

Cutting payments to physicians becomes a self defeating strategy.

#### **Faulty assumption #6: Raising deductibles saves money**

Deductibles, generally running about \$1000 per year, are designed to act as a speed bump when patients consider medical care. Patients will spend their own money more wisely and frugally than they would spend the insurance carrier’s money, according to the theory, thus avoiding unnecessary care and saving money.

Deductibles, unfortunately, act as a blunt instrument, perhaps doing more harm than good by failing to differentiate necessary from unnecessary medical care. Reducing

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<sup>158</sup> Sandeep Jauhar, Busy Doctors, Wasteful Spending, New York Times, July 20, 2014

*unnecessary* care can, indeed, save money. But reducing *necessary* care can lead to poorer outcomes and higher costs.

Consider, by contrast, the French approach to deductibles. The French modify or exempt from cost sharing by **person** (disabled, elderly or sick), **treatment** (expensive, effective or necessary) and **medical condition**. The deductible is waived for people suffering from one of 30 'long and costly diseases' like cancer, severe chronic disease or long term psychiatric illness *for medical care is related to that condition*. But these people are still responsible for unrelated medical deductibles, say a broken leg or sprained ankle.

Our 'one size fits all' deductibles, by not differentiating among people, treatments or medical conditions sometimes actually add to costs rather than reducing them. One Medicare study showed that adding a modest copayment reduced the number of outpatient visits by about 20% per year.

But that came at the cost of 2 additional hospitalizations per 100 patients per year. The study conclusion, published in the New England Journal of Medicine:

uniform increases in cost sharing for prescription drugs can have deleterious effects on health <sup>159</sup>

without reducing costs at all.

These faulty assumptions – and the system developed from them – lead to these types of conclusions by eminent scholars:

- American health outcomes among insured populations lag substantially behind those of other countries. <sup>160</sup>
- Americans at top income levels live longer than people at bottom income levels, *but less long than people at top income levels of other countries* <sup>161</sup> and
- Even the people most likely to be healthy, like college-educated Americans and those with high incomes, fare worse on many health indicators ... <sup>162</sup>

Despite us paying more for medical care than any other country in the world!

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<sup>159</sup> Trivedi 'Increased Ambulatory Care Copayments and Hospitalizations Among the Elderly, NEJM Jan 28, 2010

<sup>160</sup> Bradley and Taylor, The American Healthcare Paradox, page 9

<sup>161</sup> Gudrais 'Unequal America' Harvard Magazine July 2008 referring to research by Harvard Prof Majid Ezzati

<sup>162</sup> For Americans Under 50, Stark Findings on Health, Tavernise, NY Times, Jan 9, 2013

## The Fundamental Problem: Old School Thinking

Our systemic confusion and complexity has led to remarkable levels of specialization, not only in medical care but even in the brokerage community. Some brokers focus on Medicare, others on large group benefits, others on small group, some operate only in 1 state, others in many. Some agencies have wellness specialists, tax specialists and CDH specialists, others contract these functions out.

But few advise their clients about medical care issues, leaving that arena to physicians, often harried, often leading time compressed lives.

Our healthcare distribution system looks like is:



Two equally important but completely unrelated boxes. In the Old School, brokers provide financing programs while physicians provide medical care, but never the twain shall meet.

Brokers typically explain that they can't give medical advice because they're not trained or licensed to do this, which is, of course, true. **But I think they've conceptualized the problem incorrectly, relying more on superficial thinking than serious analysis.** Read on...

In the Old School 'nonintegrated' model, we expect physicians to address the following issues during an average 15 minute meeting with each patient:

- Patient's personal health status
- Disease diagnosis
- Treatment recommendations and alternatives
- Lifestyle issues and impacts on health
- Medication options, benefits and risks of each
- Individual risk factors and likelihood of future medical events
- Specific tests including benefits and risks of each
- Trends in medical care and new information since the patient's last visit
- Risks of having / not having specific tests or treatments
- Referral options *and more*

It's obviously very difficult to address all these issues satisfactorily in 2 hours, let alone 15 minutes.

## Five concerns about leaving all medical education to doctors

### **First, doctors respond to uninformed patient demand.**

Studies show that about 1/3 of physicians would order a clinically unwarranted MRI if the patient demanded it, which raises patient risks without benefits since the MRIs in question are ‘clinically unwarranted’. <sup>163</sup>

Many patients assume, as discussed above, that more medical care is better medical care, so a physician who doesn’t prescribe a medication, test or treatment is a poorer physician.

Increasingly, physicians are compensated based on patient satisfaction survey results. Patients who believe ‘more care is better care’ penalize doctors who withhold painkillers, fail to prescribe a requested drug or test or skimp on referrals. This decreases the physicians’ ability to counter the ‘more is better’ argument, even if they want to.

Studies show that, perhaps as a result of these factors, when faced with a potential screening test option, 95% of physicians recommended the screening test to their patients, and when faced with the option to prescribe medications, over 90% of physicians prescribed. <sup>164</sup>

**Second, doctors respond to our legal / tort system**, in which fear of malpractice lawsuits leads to excessive testing, Rx prescribing, excessive diagnoses and treatments. In one Gallup survey, physicians attributed 34 percent of overall healthcare costs to defensive medicine and 21 percent of their practice to be defensive in nature. Specifically, they estimated that 35 percent of diagnostic tests, 29 percent of lab tests, 19 percent of hospitalizations, 14 percent of prescriptions, and 8 percent of surgeries were performed to avoid lawsuits. <sup>165</sup>

**Third, doctors get burned out** so sometimes order tests, medications or treatments because it’s easier than not ordering. One doctor described his interaction with a patient this way:

*I could tell she wasn’t happy. I decided that discussing the evidence would have been futile and I was too tired anyway*

**Fourth, doctors pathologize** or medicalize normal human behavior. Consider the patient who tells his doc ‘I sometimes forget people’s names in social settings.’ Early stage dementia? (There’s a drug for that). Social anxiety (There’s a drug for that too.)

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<sup>163</sup> O’Reilly, Patient satisfaction: when a doctor’s judgment risks a poor rating, AMED News, November 26, 2012

<sup>164</sup> Data from presentation by Benjamin Moulton at Dartmouth’s 2014 Summer Institute for Informed Patient Choice

<sup>165</sup> Hettrich, The Costs of Defensive Medicine, AAOS Now, December, 2010. AAOS Now is the Journal of the American Association of Orthopedic Surgeons

Or a normal human reaction to noise and social stimulation? (There may even be a drug for that but it's probably not necessary.)

Or the patient who went to the beach last weekend and tells his doc 'I love watching the women parade around in their bikinis.' Diagnosis: hyper-sexual disorder.

But the next patient, who went to the same beach, reports that 'I completely ignored all the women parading around in their bikinis.' (Low-T and, of course, there's a pill for that)

Pathologizing, of course, ties closely to malpractice issues described above as well as the problem of uninformed demand.

**Fifth, physicians favor interventions.** This is sometimes called 'supply sensitive care' which simply means that if medical technologies or interventions are available, physicians will use them.

This is also sometimes called Roemer's Law after Professor Milton Roemer who first discovered the relationship between medical supply and utilization in the 1950s. Roemer found that as more hospital beds are built in a community, more hospital beds are used. His law: a hospital room built is a hospital room occupied because physicians, whether consciously or not, tend to use all the medical resources at hand.

Let's apply Roemer's Law to radiologic scanners. Consider the growth of scans since the mid 1990s as more and more machines became available.

Scans per 1000 people/year <sup>166</sup>

|      | MRI | CT |
|------|-----|----|
| 1996 | 52  | 17 |
| 2010 | 149 | 65 |

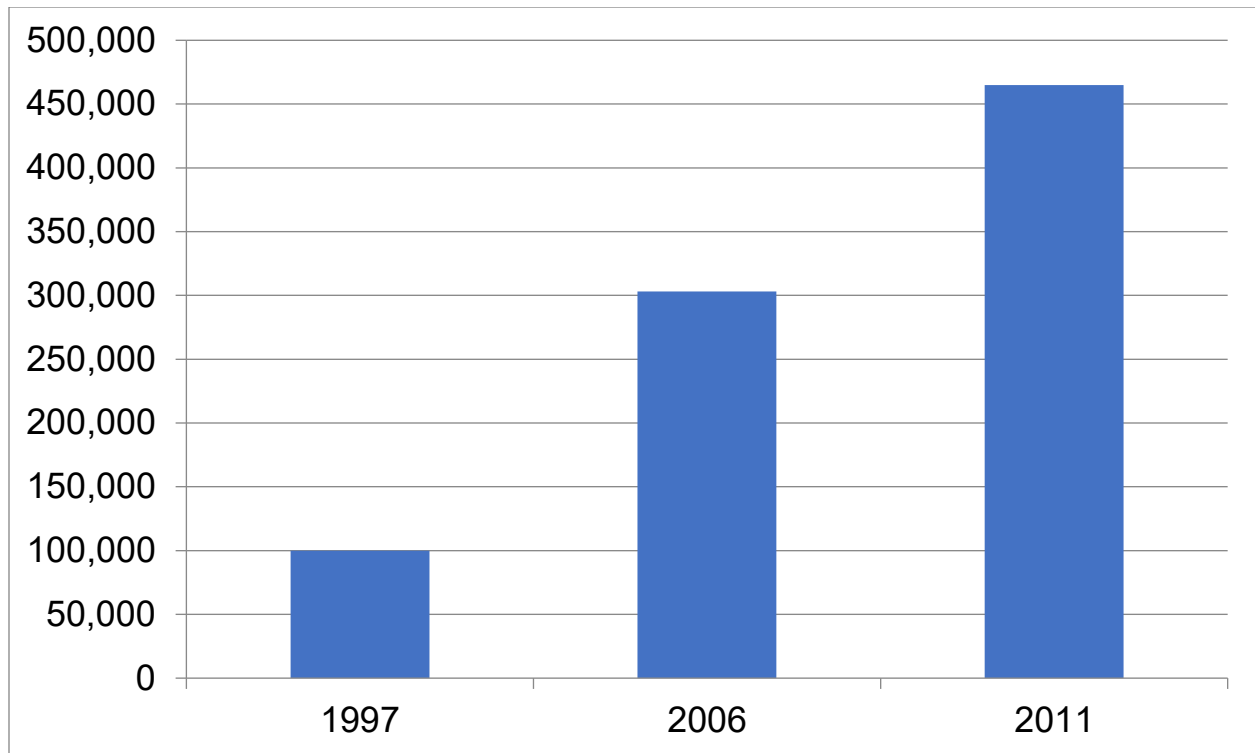
Note in passing the (non) impact of the internet on reducing medical care intensity. Google doesn't have much impact on reducing excessive or unnecessary care, despite most patients today claiming that they're 'well informed' since they do online research before engaging in medical care. Sorry, I don't buy it.

Now look at the impact of graduating more orthopedic specialists from medical schools:

### **Number of Spinal Fusion Surgeries performed annually in the US**

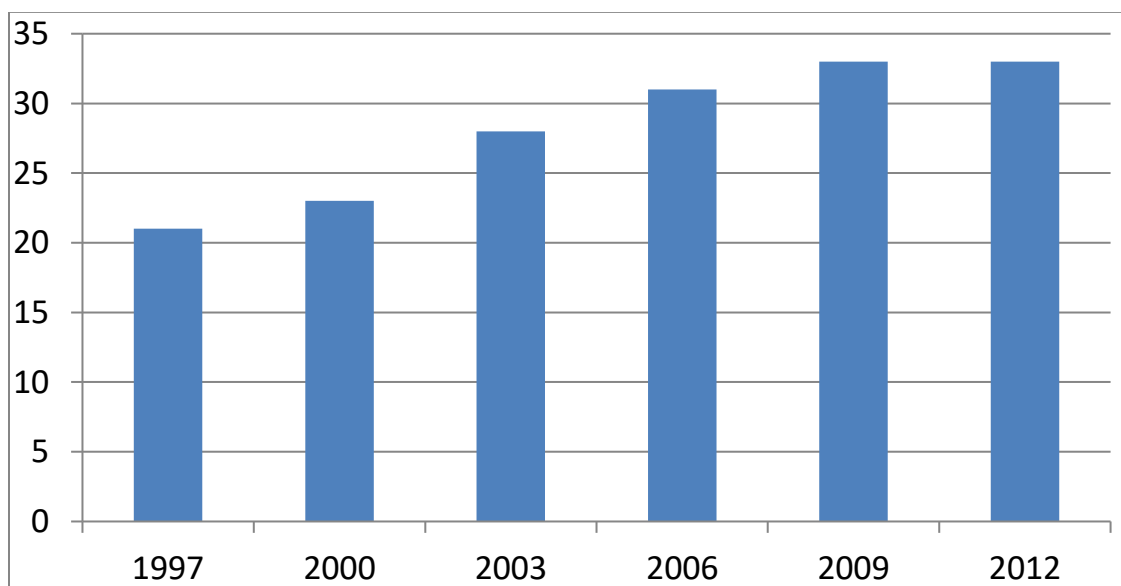
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<sup>166</sup> These data presented by Dr. Steven Woloshin at Dartmouth's Summer Institute for Informed Patient Choice, 2014



Since the mid-late 1990s, fetal oxygen sensors have become almost universally adopted in delivery rooms, despite the US Preventive Services Task Force not endorsing this technology in birthing. Fetal oxygen sensors identify stress on the fetus' heart and can lead to emergency C-sections. That's one of potentially many reasons for our increased rate of C-section deliveries since the mid-1990s.

**Rate of C-sections**  
as percentage of all US births





Many more examples exist. But to summarize: Doctors face different financial, corporate and emotional pressures and incentives from the patients they advise. Here are some of those differences:

| <u>Physician Issues and Concerns</u>                | <u>Patient Issues and Concerns</u>                      |
|-----------------------------------------------------|---------------------------------------------------------|
| Success                                             | Success                                                 |
| Fear of lawsuit                                     | Pain                                                    |
| Fear of feeling guilty                              | Recovery process                                        |
| Local / regional / hospital norms                   | Infection / readmission risk                            |
| Income and time constraints                         | Impact on family                                        |
| Personal preferences<br>(religion, experience, etc) | Personal preferences<br>(religion, personal image, etc) |

Asking ‘Doc, what would you do if you were me?’ tends to get answers from the Physician List, while patients worry about issues on the Patient List.

Doctors may also have different goals and risk tolerances from patients. Research suggests, for example, that 72% of oncologists advising early stage breast cancer patients rate ‘keeping your breast’ a top goal while only 7% of patients do.

Meanwhile, 0% of oncologists rate ‘avoid using prostheses’ highly while 33% of patients do.<sup>167</sup>

We have learned, over the past few decades, that leaving medical education entirely to physicians - even with a bit of online research - has led to healthcare inflation at approximately gdp + 3 to 5% with, unfortunately, poorer national statistics than other countries that spend less on medical care.

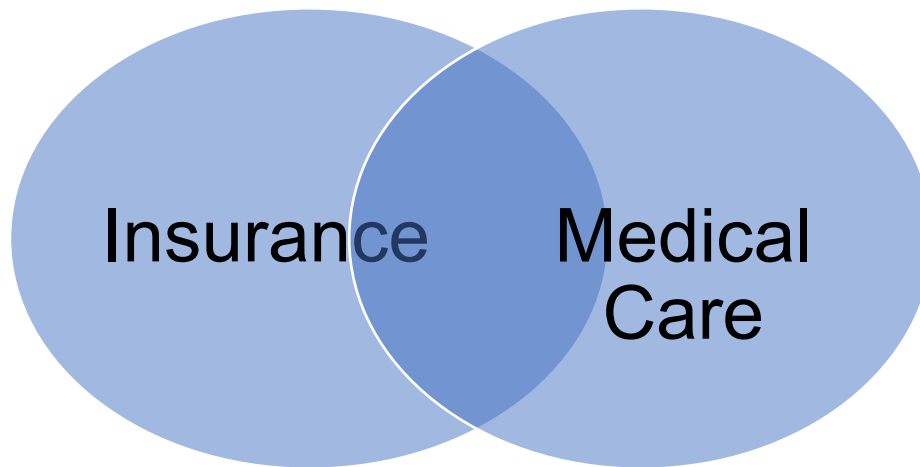
Splitting healthcare financing from healthcare delivery has been proven inefficient. It’s time to reconsider the Old School model.

### **New School: Integrating Finance and Care Delivery**

Rather than continue with the ineffective Old School model, let’s introduce a New School approach.

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<sup>167</sup> Data from presentation by Benjamin Moulton at Dartmouth’s 2014 Summer Institute for Informed Patient Choice



In the New School, financing and medical care overlap.

- Doctors understand networks, deductibles, plan designs and prices and *include them in treatment prescriptions*.
- Brokers understand medical terms, preference-sensitive decision making, outcome metrics, treatment intensity issues and *include them in plan designs*.

To do this, brokers need to understand and communicate 3 fundamental concepts to their subscribers:

- **Outcomes**, meaning how well does a medical intervention work. Brokers who help their clients focus on medical outcomes will help them avoid unnecessary medical care and choose higher quality care over lower.

The best way to determine outcomes is from studies comparing patients who had a specific medical intervention with patients who did not. Other attempts to quantify outcomes are less robust, provide less good information and can lead to suboptimal medical decisions.

We too often in this country, use proxies for outcomes. Proxies include 'famous hospital', 'well known surgeon', 'well advertised medication', or 'game changing therapy'. Proxies may or may not correlate closely to actual patient outcomes.

The important point for brokers to communicate to their clients: shop for medical care based on outcomes. They'll enjoy better outcomes that way.

- **Process**, meaning *how* providers implement a particular treatment.

Extensive evidence shows that some hospitals favor C-sections in situations that other hospitals do not, and that doctors in some regions routinely treat early stage breast cancer with mastectomies while doctors in others routinely prescribe other treatments. The Dartmouth Atlas of Healthcare has tracked these differences at hospital, regional and state levels for years.

One simple tool for brokers here: advise patients to ask their physician ‘am I in a high or low intensity region / hospital for this procedure?’ They can use that information when they obtain a second opinion.

- **Preference-sensitive**, meaning that two patients with similar diagnoses and prognoses may choose different treatments *and both be right*.

This is, perhaps, the single most important issue in American medicine. Scholars ranging from Harvard Business School’s Regina Herzlinger to Dartmouth’s John Wennberg suggest that patients enjoy the best outcomes, often at the lowest costs, when they make well informed decisions. ‘Well informed’ means knowing the likely treatment outcomes (both benefits and risks), their process options (mastectomy or lumpectomy for example) and the prices.

Laura Landro, writing in the Wall Street Journal, summarized the impact: <sup>168</sup>

*Studies show that when patients understand their choices and share in the decision making process with their doctors, they tend to choose less-invasive and less expensive treatments than they would otherwise have received.*

The broker’s educational role in this New School paradigm is to inform patients that they have choices and help them access key information to make wise choices; it is **not** to give specific medical advice.

### **My Proposed Decision Making Tree that integrates clinical and insurance information**

Brokers and benefits advisors can teach people to use this Decision Tree. It can organize your thinking and ensure that you address the key issues in making your medical decisions.

**First identify the most likely benefits and risks of a particular medical intervention and the chance of each.** Ask ‘do the likely benefits of this medical intervention outweigh both the treatment risks and doing nothing?’

If you answer ‘no, the likely benefits do not exceed the risks and are not better than doing nothing’ then stop.

But if you decide that the likely benefits exceed the risks, continue.

**Second identify your intervention options.** You almost always have them. You can have surgery or physical therapy for example, take a brand name medication or generic, have an injection or take a medication, change your diet or take a pill.

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<sup>168</sup> Laura Landro, Weighty Choices in Patient’s Hands, Wall Street Journal, August 4, 2009

Decide which process you prefer. Research shows that different processes often generate similar outcomes. There's often no objectively right or wrong process decision. Rather these are personal choices or preference-sensitive decisions.

**Third decide which provider generates the best outcomes using the treatment process you prefer.** Some orthopedic surgeons may generate better spinal fusion surgical outcomes than others; some physical therapists better knee pain reductions.

Provider outcomes often – though not always – correlate with experience. The more shoulder surgeries a surgeon performs, the better his/her shoulder surgery patients tend to do.

If you can't determine actual outcomes by physician, use volume or experience with patients like you as a responsible proxy. Though not perfect, it can lead you in a positive direction.

**Fourth, if two providers generate the same outcomes using the process you prefer, consider price.**

Be sure to consider price 4<sup>th</sup>, only after you've determined that an intervention is likely beneficial, that you're getting the process you prefer and that you've chosen the best provider available.

Follow this 4-step process and you'll likely end up with better outcomes, be more satisfied with your care and perhaps even save some money along the way.

America's research community is developing tools to help patients with these tasks.

### **The Affordable Care Act on Decision Aids and Shared Decision Making**

Section 3506 of the Affordable Care Act or Obamacare addresses Decision Aids and the Shared Decision Making process. The goal is to engage patients in *informed* decision making with healthcare providers.

**Decision Aids** are **tools** that present clinical evidence of risks and benefits of treatment options; they focus on likely outcomes. Decision Aids are not simply articles describing how a medical treatment works but without quantifying likely benefits and harms; that's an encyclopedia, not an Aid.

**Shared Decision Making**, on the other hand, is a **process** in which patients and their physicians decide together how to proceed. Unlike the old school paternalist model in which physicians *tell* patients which treatment to have, in the Shared Decision Making model physicians *help patients decide* which treatment option best suits their goals.

Shared Decision Making acknowledges that about 85% of medical decisions are 'preference sensitive', meaning the patient has more than 1 reasonable option and that two different patients suffering from the same medical condition can make different treatment decisions but both be right.

This may seem intuitively obvious to many. Unfortunately, research shows that physicians only discuss alternatives with patients about 14% of the time, and only about 9% of physicians inform patients that they have choices.<sup>169</sup> As a result, the impetus to inform patients that options exist most of the time may fall on the insurance community.

Decision Aids and Shared Decision Making also implicitly acknowledge a new vision of the physician's role. The ideal modern physician, suggests Dr. Atul Gawande of Harvard Medical School insightfully

should be neither paternalistic nor informative but rather interpretive, helping patients determine their priorities and achieve them.<sup>170</sup>

This means patients need to learn basic outcome and intensity information outside the doctor-patient framework and opens a new, and potentially role redefining opportunity for brokers and carriers.

### **A Decision Aid Example**

Decision Aids, currently under development at several medical schools and institutions, provide outcome data quantifying risks and benefits of medical interventions.

Consider the Number Needed to Treat. This tells how many people need to take a medication, have a test or have a treatment for 1 person to benefit from it.

The NNT acknowledges that medicine doesn't work perfectly, equally well on all people, all the time. But various interventions work - to paraphrase Abraham Lincoln - on some of the people, some of the time. The NNT tells how often, so how likely you are to benefit from a particular intervention.

The most comprehensive source of NNT information is a website entitled, not surprisingly, TheNNT.com.

Here's an example: 18 adults suffering from acute sinusitis need to take a course of antibiotics for 1 to benefit by having a faster resolution of symptoms.<sup>171</sup> The Number Needed to Treat for adults with sinusitis to benefit from antibiotics is 18.

Another example: 5 kids suffering from the croup need to take steroids for 1 to enjoy respiratory improvement. The NNT here is 5.

Some more NNT examples<sup>172</sup>

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<sup>169</sup> Benjamin Moulton, op. cit.

<sup>170</sup> Sheri Fink's review of Atul Gawande's *Being Mortal*, New York Times Book Review, November 6, 2014

<sup>171</sup> <http://www.thennt.com/nnt/antibiotics-for-clinically-diagnosed-acute-sinusitis/>

<sup>172</sup> This chart appeared in *BusinessWeek*, January 2008.

## THE NUMBER NEEDED TO TREAT

How well do drugs work? Ads and news stories usually say that a medicine slashes the risk of, say, heart attacks by a big number, like 50%. But that often overstates the benefit, because it fails to provide the absolute risk. If only 2 people in a group of 100 are expected to have a heart attack, then a drug that cuts the rate by 50% prevents just 1 heart attack when taken by all 100 people. That's why researchers favor using the "number needed to treat" (NNT). It shows how many people must take a drug for one person to benefit.

| DRUG                                                                                                                                                       | NNT                                                               | DETAILS                                                                                                                                 |
|------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|
| <b>Antibiotic cocktail</b> to eradicate ulcer-causing stomach bacteria ( <i>H. pylori</i> )                                                                | <b>1.1</b> to eradicate bacteria                                  | Bacteria will be eradicated in 10 of 11 people with 6 to 10 weeks of treatment.                                                         |
| <b>Antibiotic cocktail</b> to eradicate ulcer-causing stomach bacteria ( <i>H. pylori</i> )                                                                | <b>5</b> to heal ulcers                                           | Ulcers in 1 in 5 people will heal by the end of treatment. One in two will be cured in a year.                                          |
| <b>Lipitor and other cholesterol-lowering statins</b> , when used in people who have had a heart attack or have signs of heart disease                     | <b>16-23</b> to prevent one heart attack                          | In clinical trials, with 5 years of treatment, 1 in 16-23 people is spared a coronary event. To prevent an actual death, the NNT is 49. |
| <b>Lipitor and other cholesterol-lowering statins</b> , when used in patients without heart disease, but who have risk factors like high blood pressure    | <b>70-250</b> to prevent one heart attack or stroke               | Benefits with 5 years of treatment are smaller in those without existing disease, and the NNT increases with lower initial risk.        |
| <b>Lipitor and other cholesterol-lowering statins</b> , when used in patients without heart disease, but who have risk factors such as high blood pressure | <b>500+</b> to prevent death or serious medical conditions        | In clinical trials, there was no significant reduction in deaths or serious events, so a precise NNT can't be calculated.               |
| <b>Avandia</b> , which controls blood sugar                                                                                                                | <b>1,000+</b> to prevent heart attacks, other effects of diabetes | The drug reduces blood sugar, but that does not translate into fewer problems, such as kidney failure, nerve damage, amputations.       |
| <b>Zetia</b> , which lowers cholesterol                                                                                                                    | <b>1,000+</b> to prevent heart disease                            | Companies admit that it has not been shown to reduce heart disease or heart attacks.                                                    |

Data: Bandolier, Therapeutics Initiative, *BusinessWeek*

Knowing the NNT can help patients in two different ways:

- First, patients can decide if a medical intervention works well enough to have. An NNT of 300, for example, make work so poorly – in your opinion – that it's not worth having.

But an NNT of 2 works so well that you may decide to have this treatment.

- Second, the NNT helps patients decide which intervention works better. The lower the Number Needed to Treat, the better the medication intervention works.

### How to determine the Number Needed to Treat

Researchers compare two similar groups of people, as alike as possible, except that one group gets the medication while the other does not. This comparison study identifies the medication as the independent variable. Researchers then note the outcomes from both groups and quantify the medication's impact.

That helps explain why the NNT numbers above seem so high: most adults recover from sinusitis and most kids recover from croup even without medication.

TheNNT.com lists dozens of medical interventions.

## **A second type of Decision Aid**

ChoosingWisely, an initiative of the American Board of Internal Medicine Foundation, invited dozens of specialty medical associations to list *5 Things Patients and Doctors Should Question*. The ABIM Foundation then posted these lists on a website called ChoosingWisely.

Here are 3 examples from the hundreds listed:

- *Don't do imaging for low back pain within the first six weeks, unless red flags are present*, a recommendation of the American Academy of Family Physicians.

The Family Physician Academy's justification: Imaging of the lower spine before six weeks does not improve outcomes

- *Don't indiscriminately prescribe antibiotics for uncomplicated rhinosinusitis*, a recommendation of the American Academy of Allergy, Asthma & Immunology.

The Allergy, Asthma & Immunology Academy's justification: Viral infections cause the majority of acute rhinosinusitis and only 0.5 percent to 2 percent progress to bacterial infections.

Most acute rhinosinusitis resolves without treatment in two weeks.

- *Don't perform annual stress cardiac imaging as part of routine follow-up in asymptomatic patients*, a recommendation of the American College of Cardiology.

The College's justification: Performing stress cardiac imaging or advanced non-invasive imaging in patients without symptoms on a serial or scheduled pattern (e.g., every one to two years or at a heart procedure anniversary) rarely results in any meaningful change in patient management. This practice may, in fact, lead to unnecessary invasive procedures.

As of January, 2015, some 63 medical associations participated in the ChoosingWisely campaign, posting more than 300 treatment recommendations.

Other Decision Aids exist and are being developed all the time.

Decision Aids help focus doctor-patient discussions. No longer need patients argue about anatomy and physiology. Instead, doctors and patients can interpret Decision Aids together and discuss treatment outcomes and processes – far more fruitful discussions.

## **Decision Aids: necessary for Shared Decision Making**

The Decision Aids listed above – and others - are a necessary step toward true patient involvement in medical decisions. 'Involvement' is sometimes called 'Shared Decision Making' in which patients and doctors together decide how to proceed.

Decision Aids are tools; Shared Decision Making is a process. Both work together.

### **How impactful are Decision Aids and Shared Decision Making?**

Research presented at the Dartmouth Summer Institute for Informed Patient Choice, Hanover New Hampshire, June 2014 shows the following:

- Patients with stable coronary angina who used Decision Aids and engaged in Shared Decision Making with their physicians, were 20% less likely to choose stent insertion than patient who did not so engage
  - Absent Decision Aids, 88% of patients thought stents would help them
- Patients suffering from hip or knee arthritis were 25% less likely to choose hip or knee replacement after viewing Decision Aids
- Back pain patients with herniated disks opted for spinal fusion surgery 30% less frequently
- Men diagnosed with early stage prostate cancer were 50% more likely to choose 'watchful waiting' than more invasive treatments.

### **Using Deductibles and HRAs with Decision Aids**

The broker can now evolve from CHD version 1, deductibles with some tax benefits, to CDH version 2, deductibles that can incorporate consumer education into a true employee engagement / benefits program.

To move successfully from CDH 1 to CDH 2, brokers need to incorporate three components into their programs:

- Content
- An employee communication program, and
- Plan design incentives

Let's brainstorm, first with a radiology education program:

### **Consumer Engagement Example: Radiology**

**Incentive:** \$25 per employee to complete the following educational module. Then, \$50 toward the out-of-pocket costs if an employee decides to have a back MRI.

**Module content:** Low back pain is the fifth most common reason for physician visits. This brief tutorial can help you *benefit* from your physician visit and *avoid unnecessary costs and medical harms*.

Medical research shows that getting an X-ray, CT scan or MRI shortly after the pain begins rarely helps since most people feel better in a month or so with or without the scans.



But imaging raises costs and risks of unnecessary care:

- Lower back MRIs cost about \$1000
- CT scans about \$1200
- X Rays about \$250

One study found that back-pain sufferers who had an MRI in the first month were *eight times more likely* to have surgery, and had a *five-fold* increase in medical expenses—but didn't recover faster.

The excess imaging problem is that people both with and without back pain can show similar imaging results, meaning an identified abnormality in the test may not be the cause of your pain.

Once identified however, abnormalities need further evaluation. This can subject patients to costs and treatments which are often unnecessary since they don't speed recovery.

### **Review Questions:**

1. How common are visits to the doctor due to back pain?
  - Uncommon
  - Very common. Back pain is the 5<sup>th</sup> most common reason for physician visits
2. If you have back pain, should you automatically, immediately get an imaging exam, like an MRI, CT scan or X-ray?
  - Yes, as soon as you feel any kind of back pain
  - Maybe not, since people who have imaging tests don't seem to get better medical results than people who wait before having the test
3. About how much does a lower back MRI cost?
  - About \$20, my radiology co-payment,
  - About \$1000 on average

**Content continues:** Some medical organizations recommend *against* imaging tests for back pain within the first month.

The American Academy of Family Physicians, representing 105,000 primary care physicians advises:

- Don't do imaging for low back pain within the first six weeks, unless red flags are present.

- Imaging of the lower spine before six weeks does not improve outcomes, but does increase costs.

The North American Spine Society, representing 7500 doctors, advises:

- Don't have advanced imaging (e.g., MRI) of the spine within the first six weeks for non-specific acute low back pain in the absence of red flags.
- In the absence of red flags, advanced imaging within the first six weeks has not been found to improve outcomes, but does increase costs.

The American College of Physicians, representing 126,000 physicians, advises:

- Don't obtain imaging studies in patients with non-specific low back pain.
- In patients with back pain that cannot be attributed to a specific disease or spinal abnormality, imaging with X-ray, CT scan or MRI does not improve patient outcomes.

The American Society of Anesthesiologists – Pain Medicine, representing 50,000 members who advocate for patients in pain, advises:

- Imaging for low back pain in the first six weeks after pain begins should be avoided in the absence of specific clinical indications
- Most low back pain does not need imaging and *doing so may reveal incidental findings that divert attention and increase the risk of having unhelpful surgery.*

### **Review Questions:**

1. Do many medical professional organizations recommend that you wait 4 – 6 weeks before having a back imaging test, or have the test immediately upon feeling pain?
  - Wait 4 – 6 weeks unless specific red flags are present
  - Have the test immediately
2. Why do several medical professional organizations recommend waiting 4 – 6 weeks before having an imaging test?
  - To reduce patient costs and risks
  - To harm patients

Here are some Red Flags:

- a history of cancer or unexplained weight loss,
- fever or recent infection ,
- loss of bowel or bladder control,

- abnormal reflexes or loss of muscle power or feeling in the legs.

And here are some Key Questions to ask your doctor:

- Do you agree with the recommendations from the American Academy of Family Physicians and others that I wait 6 weeks before having a scan for my back pain?
  - If not, why not?
  - Do you think those recommendations apply to me?
- Do you worry that back imaging tests may incorrectly identify the cause of my back pain?
- Do I have the red flags listed above?
- And What other therapies do you recommend?

### **Many more Decision Aids and Educational Modules exist**

Research organizations are continuously developing Decision Aids about the major healthcare cost drivers. A short research project will identify some of these for you. That's the easy part.

The hard part is integrating the clinical information with insurance plan designs. Though difficult, it's necessary if brokers want to change the Zywave reported client satisfaction numbers:

- Creates strategic plan that aligns with company goals: **43% unsatisfied**
- Offers employee benefits and consumerism communication / education: **41% unsatisfied**
- Assists with creating or maintaining a workplace wellness program: **66% unsatisfied**

Brokers face a dilemma: whether to remain in their comfort zone which we call CDH version 1, providing spreadsheets, products and compliance services or move to CDH version 2 that integrates financial and clinical considerations into plan designs.

I encourage anyone who has read this chapter to consider: If you were a client, would you prefer a broker who engaged in traditional insurance brokerage or who integrated clinical education into plan designs?

I'd also encourage people to consider their own history: Are you satisfied with health insurance trend and utilization rates?

I suggest that if you consider these two questions, your path forward becomes clear.

Robert Frost articulated the options poetically:

Two roads diverged in a wood and I –  
I took the one less traveled by,  
And that made all the difference

## Review Questions

Answers on next page

1. One consequence of having employer based health insurance as the central mechanism of financing medical care in this country is the development of various 'fill in' programs for non-employed people. Examples include Medicare for elderly people and the Veteran's Healthcare Administration for military veterans, each with its own eligibility requirements, access criteria and payment programs. About how many such major programs exist in the US?

- a. 1
- b. About 6
- c. About 295
- d. About 13,500

2. We have two different definitions of 'well informed consumer'. The health insurance industry defines a well informed consumer as one understanding deductibles, network restrictions, referral requirements and similar. How does the medical industry define well informed consumer?

- a. The same way, someone who understands deductibles, network restrictions and referral requirements
- b. As someone who understands how well medical care works
- c. As someone who has read lots of books about medical care
- d. As someone who uses google to research their treatments

3. Can we usefully separate healthcare *financing* from healthcare *service* provision?

- a. Yes. A professional broker, for example, only need describe the insurance policy to provide a complete service to his/her customers
- b. No. We cannot usefully separate healthcare financing from service delivery. Every attempt to do that has resulted in higher costs and poorer outcomes
- c. Sometimes. We can usefully separate financing from service deliveries for orthopedic conditions but not for cardiovascular
- d. Sometimes. We can usefully separate financing from service deliveries for acute conditions but not for chronic

4. What is the best way to determine a medical care outcome?

- a. From a comparative test, one that compares a group of people who had a specific medical intervention with a similar group that did not
- b. By reviewing the relevant biological information
- c. By reviewing the relevant anatomical information
- d. By reviewing the relevant genetic information

5. What does 'preference sensitive' mean in medical care?

- a. That one patient may prefer one treatment process while another, similar patient may prefer something different and that both patients can make the right decisions
- b. That some people prefer one physician while others prefer someone else
- c. That some physicians prefer one type of patient while other physicians prefer a different type
- d. That some patients may prefer one hospital while others prefer a different hospital

6. What is the Number Needed to Treat?

- a. The number of patients who need to have a treatment for one to benefit
- b. The number of doctors who need to perform a surgery for 1 to get it right
- c. The number of patients a doctor needs to treat in order to have one patient benefit from his/her care
- d. The number of surgeries a hospital needs to host to get optimal outcomes

7. What are Decision Aids?

- a. Decision Aids are tools that present clinical evidence of risks and benefits of treatment options; they focus on likely outcomes.
- b. Techniques that can aid a physician who needs to make an important decision
- c. Surgical tools to help hospital residents make better use of their time
- d. Computer programs that determine the optimal treatment protocol for a specific patient

8. Which, below, is NOT a credible decision aid?

- a. TheNNT
- b. ChoosingWisely
- c. The US Preventive Services Task Force
- d. Brochures developed by Pfizer, the manufacturer of Lipitor, that explain the benefits of taking statins

## Review Questions

Correct answers in bold

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## **Risk Management Overview**

This chapter was originally written as the introduction to a book on the history of medical education by Andy Lazris, a primary care physician in Maryland. My thanks to Dr. Lazris for allowing me to include it here.

It was a chilly fall day in Baltimore, 1911, and Abraham Flexner was preparing for his meeting with William Welch. He meticulously parted his thinning, dark hair that sat on a long and stern face, barely cracking a smile. He slipped into his dark suit and wide tie, and then trod over to the kitchen for a cup of black coffee. He stood tall at just over six feet. He Semitic features were somewhat obscured by a bushy mustache that was curled at its edges. He wore small wire spectacles over his beady black eyes. He was neither engaging nor distant; he seemed to exist in a space all his own, and, as his friends and enemies often said, he lived within his own perception of reality. In a mere year, this former minor educator vaulted himself to fame and prominence, taking the entire medical world by storm. He understood the significance of his accomplishments and his new-found worth, and today he hoped to transform that into something that would forever alter American health care.

His hotel sat just outside the Johns Hopkins medical campus, in a well-manicured area of East Baltimore well beyond the stench of its more industrial harbor. Here there was a mix of poverty and wealth, and the Johns Hopkins Hospital, an innovative leader in medical education, had catered to both, transforming itself into the beacon of American medical excellence. Flexner himself had graduated from Hopkins many years ago with a degree in education. He obtained his diploma in just two years before moving to Indiana to establish a school. His brother, Simon, was a prominent doctor on staff, a man who had gained fame in discovering a bacterial infection that still bears his name. Now Abraham even eclipsed Simon in fame; William Welch, Johns Hopkins Hospital's president and a pathologist on staff, sought to meet with him to discuss perhaps the most significant change that the medical school, and all of American health care, would ever incur.

To Abraham Flexner, who believed in process and order, it was going to be just another day. One year earlier he had penned a comprehensive report sponsored by the Carnegie Foundation that scrutinized all of the nation's medical schools and picked winners and losers from among them. For Flexner and his allies, the report that would ultimately bear his name was the first requisite step in professionalizing and standardizing not only medical education, but the entire field of American health care. This was the culmination of work from the American Medical Association (AMA), an organization that had been fighting for half a century to gain control over the training and practice of doctors. Now with Flexner's report, the AMA, whose prior work had spurred Flexner's findings, put itself in a position to be the final arbiter regarding what a school must prove to be worthy of graduating "credentialed" physicians. Many schools did not make the cut and quickly died a natural death. Many doctors—women, blacks,

alternative practitioners, those without certified education—lost their ability to practice medicine. In an instant, because of Flexner, the entire medical landscape changed.

Flexner believed that it was about time that American health care followed the European example and adapted a rigorous scientific approach to education. And it was at Hopkins he hoped to drive in the first stake of a grand new program of reform. As he finished his single slice of toast and coffee, Abraham Flexner prepared to meet with Welch, an ally of his, and the most powerful man at Hopkins since Sir William Osler retired. Doctors Welch and Osler had personal enmity for each other and proclaimed very different visions about what health care, and specifically Johns Hopkins' mission, should encompass. One of America's premier medical institutions, Johns Hopkins stood at the forefront of the medical world, but both Welch and Flexner knew that it could be even better. With Osler gone, and with both Flexner's report and the promise of large amounts of corporate money in his back pocket, Dr. Welch now could do as he had always hoped. He would conspire today with Abraham Flexner to transform Johns Hopkins from a clinical institution that taught students how to care for patients to the nation's most prominent research facility, replacing clinical staff with full time scientists, and instituting a rigid curriculum for students that emphasized a pursuit of pure science, a curriculum (based on Flexner's recommendations) ultimately that every credentialed school would be compelled to follow, and one that largely has remained intact even today.

To exorcize the ghost of William Osler from Hopkins, Welch needed money and a template, and on this day in Baltimore, Abraham Flexner was prepared to offer him both. Now working for the Rockefeller Foundation, Flexner promised Welch with enough money to hire full-time research faculty, increase lab facilities, and institute a rigorous 4-year scientific curriculum. With Osler gone, William Welch could have his way.

Osler had established a program of clinical instruction, in which community physicians like him and his colleagues trained Hopkins students. As Osler said, "Medicine is learned by the bedside and not in the classroom. Let not your conceptions of disease come from words heard in the lecture room or read from the book. See, and then reason and compare and control. But see first." Osler not only reformed Hopkins and transformed it into a premier medical institution through his novel bedside patient-centric approach to teaching, but he did it with part-time instructors who were actual doctors and made their living by seeing patients. While he valued research and teaching, he believed that both were subservient to an education obtained in the real world by working with real patients. "He who studies medicine without books sails an uncharted sea," he said. "But he who studies medicine without patients does not go to sea at all." Osler never did any research on his own; he published books and gave lectures around the world about how to take care of patients, and how to raise a new class of physicians who would be expert in patient care. Hopkins was his grand laboratory for change.

William Welch despised Osler and sought to move Hopkins away from the community and into the lab. As a pathologist and a disciple of the scientifically-oriented German school of thought, he believed that clinical teachers were no more than greedy hacks who would sully students and prevent them from achieving medical greatness. Osler held sway at Hopkins, at least while he remained. But once he retired, his hand-picked clinical colleagues lacked the influence to maintain Osler's vision. Welch slowly drove them out, one by one, replacing them with scientists. When Flexner approached him with money and new method of education—one that Welch himself help to formulate through his position at the helm of the AMA—Welch now had the power and authority to entirely expunge Osler's stamp from Hopkins. He hired full-time faculty and fired all the clinical staff, including many of Osler's friends. Students now received their education in the class, in labs, and on the wards, not with patients in the community. They were taught by doctors who did not practice medicine but who merely read and researched it. All of this happened rapidly once Welch and Flexner shook their hands and made a deal on that chilly fall day in 1911. Hopkins was entirely transformed, and a new epoch of medical education began.

But 3500 miles west in London, Sir William Osler was fuming mad. A man known for his biting wit, his sardonic insults, and his medical genius, Osler had laid the path of modern medicine in America through his teaching and writings. Now, with Flexner's report taking root at Hopkins and elsewhere, all that he held dear was being threatened by the very man now glibly eating a piece of toast in Osler's city of Baltimore, a man who knew nothing about patients or medical care, a man prepared to exterminate all that Osler had accomplished for his profession by allying with no other than Osler's nemesis, William Welch. So, Osler wasted no time; he found his allies and used his influence to save the very field and institution to which he had devoted his life.

The struggle between Osler and Flexner set medical education and the entire health care industry on a trajectory that continues to this day. Not much has changed since the battle ended. One of the men continues to be quoted and well known, although his ideas have evaporated from our medical horizon. That is William Osler, whose books and innovations are thought to have initiated the birth of modern medicine, but whose soul was permanently shattered by the battle that commenced. The other was Abraham Flexner, a man known to very few, neither a physician nor a person with any knowledge about health care, but one whose report on medical education stamped a template upon medical care in America that we use even today. Its message is the very antithesis of what William Osler had so passionately advocated, and the changes it sparked transformed health care from a field devoted to the patient, as Osler so desperately endorsed, to one devoted to science alone and to the corporate foundations that funded scientific pursuits. And when we look at the proliferation of low value medical care today, at the trillion dollars of health care money that is squandered every year on medical interventions that help no one, at the generic medical school curriculum that emphasizes rote memorization and irrelevant sciences instead of critical thinking and patient-centered care, we owe all of that to Flexner. Osler's vision was just the

opposite of what we have today. And upon Osler's ashes, the medical system took a jagged turn and went far off course.

Medical care in America sat on a precarious spire through the latter part of the nineteenth century. Most medical schools were diploma mills with few standards, and those who could pay were able to obtain a degree. Hundreds of such schools were scattered across the country, producing far too many doctors as was necessary. (B12) Educated people typically eschewed the medical field; a survey in 1851 showed that from top colleges 26% of students became clergymen and lawyers, and only 8% became doctors. The salaries were low and the competition for patients fierce, a situation that remained in tact at least until 1900. (G82-4) The result were poorly trained doctors who held no mastery of their skills. A popular book in the 1880's, *The Physician Himself*, by DW Catheell, encouraged doctors to be more concerned with showing an image of competence rather than actually being competent. According to Paul Starr, "Catheell's guide reflects the exceptional insecurity of the 19<sup>th</sup> century doctors, their complete dependence on their clients, and their vulnerability to competition from laymen as well as colleagues." (g86-8)

In many ways to counter the beleaguered state of health care, a group of physicians in 1846 started a small organization called the American Medical Association (AMA). Meeting in New York, these doctors orchestrated a national organization whose goals were to raise and standardized medical degrees with the aim of improving the caliber of practice, decreasing the physician pool, and increasing doctor salaries. Throughout the century, the AMA met only once a year and remained small, exerting most of its influence on state medical societies. By accommodating with other forms of medical practitioners, especially homeopaths and eclectics, and by becoming a confederation of local medical societies instead of a top-down voice of change, the AMA gained members and influence. It also consolidated medical licensing state by state, (G90-112) setting standards by which physicians would be required to practice. This went a long way toward creating a set of licensed doctors who could now distinguish themselves from the mass of untrained practitioners dotting American's medical landscape.

The AMA's rise was not beneficial for all physicians, nor necessarily for patients. African-American doctors, unwelcome in many local medical societies, became marginalized, unable to obtain credentials. Similarly, women and doctors who practiced non-orthodox medical care, such as chiropractors, were excluded from those able to be credentialed. At this juncture, the AMA never elucidated a vision of health care that encompassed science and patient-centered care as the core of a viable medical system; its concrete objectives were much more nuanced and vague. It essentially was more a trade association that imposed laws and restrictions that were favorable to its members. Only in 1900 did it begin to see the advantage of "touting itself as a promotor of scientific education" to advance its agenda. (H2-3) In fact, even as late as 1906, the AMA promoted a pharmaceutical policy that on the surface sought to remove

sham drugs from the market, but in reality promoted a regulatory system to “withhold information from consumers and re-channel drug purchasing through physicians.” (G129-32) The ultimate intent of the AMA was not necessarily to improve the drug market, but to make sure that doctors have control over it, so as to increase the power of physicians in health care delivery.

But one ingredient was essential for the AMA and its licensed physician members to improve their status: better control of medical education. And that is the crux of the Flexner – Osler conflict. As long as medical schools remained unregulated, as long as they could proliferate without any rules or standardization, as long as diploma mills and substandard schools could produce large numbers of poor physicians, then American doctors could not achieve the status, money, and exclusiveness that the AMA sought. And as long as the AMA did not directly control the apparatus of medical education, then the less its influence would be over the health care delivery system. The AMA sought to cultivate a landscape with fewer schools training fewer doctors that were directly controlled by the AMA’s regulatory system. To that end, in 1904 the AMA established a council of medical education, formulating minimal standards that should be implemented in all medical schools. In 1906 it inspected all 160 medical schools and made judgments about which ones (82 in all) met minimal standards. But it kept its findings secret, fearful that any judgment it imposed on medical schools would be viewed as being self-serving, (G11-18) which of course it was.

To appear more objective, the AMA commissioned the Carnegie Foundation essentially to repeat its survey of medical schools and render an opinion about which schools met standards, so as to get “independent and presumably disinterested support for its efforts.” (B73) By 1908, when the AMA sanctioned this second survey, medical education had already been improving on its own, primarily due to state regulations and also the high cost of providing of running a school. The 450 schools training doctors in the late 1800’s had already been whittled down to 150. Many schools were already undergoing reforms to improve themselves. Many other schools remained marginal; they did not have any lab equipment or hospital affiliations, some even had sparse curricula and were situated in one room homes. 60% of schools did not have requirements for admission, only an eighth of the schools required two years of colleges, and many remained for-profit institutions. (B70-1) The Carnegie Foundation, led by Henry Pritchett, had similar concerns about medical education as the AMA, so their collaboration made sense. (B 73)

Many in the Carnegie Foundation touted the German model of medical education as a good template upon which any recommendations should be made. German schools utilized a hard science curriculum; students were well versed in chemistry, physics, biology, and math, and this provided the crux of their education. Labs and classroom work constituted requisite ingredients of education; clinical experience was far less important. The goal was to develop a very rigid science-based curriculum that would be the same in every American medical school without variation, emphasizing lab science,

qualifiable data, and a view of disease as a scientific entity that was not patient-specific. (I598) To orchestrate and implement the survey, Pritchett chose Abraham Flexner, an unknown former educator, a man with no medical training or background, but someone who adhered to the German model. Flexner also had a famous physician brother at Johns Hopkins, and the Carnegie Foundation had very close ties to that school and its president, William Welch. Welch, a pathologist, had transferred Hopkins into a living example of the model medical school that Carnegie and the AMA espoused.

But why Flexner? Why not a medical doctor or someone privy to the controversies in medical education? Or even someone who had set foot in a medical school? According to one source, Pritchett's hiring of Flexner was "one of the strangest appointments in education history." But Pritchett was counting on the AMA to lead the actual effort, with Flexner being more of a figurehead who followed the AMA roadmap. (B68) But Flexner was not a type of man who liked to be directed. As someone who had lived in Germany, who graduated from Hopkins, and who had experience in education, he had very established ideas about what he hoped to achieve with his survey. He made very profound decisions about many schools by only spending a few hours studying them. After consulting with doctors from Hopkins and others in the AMA, his report would do more than just set standards for medical schools; it would profoundly alter the very foundation of American medical education and practice, a legacy we will live with today, over 100 years later.

Who was Abraham Flexner? Born in Louisville, Kentucky in 1866 he was a son of Jewish German immigrants. He received a Bachelor of Arts at Johns Hopkins after only two years. He moved back to Kentucky where he founded an experimental school based on the German model, a school that ultimately failed. He met his wife, Annie Crawford, a former student in his school, and she ultimately became a successful Broadway playwright, bringing the couple to New York. Buoyed by her income, he then studied psychology both at Harvard and at the University of Berlin, never receiving a degree. While in Germany he was influenced by Fredrich Paulsen, a leader of the German school system, who believed that American education was not sufficiently serious and fact driven. Like German physician Fredrich von Mullen, from whom Flexner also learned, Paulsen advocated a stringent gymnasium system of learning whereby teachers taught students through a very formulaic and scientific fact-based curriculum. (B59, 91) After returning to New York, Flexner landed a job with the Carnegie Foundation through his brother Simon, a medical researcher at Hopkins and a good friend of Henry Pritchett's. (A63, B63)

The President of Johns Hopkins medical school, William Welch, a pathologist who also adhered to the German school of education, happened to be the president of the AMA at this time. Welch and Simon Flexner were good friends, and Welch was also connected to the Carnegie Foundation and supported its proposed survey of medical schools. Welch had co-authored the AMA's report on medical education in 1907 with Simon Flexner, a report many people think that Abraham Flexner's report is based.

Welch believed in a rationalistic and scientific view of medical education: if students can master science, they can figure out a patient's diagnosis and treatment without necessarily seeing or speaking with the patient. They just need data. Welch felt that medicine was a branch of pathophysiology, the science of studying the human body's operating system. He also insisted that all doctors, and all teachers, needed to be proficient in lab science rather than clinical skills; the vector of treatment for Welch ran from the lab to the bedside. In other words, doctors need only understand science and engage in research, and they will then be able to diagnose and treat diseases. (I599) As a corollary, Welch was adamant that all medical educators should be full time lab faculty; the clinical faculty (those who actually practiced medicine) were too busy and not sufficiently qualified to teach, he said. (K1860)

Abraham Flexner attacked tasks with purpose and an unbending agenda. Although often funny, and a person who enjoyed teasing colleagues, he also could be brutal and one-sided. He was known to be verbally abusive, scornful of compromise, self-centered, and only receptive to ideas and suggestions that mirrored his pre-conceived notions. (B2,3). Said one source, "Flexner did not temper his language to please readers—a quality that was to become typical of Flexner's style. He was as tenacious as a bulldog in holding to his positions." (D64-5). And what were his positions regarding the report he was charged to write? Clearly, Flexner derived many of opinions from the people at Hopkins and the AMA with whom he conversed, people like Welch and his own brother, who believed that research and science must be the bedrocks of all medical schools, that faculty must be research based and full time, that schools needed to have a uniform science-based curricula, and that AMA would henceforth regulate medical schools and its graduates to ensure compliance with very strict, unwavering regulations. In other words, his report would match his own personality, and reflect the German-focused vision of William Welch and the program he had constructed at Johns Hopkins. In fact, Hopkins became Flexner's model school.

Flexner felt that two-thirds of the schools were hopeless and should not be allowed to survive, and that most of the others needed significant reform. All but two African-American schools were told to shut down, and the remaining two were expected to train black "practitioners" whose main job was to care for the black community and assure that they don't spread disease to whites. Said Flexner, "The practice of the Negro doctor will be limited to his own race, which in its turn will be cared for better by good Negro physicians than by poor white ones. But the physical well-being of the Negro is not only of moment to the Negro himself. Ten million of them live in close contact with sixty million whites. Not only does the Negro himself suffer from hookworm and tuberculosis; he communicates them to his white neighbors.... The Negro must be educated not only for his sake, but for ours. He is, as far as the human eye can see, a permanent factor in the nation" (Flexner report) Similarly, all schools that trained women, and all that trained alternative doctors, were eradicated by Flexner's report. Those schools deemed salvageable all were primarily white institutions with close ties to the AMA. If they complied with the report's recommendations regarding curricular,

structural, and faculty reform, then they would be accredited by the AMA's Association of American Medical Colleges, be eligible for philanthropic funding from groups like Carnegie and Rockefeller to help defray full-time faculty and structural cost, and look to Hopkins as a model of how to succeed. (H2)

The report was front page news across the country. The New York Times headline stated that most medical schools were "Factories for the making of Ignorant Doctors," lauding the Carnegie Foundation for uncovering the basest features of medical education and practice in the United States. (B69) No organization or newspaper said much about Flexner or his motivations, linked the report to Hopkins or the AMA, or questioned the report's conclusions. The report, it was believed, represented a milestone in American medical care, a turning point whereby the health care delivery system in this country would be purged of its most corrupt and loathsome elements. The response was fairly uniform adulation.

The focus of the report, and the model of what a reconstructed American health care system would look like, could be found at Johns Hopkins. Medical schools now looked to Baltimore for guidance, to William Welch, and to the German model. All doctors henceforth trained and credentialed in America would be scientifically oriented and experts in research. They would be taught by full time researchers, not clinicians who saw patients. And they would follow a science-based pre-medical and medical curriculum uniform in structure. But in reality, a purely scientific bent to medical education did not reflect the reality of Johns Hopkins. Hopkins was much bigger and broader than how Flexner portrayed it, mostly because of the tremendous presence of William Osler, the most respected and well-known doctor in America, who now was knighted and retired in England. His legacy was the blood and soul of Hopkins Medical School.

"It is much more important to know what sort of a patient has a disease than what sort of disease a patient has," said William Osler as he and his contingent of practicing physicians taught the medical students of Johns Hopkins through the late 1800's. "Listen to your patient, he is telling you the diagnosis." To Osler and the clinicians of Hopkins, the vector of education ran from the patient to the lab; students learned from seeing and working with patients, not from research or lectures, and then brought that information back to the scientific theater. Teachers needed to be practicing physicians, and students needed to learn at the bedside. Osler believed in the very opposite ideals of his nemesis William Welch and of the German school. And until his retirement, Osler's word was law at Hopkins.

William Osler was born in Ontario, Canada in 1849. After graduating from medical school in Canada, and working at McGill, he was recruited in 1889 to be the lead physician at the new Johns Hopkins Hospital in Baltimore, and in 1893 he helped create and lead the new Johns Hopkins Medical School. He essentially created the school from scratch, designing a curriculum based on his primary dictate: that students learn



only through immersion in direct patient care. To that end he eschewed a focus on science and the lab, and he hired as instructors practicing physicians in Baltimore. From the day they entered the school, students interacted with patients, an act that became their only forum of learning in the third and fourth year. To further their clinical proficiency, Osler invented the residence, whereby after graduating from medical school, new doctors would essentially take apprenticeships for several years before going off to practice on their own.

While men like William Welch did expose students to lectures and lab work, this was not the focus of Hopkins. Said Osler, “I cannot imagine anything more subversive to the highest ideal of clinical school than to hand over young men who are to be our best practitioners to a group of teachers who are ex officio out of touch with the conditions under which these young men will live...” To Osler, researchers and scientists should not teach medical students; this, after all, was the very lifeblood of Hopkins’ *Zeitgeist*. (C387-9) The thrust of Osler’s educational focus was to emphasize problem-solving and critical thinking skills, and the evaluation of medical information through directive observation of and interaction with real people, whose problems not only were medical but were socio-economic and cultural as well. He specifically rejected the “inculcation of facts through rote memorization” and the assumption that one could apply scientific dogma to patients without knowing the patient first. (F6-8)

When Osler left Hopkins in 1905 he was not only the primary driver of Hopkins’ medical educational philosophy that vaulted the new school to the very pinnacle of American medical institutions, but he was also a national celebrity, having authored the widely read *The Principles and Practice of Medicine* and given lectures all over the country. He retired to England and left the cherished institution he created to his many clinical colleagues and friends.

But to William Welch and the scientists at Hopkins, a different type of school was needed to push Hopkins into the new age of medical education, one based on science, one in which full-time researchers and scientists taught students, and one in which practicing physicians (who men like Welch felt were greedy and contemptuous for earning money by seeing patients) were absent from the faculty. Welch was a powerful man, he was President of the AMA, he helped to write the first national review of medical schools, he had connections at the Carnegie Foundation. And he helped Flexner turn Hopkins away from a clinical institution to one that was inexorably married to hard science, research, and an inflexible curriculum based on the German school of thought.

By painting Hopkins as his model school, Flexner was in fact looking at a Hopkins that existed not in the realm of reality, not in the blueprint of its founder and primary architect, but rather through the stilted lens of non-clinical researchers like Welch, who sought to increase their power and influence now that Osler had slipped away. That Hopkins was the type of school that Flexner revered is a great absurdity; in many ways

it was the very anthesis of the rigid science-based bastion of learning that Flexner sought to promote in his report. But by painting the school using brushes and canvas supplied by Welch, Flexner in essence altered the very heart of Hopkins by making it comply with what he believed it already was.

From his perch in England, Osler did not stay subdued for long. Known for his fiery personality and pointed wit, he immediately conferred with his clinically-minded friends still at Hopkins, many of whom were being threatened by Welch with dismissal and demotion. Osler rejected Flexner's conclusions, believing that researchers should be in research institutions and not medical schools because they were poor teachers and they lacked the ability to enable students to learn how to practice medicine and interact with patients. (I600) He read the report "as a brutal and ignorant attack on his staff, his principles, and his sense of professionalism." Osler did not understand how faculty could be composed of anyone other than physicians actively practicing the art of medicine. "We chance the sacrifice of something that is really vital, the existence of a great clinical school organically united with the profession and the public," he said. He believed that the report will "likely spell ruin to the type of school I have always said should be and which we have tried to make it..." a place of refuge for the poor, a place where the best that is known is taught to the best students, where "men are encouraged to base their art upon the science of medicine...." Stating that Flexner had a "very feeble grasp of the clinical situation at Johns Hopkins Hospital" and that the institution was "more brilliant from the clinical side than the laboratory side," he felt that the report would diminish the educational experience of its students drastically. "The danger would be of the evolution throughout the country of a set of clinical prigs, the boundary of whose horizon would be the laboratory, and whose only human interest was research, forgetful of the wider claims of a clinical professor as a trainer of the young...." (C385-88)

Osler and others fought back as best they could. He wrote to Welch and to his clinical colleagues, asking them to repudiate the report, and not move Hopkins and the entire medical educational establishment in a direction he knew to be deleterious to the field. At Harvard, Francis Peabody, another clinician who was trying to inculcate medical education with real-life experiences, similarly assailed the Flexner report. Peabody who famously stated that "The secret of the care of the patient is in caring for the patient," (F20) felt that Flexner's approach "weakened the soul of the clinic." He, like Osler, sought a less rigid and lab-based means of teaching students how to practice medical science that focused on actual patient care rather than theoretical scientific theories that may not apply to the individual patient for whom they were caring. (B15) They both believed that Flexner's report "fossilized medical education into following a standardized format" that moved so far away from patients as to be useless in training competent physicians. (H3). Said one author: "Osler and Peabody recognized the danger of reducing the patient to simply a pathophysiology characterized by laboratory tests" while fearing that such a parochial focus blinds doctors from "the broader contextual issues that so often play a crucial function in disease." (I600-1)

But there were larger forces afloat than merely a few men who fought over medicine's direction. Despite the experience, status, and wisdom of men like Osler and Peabody, their words evaporated in the report's wave of acclamation. In fact, although Flexner's report did reflect what he and others believed to be the most logical path upon which the American medical system needed to tread, replacing corruption and incompetence with the scientific rigor of the German school of thought, the report was also a tool used by others to achieve a very specific agenda. Not only did the AMA gain power and notoriety by now grabbing the reigns of American medical education and licensing, but other corporate philanthropic groups like the Carnegie Foundation, who sponsored Flexner's study, and the Rockefeller Foundation, where Flexner worked for much of his subsequent life, had carefully crafted the report to create an American medical system that met their needs and expectations.

For the next 15 years of his life, Flexner worked in the Rockefeller Foundation general education board, dictating which schools would receive foundation money and which would not. During that time, he approved the donation of half a billion dollars to schools that met all the rigid criteria of his report and in the process "profoundly altered the medical education landscape;" the schools that did not follow Flexner's script received no money and could not afford to stay afloat, (B1) failing too to be granted requisite accreditation by the AMA. As one author states, "Money was power, and contributors to medical education knew that." (F12)

What was the agenda of groups like the Rockefeller foundation, and why did they buy into Flexner's model? Essentially, their hope was to create great bastions of medical research, whereby American medical institutions could engage in scientific study that matched that of Europe and created breakthroughs that would advance the medical industry and, undoubtedly, generate financial gain for the foundations and their parent corporations. These foundations had very specific agendas for the many schools they sponsored, and their donations were tied to the realization of those agendas, which typically required moving the schools from a clinical direction to one that was purely scientific and lab-based. (F12) Schools had to eliminate clinical faculty, hire full-time science based faculty, emphasize basic science research in their teaching, and adhere to the very rigid science-based curriculum that Flexner laid out in his report. This instigated bitter struggles between old line clinical teachers like Osler who used to have clout, and the newer research scientists who were now taking over. Full time faculty could only exist if the schools were subsidized, and these large foundations were happy to pay the schools so long as the schools adhered to their rules. (B21-3)

As the tide of funding and accreditation became clear in the years after Flexner, most schools accommodated to the new reality. As clinical professors disappeared from these schools, full-time researchers took their place. The foundation leaders—who were in fact agents of the large corporations who funneled money to them—then dictated to these schools the forms of research they desired. Hence began a cycle in American medicine in which clinical skills fell prey to basic science, and in which

corporate entities dictated the direction of medical education and medical practice. “Whether their motives were shrewd business instincts or noblesse oblige, the influence of these industrialists and financiers was profound, some would say pernicious.” (B19) Within years, the clinical institution that Osler always envisioned, ones in which patients and clinicians taught students, and in which students would leave the school with both a scientific and humanistic knowledge of disease and treatment, completely vanished from the medical landscape. Osler’s name remained well-known and respected, but Flexner’s ideas won the day. All this occurred because the corporate boards gained enough power to impact the direction American medicine would flow. “Though the board represented itself as a purely neutral force responding to the dictates of science and the wishes of the medical schools, its staff actively sought to impose a model of medical education more closely wedded to research than to medical practice. These policies determined not so much which institutions would survive as which would dominate, how they would be run, and what ideals would prevail.” (B121)

On that chilly day in 1911, when a well groomed and stern-faced Abraham Flexner walked through Baltimore to meet with William Welch, he planned to describe to Welch a plan that both men had already conspired to create. Flexner had been working with Frederick Gates of the Rockefeller Trust, who wanted to provide Hopkins with a \$1 million grant if the school transformed to the model school described by Flexner’s findings. Essentially, Hopkins would be the nation’s premier research institute, with salaried researchers paid in part by the grant spearheading all teaching responsibilities, with all students following a rigid curriculum focused on science (A74), and with strict guidelines for admission and graduation. The clinical realm championed by Osler and his colleagues would be relegated to a footnote. Clinicians “have long ceased to be scientifically significant.... Whether the extremely prosperous physician or surgeon should have a place in such an institute as the Johns Hopkins Hospital seems to me most doubtful,” said Flexner to Gates. (C-381)

In the realm of large foundations like Rockefeller and Carnegie, medical schools served as the best repositories of research and the production of scientists, upon which these companies were focused. Often, they sought to promote research pertinent to their own corporate interests. In fact, under Flexner’s new guidelines requiring full-time faculty and ample research facilities, schools needed foundation money if they were to survive. As a result, within a decade all medical schools became dominated by researchers and not clinical physicians and teachers. “Many have argued that this was a mistake. They would have preferred to see only a few schools like Johns Hopkins training scientists and specialists, while the rest, with more modest programs, turned out general practitioners to take care of the everyday ills that make up the greater part of medical work. But this was not the course that American medical education followed....” (G123)

Despite emphatic and frequent protests from Osler in England, the world that he created at Hopkins and beyond quickly dissolved. His colleagues were fired and replaced by a

purely research-based staff. No longer did clinicians teach students, and no longer did students learn from their patients, as Osler so vehemently insisted. Welch readily accepted the million dollar grant from Rockefeller, and spearheaded a dramatic transformation in medical education and practice that relied on Flexner's template, the AMA's leadership, and Corporate dollars. Flexner went on to spend most of his career working for the Rockefeller Foundation.

The other winner in the battle for medicine's soul was the AMA, which stood as the only organization capable of assuring that Flexner's vision was properly implemented and executed. After Flexner, "the AMA would largely control medical school accreditation which would become bureaucratized and sclerotic. It also became the officially recognized entity authorized to speak on behalf of all physicians." (H3) Because doctors had to be licensed, and because licensing was controlled by the AMA, and because only AMA sponsored medical schools could graduate certified physicians, the AMA in fact controlled the global American medical system, and in many ways it was beholden to corporate foundations that help fund them and the schools. Flexner himself believed that medical education and practice would change and grow as times changed. "The flexibility and freedom to change—indeed the mandate to do so—was part of the system's mission from the very beginning. Contrary to popular myth, the system was always intended to evolve." (F25). Unfortunately, groups like Rockefeller and the AMA were not interested these changes.

Today, medical schools, and the entire health care network in this country, reflect the legacy of Flexner. As one author stated, "The practice of medicine was seen as a rigorist science with clear answers to defined questions, the foibles of patients being the province not of the laboratory-trained physicians but of clergymen and social workers." (K1860-1) The medical system would now focus on "disease organically defined, not on the system of health care or on society's health more generally." Patient-centered care, prevention, and the nuances of disease all were extirpated from training as a very parochial view of science as fact reduced medical education to a technical pursuit. (F25). Using a narrow set of courses in chemistry, physics, and biology to determine which students best qualified to be physicians, and then teaching students the science of the human health through a set curriculum that today is nearly identical to the one recommended by Flexner, medical schools have moved far away from the vision of Osler. Humanistic qualities, critical thinking, and a patient-focused approach to care have lost all significance both in the selection of students and in their training. "Isn't it astonishing that the medical school curriculum structure has remained unchanged for more than 100 years? And if we omit the 'dynamic sociological encounter between patient and physician' [as Osler advocated], is it any wonder a health care crisis would emerge?" (H3)

The legacy of Flexner's report and the rise of the AMA has left many scars with which we are living today. On the positive side for physicians, many charlatan practices have disappeared, and physician competency and income increased considerably. In 1900

the average doctor earned \$750-\$1500. By 1928 they were already earning on average \$6354, with salary escalating continually due to a deliberately low physician supply and strong advocacy by the AMA. (G142)

But the physician class changed dramatically. Now only one, scientifically-based model of medical care predominated; the field became quite homogeneous and dependent on a scripted formula of practice to achieve success. The increased cost of medical education, required to help defray costs for full-time faculty and research facilities, eliminated all but the wealthy from the ranks of medical students. And Flexner's report and its ramifications triggered deliberate policies of discrimination against women, African-Americans, and Jews. (G124) Only two African-American medical schools remained, and the black doctor only survived through the efforts of the newly created National Medical Association (NMA) which sponsored a parallel black medical system given the pervasive bigotry sewed into the AMA and the American medical system it helped to create.

The other casualty of Flexner was the slaying of Osler. Today many people know Osler, or at least have heard the name. Virtually no one has heard of Flexner, the Rockefeller and Carnegie Foundation, or men like William Welch. Yet Flexner's report and its subsequent embrace by the AMA, charitable foundations, and established medical schools like Hopkins have secured Osler's irrelevance to the practice of medicine and the training of physicians. Researchers and specialists have trumped clinical generalists, the very physicians Osler's bold reforms were promoting as the cure to health care's ills at the turn of the century. After Flexner, researchers were "regarded as of greater intellectual worth than clinical practitioners which, not lending itself to grants, publications, or academic glory, was deemed a lesser calling." Even when schools trained non-research physicians, the emphasis on clinical education revolved around specialization and a scientific view of disease. (K1861) According to historian Howard Berliner, Flexner's "language leaves little doubt that he held the mass produced 'family doctor' in low esteem and he considered the new standard among physicians to be the highly scientific and sophisticated clinicians molded in the Hopkins environment of its equivalent." (B15)

In 1984 an AAMC report recommended changes in medical education that would move clinical medicine beyond the narrow confines of Flexner's report, changes they predicted would take root within just a few years. These were to:

- Develop analytic skills and instill patient-centric values into the curriculum.
- Encourage a broad liberal arts pre-med education
- Emphasize critical thinking over memorization
- Ensure that clinical clerkships encourage respect and concern for patient values
- Reward doctors who are educators. (I598)

Needless to say, none of those reforms transpired. Pre-meds are required to focus on science, and the Medical College Admission Test (MCAT) requires memorization and regurgitation of a large quantity of purely scientific data. Even through medical school, memorization, not critical thinking, is the skill that is necessary for testing success. Virtually no generalists teach students, and students are exposed almost entirely to specialized highly-scientific medical practices and ideas. Most significantly, patient-centered care as advocated by Osler has become a token gesture rather than the crux of all medical education.

We are indeed in a health care crisis. In our country we spend a trillion dollars of health care dollars for interventions that have been shown to be ineffective or even dangerous. Almost 50% of all we do as doctors is considered low value. Despite all we spend on health care, we rank among the worst in outcomes among all industrial countries. We are a nation of specialists, of high-tech medical practice, and of excessive drug use. Virtually all research is financed and controlled by industry and is conducted within medical schools whose research faculty are dependent on industry to survive and thrive, thus leading to conclusions that are sullied by self-interest. Patients feel frustrated, and their needs often fall prey to generic protocols and an emphasis on rigid scientific dogma. Students continue to be trained as scientists and not as physicians. Said one historian, "The Flexner Report... has taught us the danger of establishing a confining (and ultimately damaging) standard" in medical education and practice. (1601)

Can our health care delivery system ever change? To do so, we first must understand why it has moved so far off the rails of common sense and medical sanity. Today, over 100 years after Flexner, we should ask why we have not changed yet. Are there too many people and organizations benefitting from the current system? Do medical thought leaders believe that Flexner's formula is still the best one for our health care delivery system? Or is it perhaps inertia and a lack of understanding of what needs to be fixed? In the end, we should peak back to a time before Flexner and grasp what William Osler had already gifted to the medical world. When read today, Osler's words and ideas make sense. Certainly, if we are ever to transcend the health care mess in which we are embroiled, we must understand and embrace Osler and finally acknowledge the flaw of Flexner's errant course.

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## **Review Questions**

Answers on next page

1. Which statement below best summarizes the European or Flexner approach to medicine?
  - a. Medicine is entirely scientific. As long as doctors gather enough data on the patient and are well enough trained, they will make the correct diagnosis and prescribe the correct treatment
  - b. Medicine is entirely an art. Tests and data are irrelevant since each patient is unique
  - c. Medicine is a combination of science and art. Doctors need to combine patient hard data from tests with wisdom and experience
  - d. Medicine is a religion. As long as patients believe strongly enough, they will recover from their medical ailments
2. Who said "It is much more important to know what sort of a patient has a disease than what sort of disease a patient has...Listen to your patient, he is telling you the diagnosis."?
  - a. William Osler
  - b. Abraham Flexner
  - c. Alfred E. Neuman
  - d. Albert Einstein
3. Which type of physician would you prefer to diagnose and treat you: one trained in the Flexner style or one trained in the Osler style?
  - a. Flexner
  - b. Osler
4. How can a patient determine which type of physician – a Flexner or an Osler follower – treats them?
  - a. By interviewing the physician before receiving care. Note that this requires that the patient be well informed (medical definition) about care and treatments
  - b. There is no good mechanism available today to help patients make that choice
  - c. By staying 'in-network' based on your health insurance plan
  - d. By getting all your medical care overseas



## Review Questions

Correct answers in bold

1. Which statement below best summarizes the European or Flexner approach to medicine?

- a. **Medicine is entirely scientific. As long as doctors gather enough data on the patient and are well enough trained, they will make the correct diagnosis and prescribe the correct treatment**
- b. Medicine is entirely an art. Tests and data are irrelevant since each patient is unique
- c. Medicine is a combination of science and art. Doctors need to combine patient hard data from tests with wisdom and experience
- d. Medicine is a religion. As long as patients believe strongly enough, they will recover from their medical ailments

2. Who said “It is much more important to know what sort of a patient has a disease than what sort of disease a patient has...Listen to your patient, he is telling you the diagnosis.”?

- a. **William Osler**
- b. Abraham Flexner
- c. Alfred E. Neuman
- d. Albert Einstein

3. Which type of physician would you prefer to diagnose and treat you: one trained in the Flexner style or one trained in the Osler style?

- a. Flexner
- b. Osler
- c. **The correct answer is up to each individual patient**

4. How can a patient determine which type of physician – a Flexner or an Osler follower – treats them?

- a. **By interviewing the physician before receiving care. Note that this requires that the patient be well informed (medical definition) about care and treatments**
- b. **There is no good mechanism available (either a or b can be correct)**
- c. By staying ‘in-network’ based on your health insurance plan
- d. By getting all your medical care overseas

## **Some Risk Management Problems in today's health insurance environment**

As Andy Lazris so eloquently discussed in the previous chapter, Abraham Flexner believed in science and facts. He idealized the then-cutting-edge German approach to medical education that focused on 3 laboratory based disciplines - physiology, pathology and bacteriology – at the expense of the humanities and experience. Science gives answers, 'facts', and the medical student's role to Flexnerians, is to collect them.

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The more facts the student accumulates, the better the student.

The better the student, the better the doctor.

The ideal physician accumulates as many scientific facts about medicine in general, and then the patient in particular, as possible in order to make the best diagnosis and treatment recommendation. Facts drive the process.

It's not even necessary to see the actual patient in Flexner's world. To quote Andy's comments on the German approach:

if students can master science, they can figure out a patient's diagnosis and treatment without necessarily seeing or speaking with the patient. They just need data.

Or, stated differently, Flexnerians believe that the human body is a mechanical object to be understood and fixed when it malfunctions, a huge wall of knobs and dials that doctors optimize with medications, therapies and surgeries. Treating a patient essentially becomes the same as baking a cake or building a car. Cake too sweet? Dial down on the sugar. Cholesterol too high? Dial up on the statins. Knee pain? Arthroscopic debridement.

An extension of the Flexnerian mechanical world view is that there's always some way that medicine can improve the patient's condition, leading to the proposition that more medical care is better than less. Why settle for a *pretty* healthy patient when we can create, through science, a *very* healthy one?

This scientific-mechanical approach to medicine minimizes the problem of complexity, sidesteps the problem of overreach and ignores the issue of patient preference. Each independently poses a significant objection to this mechanical view of medicine. Altogether, they pose a mortal one. We'll explore below.

### **The Problem of Complexity**

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<sup>173</sup> Flexner's exact quote was 'The student is to collect and evaluate facts.' Abraham Flexner (1910). "Medical Education in the United States and Canada: A Report to the Carnegie Foundation for the Advancement of Teaching"

The human body, as any practitioner or recipient of medical care knows, is north of unbelievably complex. Each medical intervention creates primary effects, side effects and rebound effects which may serve to mitigate the intended impacts. Statins, for example, have a primary effect of preventing heart attacks, which they do, on average according to Pfizer's estimates of patients without known heart disease but with risk factors, about 1% of the time.<sup>174</sup>

But statins cause diabetes about half as often.<sup>175</sup> Diabetes, in turn, can cause heart attacks. So the statin rebound effect ultimately negates some of the primary impact.

Michael Porter and Elizabeth Teisberg, in their massive Redefining Health Care treatise, summarized the medicine complexity problem. 'There are too simply too many dimensions of process to track and too much heterogeneity among patients,' they write.<sup>176</sup> Clinicians may tend to focus not on the most important medical variables but on those most easy to identify, quantify and affect.

Often these become 'guidelines', 'checklists' or 'established protocols.'

We humans, it appears, like guidelines and protocols. It's one of our foibles. Checklists help us reduce the number of potentially important variables to a manageable handful, help us target our investigations and streamline the medical diagnostic and treatment process. Guidelines help us avoid starting every patient analysis from the underlying biological and physiological principles, then reasoning toward a specific diagnosis and treatment. Protocols tell us which interventions commonly succeed with a particular type of patient.

Those efficiency gains are the good bits.

The bad bit comes from a second human foible: intellectual and bureaucratic inertia. Once we accept a standard approach, we tend to ignore contrary evidence, put blinders on in other words. Some research suggests that this is the reason it takes up to 10 years for a new medical process to become widely accepted even if it's clearly scientifically based and clearly better than the old process, or even longer for an outdated one to disappear.<sup>177</sup>

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<sup>174</sup> See the Lipitor ad, Dec 4, 2007 Wall Street Journal. The small print, bottom left of that ad states 'in a large clinical study, 3% of patients taking a sugar pill or placebo had a heart attack compared to 2% of patients taking Lipitor.' This study was of patients without known heart disease. The number differ for patients with heart disease.

<sup>175</sup> See Statin Drugs Given for 5 Years for Heart Disease Prevention (Without Known Heart Disease), 2017 version by John Abramson on TheNNT.com.

<sup>176</sup> Porter and Teisberg, Redefining Health Care, page 87

<sup>177</sup> See Vinay Prasad, Ending Medical Reversal and Richard Pearl, Mistreated for more on these estimates.

In Flexner's model, physicians would, theoretically, constantly review and revisit guidelines and protocols to ensure their accuracy in the face of new research and information. But that's simply not what happens in real life. Our foibles – fatigue, complacency, greed, intellectual laziness perhaps - don't permit it.

As Atul Gawande summarized in his 2015 Overkill New Yorker article:

We can recommend care of little or no value because it enhances our incomes, because it's our habit, or because we genuinely but incorrectly believe in it.

Flexner apparently thought well trained physicians wouldn't take this approach; Gawande, the product of our Flexner based medical education system, admitted to it.

How often does this actually happen? Vinay Prasad answered that in a brilliant analysis of medical reversal.<sup>178</sup>

Prasad and his team reviewed every article in the New England Journal of Medicine between 2001 and 2010 and pulled out those that tested an established medical practice, one commonly used on patients like intensively lowering blood sugar in Type 2 diabetics to reduce cardiovascular events ... interventions, in other words, that were scientifically fact based and that the medical community embraced.

363 studies qualified.

Prasad then asked 'Of those 363 studies, how many *affirmed* the practice?' i.e. found that it benefited patients.

38% affirmed the practice, 40% negated the practice, (found it ineffective or harmful) and 22% were ambiguous.

The Prasad team's research shows that if you base your medical decisions on biology, physiology, anatomy and logic – *exactly as Flexner prescribed* – you are wrong about as often as you are right.

That strikes me as a pretty dismal report card on the Flexner / Germanic approach to medical education.

Porter and Teisberg attack Flexner's medicine-as-mechanics approach from a second point of view also. Mediocrity, errors and the important human / personal interaction factor in doctor-patient relationships go unaddressed. Even if two physicians have managed to master Flexner's scientific facts equally well, one may be a better medical practitioner. Fact based knowledge and process compliance don't always lead to similar outcomes.

Consider cystic fibrosis treatment and outcomes.<sup>179</sup>

All CF patients receive care from one of 117 ultraspecialized centers that follow the same extremely detailed treatment guidelines. CF specialists attend the same

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<sup>178</sup> Prasad, A Decade of Reversal, Mayo Clinic Proceedings, August 2013

<sup>179</sup> This discussion comes from Atul Gawande's article The Bell Curve in his book Better, 2007.

conferences, shared the same knowledge base, focus on the same variables and facts, and treat patients the same way. But they generate different patient outcomes.

The two primary CF outcome metrics are lung function and longevity. The Flexner / German expectation would be that all centers would generate approximately similar outcomes on these two measures, within a fairly narrow margin. After all, they all use the same science and facts in their diagnostic and treatment protocols and treat similar patients.

But research shows that the 117 cystic fibrosis facilities generate quite discrepant outcomes. The average clinic, according to a 1997 study, generated patient life expectancies of just over 30 years. But the best managed 46.

Ditto for lung capacity.

That's only part of the issue. Perhaps the more astonishing thing is that one CF center routinely outperformed the others. It was at Fairview-University Children's Hospital in Minneapolis. (This is based on an early 2000's study, is likely out of date and I don't give cystic fibrosis treatment advice.) Patients at Fairview apparently routinely had lung capacities equal to the average non-CF population, higher than at most CF clinics.

How could a facility far outperform the average, and how could the same one outperform the average year after year? The answer appears to be some amorphous combination of physician-patient connections, a corporate culture that wouldn't accept sub-par outcomes and the personality of the director.

Flexner's mechanical model doesn't describe or account for these results.

But William Osler's does. 'The good physician', he claims, 'treats the disease. The great physician treats the patient who has the disease.' Medical excellence is only partially grounded in science and facts – those are necessary but not sufficient conditions. Excellence also requires empathy, interpersonal connections, clinician perceptiveness and a human connection that somehow, almost indescribably, adds therapeutic value. That's the art of medical care, present to Osler but missing from Flexner.

The difference between good and great to Flexner is some measure of scientific understanding and fact accumulation. The difference between good and great to Osler appears in other arenas like human connections, the non-scientific ones that medical education too often leaves out.

But we've so far only discussed the 'complication' critique of Flexner's approach. Let's now turn to the treatment overreach objection.

### **Low Quality and Unnecessary Care**

The US medical care system, and perhaps others with which I'm unfamiliar, offers an astonishing amount of poor quality care. I'll define poor quality in a couple of ways:

- Unnecessary care or waste: Care that generates no patient benefit according to comparative studies. In other words, outcomes from the control and treatment groups are the same or practically so.
- Low quality care: Care that generates some benefit to a clearly specified group of patients according to studies but that is offered to a wider group so likely generates no benefit to the wider population.

Consider statins to prevent heart attacks as a simple example.

TheNNT.com estimates the Number Needed to Treat (NNT) is 39 for people with known heart disease, meaning that for every 39 people with known heart disease who take statins for 5 years, 1 will avoid a heart attack.

The Flexnerian, caring physician might look at a patient *without* heart disease though and say ‘This patient shares certain important biochemical and physiological factors with the studied group. I think patients without heart disease will also benefit though probably not quite as much’ and prescribe statins to the wider group, expecting somewhat similar results.

But that’s not the case, at least not by an order of magnitude. TheNNT.com estimates that only 1 in 217 patients without known heart disease will benefit by avoiding a heart attack over 5 years.<sup>180</sup>

Are 1 in 39 and 1 in 217 similar care quality? I think not. There seems to me at least, a qualitative difference here. I’ll postulate as a thought experiment that if 1 in 39 is ‘good quality care’, then 1 in 217 is ‘low quality care’.

And if 1 in 39 is ‘low quality care’, then 1 in 217 is ‘unnecessary care or waste’. (Yes there’s some benefit but differentiating value from waste at these levels strikes me like splitting hairs with an axe.)

And we haven’t even considered the treatment risks.

Where would a caring physician, draw the line between high and low quality care, or between low quality and unnecessary? I certainly don’t know.

And neither, I’ll postulate, does a Flexnerian, fact based scientist.

Extending this argument – that care generating reasonable quality care to a narrowly defined group might generate low quality care to a larger group – uncovers tremendous waste throughout our medical system.

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<sup>180</sup> <http://www.thennt.com/nnt/statins-persons-low-risk-cardiovascular-disease/>

David Cordani, Cigna's CEO estimates somewhat conservatively, that 'slippage' or care that should benefit patients but doesn't, accounts for at least 25% of all US healthcare spending but probably much more.<sup>181</sup>

Aetna, another huge national health insurer, says less conservatively on its website that

Wasteful spending likely accounts for between one-third and one-half of all US healthcare spending.<sup>182</sup>

And the Dartmouth Atlas, generally considered the bible of healthcare utilization analytics, uses a widely quoted estimate of 'up to about 1/3' of all US healthcare spending but added 'we view this as an underestimate given the potential savings even in low cost regions'.<sup>183</sup>

I think they're right, especially about the 'underestimate' bit.

This shouldn't happen according to Flexner's German school view. Physicians should accumulate all the facts and develop the right interventions. That's what science is all about – being right.

They shouldn't miss 30 – 50% of the time!

Let's put some meat on this low quality and unnecessary care bone by reviewing a 2018 Washington State study.<sup>184</sup> The Washington Health Alliance analyzed utilization and billing data from 2.4 million commercially insured patients and found that 45% of services delivered were wasteful. 45%!

Why does our system engage in so much low quality care? I think our human foibles are largely to blame. These fall into 3 general categories:

- Physician role definition, basically 'this treatment *might* benefit my patient and I don't want to withhold any potential benefit'. We might call this the medical plausibility foible – 'it might happen';
- Tort issues, basically 'I might get sued if I don't do it'; and
- The Upton Sinclair insight that 'it's difficult to get a man to believe something when his salary depends on him not believing it.' That's why surgeons tend to recommend surgery, therapists therapy and urologists interpret PSA study results differently from the US Preventive Services Task Force.

None of these foibles fit Flexner's world view. They're not science and fact based.

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<sup>181</sup> Cordani's Keynote Address at the 2015 Yale Healthcare Conference

<sup>182</sup> <http://www.aetna.com/health-reform-connection/aetnas-vision/facts-about-costs.html>

<sup>183</sup> <http://www.dartmouthatlas.org/keyissues/issue.aspx?con=1338>

<sup>184</sup> First, Do No Harm: Calculating Health Care Waste in Washington State, February 2018, [www.wacommunitycheckup.org](http://www.wacommunitycheckup.org)

But they're all human characteristics and all impact the actual practice of medicine.

And they all, in various ways, touch on the third major flaw in Flexner's approach, the problem of patient preferences.

### Preference sensitive decisions

Unnecessary care to one person might be reasonable care to another just like in our statin example above. John Wennberg, founder of the Dartmouth Institute calls this a 'preference sensitive' decision, meaning that one patient might opt for the statins while another declines and **both may be right**. This is a tacit admission that there are rarely clear cut medical decisions.

Wennberg calls these relatively few obvious medical decisions 'effective care' defined as services that, on the basis of reasonably sound medical evidence, are known to work better than any alternative.<sup>185</sup> This group of treatments accounts, based on his research, for only about 15% of all medical care.

It's the category in which Flexner's analysis applies and probably flourishes. Examples include childhood immunizations, lifesaving drugs for patients with heart attacks, and regular blood tests and eye exams for diabetics.

A far larger category is 'preference sensitive' care meaning care for which there is more than one option and in which different people can make different decisions and all be correct. Preference sensitive care requires judgment to evaluate the risk-benefit tradeoffs. Wennberg estimates it's at least 25% of medical care.<sup>186</sup>

We've already discussed preventive services – statins as primary prevention. Now consider treatment for torn or injured rotator cuffs. A surgeon will likely recommend surgery after examining the patient and identifying a rotator cuff tear. But a physical therapist, reviewing the same data on the same patient, might well suggest PT.

That rotator cuff situation arose for a student of mine. He recounted that he first saw an orthopedic surgeon who took an MRI, identified the cuff tear, showed him the picture and recommended surgery. 'I would have agreed to surgery' he went on to say, 'prior to hearing your discussions about preference sensitive decision making.' (See – there actually is some value to continuing education classes!)

'But I asked the surgeon if all physicians would agree with that analysis and recommendation.' (In other words, was this an effective care situation in Wennberg's terms?) The surgeon 'answered with a snort that some clinicians might suggest physical

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<sup>185</sup> Wennberg, *Tracking Medicine*, pages 8 – 10, then Parts II and III

<sup>186</sup> Wennberg's definitions of 'preference sensitive' and 'supply sensitive' care overlap. According to some interpretations, 'preference sensitive' may describe 85% of medical care. The exact definition and amount doesn't matter for this analysis; it's a lot no matter how we define the terms.



therapy but that would be a waste of time and that I'd be back in his office shortly thereafter.' (In other words, this was a preference sensitive decision.)

My former student decided to try PT and reported when next I saw him that his shoulder was pain free and that he had regained 99%+ range of motion – it might have been 100% but he wanted to be conservative - in the same time as surgical recovery but without the costs and risks of surgery. 'Thanks' he smiled as he relayed the story.

Was the surgeon wrong? Probably not. Surgery probably would have worked.

Was the patient right to ask about therapy? Clearly. Not only did it solve his problem but he preferred it. His choice defined the best medical treatment.

None of this makes sense in Flexner's the-human-body-is-a-big-mechanical-device world view. There's an answer in the Flexnerian world and the doctor's job is to find it.

But in the real world, doctors have foibles. They don't always diagnose and prescribe correctly because the human body is so complex. They frequently overreach because of their desire to help, combined with their economic incentives. And often misunderstand their patients' preferences.

Together these three problems doom Flexner and his Germanic approach.

Atul Gawande summarized the modern physician's role more appropriately by acknowledging that emotion complements science and that each patient has individual hopes, aspirations, fears and conditions:

The ideal modern doctor should be neither paternalistic nor informative but rather interpretive, helping patients determine their priorities and achieve them.<sup>187</sup>

That approach, far more than Flexner's, warms my heart as a patient.

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<sup>187</sup> Sheri Fink, Atul Gawande's Being Mortal, NY Times Book Review, Nov 6, 2014

## **Review Questions**

Answers on next page

1. What is medical reversal?
  - a. Stop providing medical care when studies show that it doesn't benefit patients
  - b. Save a dying patient. In other words, reverse the biological process
  - c. Have a different specialist undo the treatment you previously received
  - d. Have a doctor change his/her mind as in 'I thought that Treatment A would help you but I was wrong, so now we'll try Treatment B.'
2. What is one definition of low quality care?
  - a. Care that generates some benefit to a clearly specified group of patients according to studies but that is offered to a wider group so likely generates little to no benefit to the wider population.
  - b. Cheaper care when more expensive care is available
  - c. Care based on virtually any non-state of the art equipment
  - d. Low technology care when higher technology care is available
3. What is the NNT or Number Needed to Treat?
  - a. The number of patients who need to receive a treatment or test in order for 1 patient to benefit
  - b. The number of physicians who need to treat a patient for the patient to benefit
  - c. The number of times a physicians must perform a test or treatment in order to achieve excellence at it
  - d. The number of patients a hospital must treat in order to avoid harming any
4. What is a definition of unnecessary care?
  - a. Care that does not generate any patient benefit
  - b. Care that does not generate any physician income
  - c. Care that does not generate any hospital income
  - d. More expensive care when less expensive care is available
5. What lesson can we learn from Atul Gawande's analysis of cystic fibrosis treatments?
  - a. That beneficial medical care is a combination of science, art, human interactions and emotion
  - b. That physicians who follow the guidelines most closely generate the best patient outcomes
  - c. That physicians who ignore guidelines generate the best patient outcomes
  - d. That medicine is almost exclusively a science and the best physicians are those who understand the underlying biological, physiological and anatomical processes the best
6. What does preference-sensitive mean in medical care?

- a. That different patients, with the same medical condition, can choose different treatments and all be right
  - b. That different patients, with the same medical condition, should always choose the same treatment
  - c. That there is 1 correct treatment for a given medical condition and dozens, perhaps, incorrect treatments
  - d. That doctors often prefer to give different treatments to similar patients simply to add variety to their professional lives
7. According to this chapter, is the human body a big mechanical device?
- a. Yes
  - b. No. People consist of bodies and minds. The wisest physician understands this and seeks to engage both when prescribing medical care
8. This chapter suggested 3 reasons why physicians prescribe unnecessary and low quality care. Which below is not one of those reasons?
- a. Physician hopes and role responsibility, basically thinking 'this treatment *might* benefit my patient and I don't want to withhold any potential benefit'
  - b. Tort concerns, basically 'I might get sued if I don't do it'
  - c. The Upton Sinclair insight that 'it's difficult to get a man to believe something when his salary depends on him not believing it.' That's why surgeons tend to recommend surgery, therapists therapy and some providers routinely recommend the most expensive interventions
  - d. The boredom defense, basically 'I didn't have a lot to do in the hospital that day so I decided to provide some unnecessary care to break up the boredom'

**Review Questions**  
Correct answers in bold

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- a. **That different patients, with the same medical condition, can choose different treatments and all be right**
  - b. That different patients, with the same medical condition, should always choose the same treatment
  - c. That there is 1 correct treatment for a given medical condition and dozens, perhaps, incorrect treatments
  - d. That doctors often prefer to give different treatments to similar patients simply to add variety to their professional lives
7. According to this chapter, is the human body a big mechanical device?
- a. Yes
  - b. **No. People consist of bodies and minds. The wisest physician understands this and seeks to engage both when prescribing medical care**
8. This chapter suggested 3 reasons why physicians prescribe unnecessary and low quality care. Which below is not one of those reasons?
- a. Physician hopes and role responsibility, basically thinking 'this treatment *might* benefit my patient and I don't want to withhold any potential benefit'
  - b. Tort concerns, basically 'I might get sued if I don't do it'
  - c. The Upton Sinclair insight that 'it's difficult to get a man to believe something when his salary depends on him not believing it.' That's why surgeons tend to recommend surgery, therapists therapy and some providers routinely recommend the most expensive interventions
  - d. **The boredom defense, basically 'I didn't have a lot to do in the hospital that day so I decided to provide some unnecessary care to break up the boredom'**

## **Deductibles and Plan Management**

Successful and sustainable healthcare cost control programs require that you teach your employees how to identify and avoid unnecessary, ineffective, wasteful and low quality medical care.

Attempts to control expenses with plan design changes or ancillary programs but without this educational component never live up to their billing.

Here's a condensed 50 year history of commercial health insurance:

- Cost sharing or 'major medical' in the 1970s was inflationary so replaced by
- First dollar coverage or HMOs – the opposite of cost sharing - in the 1980s and 90s. People found these plans too restrictive so replaced by
- High deductible plans - the opposite of first dollar coverage - post 2000. People complain about the deductible size and have trouble differentiating necessary and beneficial medical expenditures from unnecessary and wasteful.
- None of these programs integrated the necessary educational component into their fabric. Any would have been far more successful with it.

You've probably tried

- Wide hospital networks figuring more competition leads to lower costs and
- Narrow hospital networks figuring more carrier control leads to lower costs,
- Defined benefit plans to give employers more plan design latitude and
- Defined contribution plans to give employees wider choice, and
- Several other things that didn't work out too well ...but never with a fully integrated employee education component.

The unwritten assumptions behind all these plans and design changes: the right financing program will motivate employees either to (a) use better medical care, (b) use less medical care or (c) use less expensive medical care.

History has conclusively shown these assumptions wrong.

Your employees will always find a way to access the medical services that they believe will improve their health whether or not that belief is valid. Attempting to influence their behavior with financing restrictions annoys them, doesn't work and doesn't improve their treatment outcomes or health.

**The fundamental axiom**  
***that any effective healthcare financing program honors***

Good health is cheaper than bad health. That's universally and patently true.

So is its extension: the more quickly and efficiently you can turn an employee from sick to healthy, the less it costs, especially if you factor in absenteeism and presenteeism.

Better care quality – better outcomes in other words – is cheaper than poorer care. (Yes, I understand that some MRIs cost less than others. But I wonder how many are necessary and actually improve employee health.)

If your employees choose medical care based on likely outcomes, they'll get healthier and you'll save money. It's the best possible win-win.

But if your financing program tries to get them to choose medical care based on other criteria ... not so much.

### **This presents a new focus**

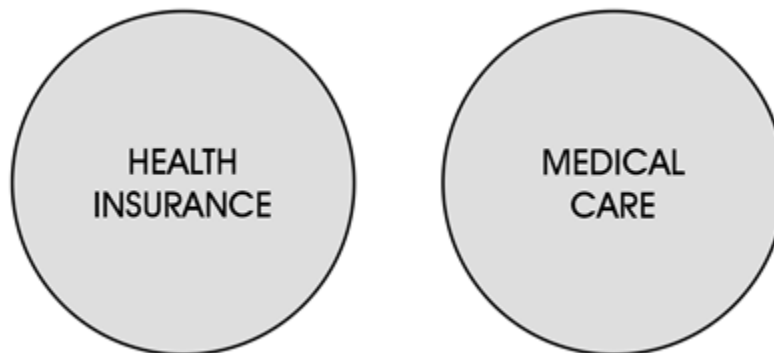
I suggest that corporate healthcare programs have as their #1 priority teaching employees how to choose care based on the outcomes they're likely to enjoy.

Design and develop that program first. This book can help. So can my online education program [www.TheMedicalGuide.net](http://www.TheMedicalGuide.net).

Then design a financing system to enhance and support your educational effort.

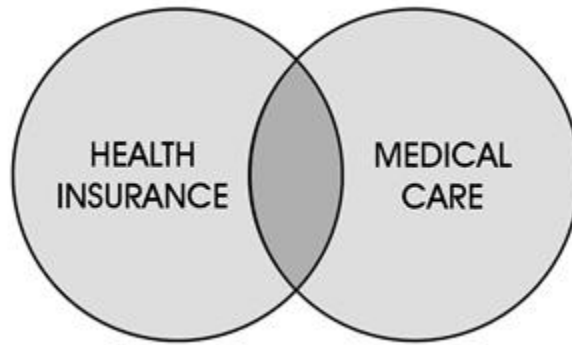
Don't do it the other way around.

The Old School approach currently in effect



Corporate engagement programs focus on understanding insurance coverage. Employees ask 'is the service covered?' and often conclude that 'if it's covered, I want it.'

### **The New School approach proposed in this book**



The interesting work takes place in the overlap.

Corporate engagement programs include medical literacy.

Employees learn to ask 'is the service covered, *does it benefit me and do I want it?*'

### **What this chapter is about**

Millions of well insured Americans get too many tests, take too many medications and have too many medical interventions. Our currently in-vogue benefits programs – deductibles, HSAs, wellness programs, etc. – haven't stemmed that tide.

Instead, I'll show you how to identify and avoid unnecessary, excessive, ineffective and low quality medical care.

I'll teach you the Five Most Important Questions to Ask Every Doctor, At Every Appointment, About Every Medical Intervention.

- If you learn, understand and ask these questions, you'll get better medical care with less risk. And you'll save a bunch of money along the way.
- If your company adopts this approach, it will save money and help its employees enjoy better outcomes with less intervention risk.

Too much care – and the wrong care - is bad for your health, both medical and financial. We currently waste according to many, up to \$1 trillion annually. That's almost Russia's total GDP!

Consider these estimates.

- David Cordani, CEO of Cigna claims that slippage or 'things that don't work the way they're supposed to' accounts for at least 25% of all medical spending but 'probably much more'.
- Aetna's website says that 'wasteful spending likely accounts for between one-third and one-half of all US healthcare spending'.



- The Dartmouth Atlas, generally considered the bible of healthcare utilization analytics, suggests that up to about 1/3 of all US healthcare spending generates no patient benefit views this 'as an underestimate given the potential savings even in low cost regions'.

The specifics may shock you. We Americans annually, for example,

- get 36 million prescriptions for a blood pressure lowering medication that doesn't prevent heart attacks or save lives,
- spend \$1 billion on a back procedure that works no better than a placebo,
- spend \$3 billion on a knee procedure that can work less well than a placebo,
- spend over \$2 billion on a cholesterol lowering drug that has not been shown to prevent heart disease or heart attacks according to its own advertising,
- and much more.

I'll name names and provide details. I'll also discuss some common medical procedures and show you that, for example,

- A quarter, maybe more, of the mastectomies in Connecticut generate no patient benefit.
- Half, maybe more, of the back surgeries in Fort Myers Florida generate no patient benefit.
- 30% or maybe even half of the c-sections in Florida, New Jersey and Louisiana provide no patient benefit.

This excess can lead to patient harms caused by medical care. Consider this trend:

- The 1999 Institute of Medicine report 'To Err is Human' found that up to 98,000 patients die annually from medical errors.
- Seventeen years later, a 2016 Johns Hopkins study found that over 250,000 Americans die annually from medical errors.

All this leads to a dismal healthcare summary:

- Americans spent \$328 billion more for healthcare in 2015 than 2013. That's about \$1000 more per person.
- But we lived slightly less long in 2015. For the first time in decades, our national life expectancy actually fell despite the increased medical spending.

This gross inefficiency puts enormous responsibility on individual patients to choose healthcare wisely.

Step 1 of that process is acknowledging and understanding the problems.

Step 2 is learning how to make wise medical decisions.

### **How to make a wise medical decision**

Follow this process to get better outcomes with less risk and at lower costs:

- First, determine how well the medical intervention works.
- Second, evaluate your treatment options. You almost always have them.
- Third, determine which doctor and hospital generates the best outcomes for your preferred treatment alternative.
- Fourth, if you find two or more equally excellent providers for your preferred option, consider price. But consider price fourth, only after you've completed the first three steps!

Asking the right questions gets you the information necessary for wise decisions.

But asking the wrong questions gets you ... something else. Maybe useful information, but maybe just some of the most important information, maybe irrelevant (even if true) facts, maybe impressions, maybe incorrect information, maybe noise, who knows.

Obtaining the relevant information is a skill that most of us lack. In fact, according to the US Department of Health and Human Services, only 12% of Americans are medically literate, meaning they have the skills necessary to assess likely treatment benefits and harms though I suspect the real number – the percentage of people who understand and use the tools described in this book – is actually much lower.

Less medically literate folks have higher hospitalization rates and medical costs, and poorer health outcomes. This medical literacy problem arises because most of us haven't been taught how to approach medical investigations. This book will correct that problem.

### **The Goldilocks Rule not too little, not too much, but just right**

Too little medical care leads to undertreated patients and poorer-than-optimal outcomes.

Too much medical care leads to overtreated patients, higher-than-necessary treatment risks, higher-than-necessary medical costs and potentially poorer-than-optimal medical outcomes.

Inappropriate medical care leads to suboptimal outcomes, excessive costs, patient dissatisfaction and sometimes lawsuits.

Appropriate medical care minimizes your chance of medical harm but maximizes your chance of medical benefit.

### **Why can't I simply follow my doctor's advice and skip the rest of this chapter?**

You always should consider your doctor's advice! But temper it with our questions for two main reasons:

First, doctors generally worry more about undertesting and undertreating than overtesting and overtreating patients. (This highlights a difference between advice giving and advice receiving, a situation I'll discuss in Question 4.)

- As trainees, they're upbraided for having too little information about their patients not too much information, so learn to overtest.
- As doctors, they're typically paid to do more not less, so may overtreat.
- As caring human beings, they want to do something to relieve your suffering, not nothing.
- As professionals operating in our legal system, they're more likely to be penalized for not doing something than for doing something extra.

One result is that about a third of patients annually receive one or more useless tests or treatments.

- Dr. Atul Gawande, a famous Boston area surgeon, found that 7/8ths of his patients had.
- Millions more, he writes, 'receive drugs that don't help them, operations that don't make them better and scans and tests that do nothing beneficial but often cause harm.'

Second, many doctors assume they know what patients want, their risk / reward tradeoff decisions. But studies show doctors can get this wrong.

- One, for example, showed that most doctors assume breast cancer patients rate 'living as long as possible' as their primary goal. But only 59% of patients agreed. Doctors were wrong about 40% of the time.
- A second showed that 40% of men with benign prostate disease opted against surgery once they were fully informed of surgical risks and benefits.
- A third showed that almost 20% of patients suffering from chest pain diagnosed as stable angina opted against surgery when fully informed of their treatment options and likely outcomes.

A fundamental cause of these problems is 'information asymmetry' or 'your doctor knows more about medical care than you do so thinks he or she understands your treatment goals and preferences too.' Gawande writes

We can recommend care of little or no value because it enhances our incomes, because it's our habit, or because we genuinely but incorrectly believe in it.

Patients often want to do their homework but don't know how. Some attempt to become mini-MDs through online research. That almost certainly won't protect against unnecessary, excessive or inappropriate care; the research is clear.

Instead this book will show you how.

It will put you onto a level (or, at least, a more level) field so you can participate more wisely and effectively in your own medical decision making.

### **The 5 Question Checklist Medical Literacy in Practice**

*If you **understand** these questions, you're medically literate.*

*If you **ask** them, you're ahead of the curve.*

*If you **get them answered**, you've maximized your chance of benefit and minimized your risk of harm.*

In a typical appointment, you and your doctor discuss a medical problem and your doctor recommends an intervention.

Ask these 5 questions about that recommendation:

- Has it been tested for the outcomes that concern me?
- Out of 100 people like me, how many benefit and how many are harmed?
- Is it overused?
- Would most physicians make the same recommendation or might some suggest something different?
- How many patients like me do you treat annually?

These deceptively simple questions are based on extensive research and analysis. The better you understand them and the more you integrate them into your medical thinking, the better care you'll get.

Ask them of every doctor, at every meeting, about every medical intervention.

You can use this list as a script. Feel free to share it with your doctors.

#### **Question #1 Has it been tested for the outcomes that concern me?**

Testing determines how well a medical intervention works in real life, on real people.

When testing, medical researchers typically divide a large group of people in half to make 2 identical smaller groups. They give one group the treatment but not the other.

Then researchers watch both groups for a time period, say 5 years, and note medical differences like the number of heart attacks, deaths or strokes. They attribute any differences to the intervention.

Simple! (Actually not simple at all. Medical research methodology is very complicated and worthy of many books, each much longer than this.)

But what happens if you don't have 5 years available? Say that a new blood pressure lowering drug just came on the market, looks promising and you, a person with high blood pressure, have a doctor's appointment the next day.

Your doctor may say 'this is the newest generation of blood pressure lowering medications and has been configured to reduce the side effects of the old drug. I suggest you try it and see how you tolerate it.'

In theory the new drug works well. But it hasn't been tested yet in real life, on real people, for years.

How well does it work?

Dr. Vinay Prasad, assistant professor of medicine at the Oregon Health and Sciences University, studies that issue. He asks 'how well do medical interventions work if they haven't been tested over long time periods on real people?'

How well, in other words, did medical theory hold up to subsequent testing?

Prasad and his team conducted a fascinating study. They reviewed every article in the New England Journal of Medicine between 2001 and 2010 and pulled out those that studied and tested an established medical practice, one commonly used on patients like intensively lowering blood sugar in Type 2 diabetics to reduce cardiovascular events ... interventions, in other words, that made medical sense and that the medical community embraced.

363 studies qualified.

Prasad then asked 'Of those 363 studies, how many affirmed the practice?' i.e. found that it benefited patients.

38% affirmed the practice, 40% negated the practice, (found it ineffective or harmful) and 22% were ambiguous.

Dr. Prasad's research shows that if you base your medical decisions on biology, physiology, anatomy and logic – but not on test results – you are wrong about as often as you are right.

We'll call this Prasad's Law and refer to it throughout this book.

According to Dr. Prasad, rather than focusing on outcomes, patients often

*gravitate toward the nuts and bolts — what does it do, how does it work?*

*But the real question is: Does it work? What evidence is there that it does what you say it does? What trials show that it actually works?*

*You shouldn't ask how does it work, but whether it works at all.*

Why is this the case?

Our bodies are enormously complicated and our understanding of medical risks, causality and treatment impacts is surprisingly limited. Sometimes (often?) rather than using the most important biological or anatomical factors in our medical theories, we use the most easily accessible and measurable.

Here's an analogy to illustrate:

Assume that our bodies are controlled by a wizard located in our brain, more or less like the fellow behind the curtain in the Wizard of Oz.

The wizard in our brain has a wall of knobs that control body parts and functions - one controls cholesterol levels, another blood pressure, a third bone density, a fourth eye ball pressure, etc.

If each knob is 1 inch in diameter and 1 inch apart (so the wizard can get his fingers around it) the wall is six and a half feet high and half a mile long!

Turning any one knob affects the value of some others, which in turn affect still others.

We simply can't anticipate all the initial effects, rebound effects, interactions and modifications from turning a knob or two.

Medicine rarely works in the simplified 'if A causes B, and B causes C, then A causes C' scenario. That's why we need to test.

Wise patients always ask 'has it been tested for the outcomes that concern me?'

If it has been tested, then your doctor can tell you how well it works. All physicians today can access extensive databases of medical studies...in their offices...in real time so they can answer this question.

If answers exist.

Asking this question may motivate your doctor to refresh his or her memory and look for new studies that have been published since the last time he or she checked.

You and your doctor can then decide if the intervention works well enough for you. I'll show you how in the next section.

But you may learn that the intervention has not been appropriately tested. In that case, you know your chance of benefit is only 50/50. Prasad's Law tells us that.

And even if it benefits you, it might not benefit you very much.

### **Examples of medical care that should work, but doesn't; Case studies that illustrate the power of asking this question**

I'll present 6 case studies to show the power of asking 'has it been tested for the outcomes that concern me?' and why you need to ask this question about every medical intervention:

- Extended release niacin, a 'good cholesterol' boosting drug
- Atenolol, a blood pressure lowering drug
- Ezetimibe, a cholesterol lowering drug
- Vertebroplasty, a back surgery technique
- Arthroscopic knee surgery, a knee osteoarthritis remedy
- Rest after heart surgery, an historical example to tie everything together

**Extended release niacin.** Niacin, a B vitamin, has been shown in tests to raise good (HDL) cholesterol. More good cholesterol is associated with a lower heart attack risk, so artificially raising it should benefit patients.

Niacin doesn't lower total cholesterol like commonly prescribed statin drugs.

Cardiologists have prescribed various niacin products for years. One, Niaspin manufactured by Abbott Labs, generated about \$900 million in 2009 sales.

Then in 2011, the AIM-High trial of niacin effectiveness showed that, while extended release niacin is associated with higher HDL levels and lower triglyceride levels, there was no significant reduction in cardiovascular events.

In 2013, a second study, this time of Merck's niacin drug Tredaptive found the same thing: no difference in coronary event rates between people taking Tredaptive with a statin, and those just taking the statin.

Two studies on two different niacin based drugs arrived at the same conclusion: niacin doesn't reduce rates of heart attacks or strokes.

This is an example of Prasad's Law: interventions that appear to make biological sense and that are adopted before publication of comparative tests are proven ineffective or harmful about half the time when they finally are tested.

**Atenolol, a blood pressure lowering drug.** High blood pressure is a common condition in which the long-term force of the blood against your artery walls is high

enough that it may eventually cause health problems such as heart disease. High blood pressure can damage the heart and coronary arteries and lead to heart attacks, strokes and death, among other events.

Lowering blood pressure, therefore, should reduce the number of heart attacks, strokes and deaths. So strongly do physicians subscribe to this theory that they write millions of blood pressure lowering medication prescriptions annually, worth billions of dollars, including 36 million prescriptions for Atenolol in 2010.

Atenolol recorded \$161 million in 2014 sales.

Unfortunately comparative study hard outcomes do not always support the theory.

Start in 2002 with publication of the LIFE study on two of the most commonly prescribed blood pressure lowering medications called beta blockers, Losartan and Atenolol. Atenolol placed 2nd in preventing heart attacks and strokes.

Was that because Losantan was superior or because Atenolol was actually ineffective?

That question was answered in a 2004 meta review (a compilation that integrates results from several different studies to develop a single conclusion) in the Lancet entitled 'Atenolol in hypertension: is it a wise choice?'

Those reviewers found that

there were no outcome differences between Atenolol and placebo in the four studies, comprising 6825 patients, who were followed up for a mean of 4.6 years on all-cause mortality, cardiovascular mortality, or myocardial infarction [heart attacks].

The PubMed abstract summary concludes:

Our results cast doubts on atenolol as a suitable drug for hypertensive patients.

The theme was then picked up in the March 15, 2005 issue of The American Family Physician, a publication of the American Association of Family Physicians. Dr. Henry Barry's article 'Should Atenolol Be Used for Hypertension?' concluded that, though atenolol did lower blood pressure,

It does not appear to reduce the rates of cardiovascular mortality or morbidity.

Let's summarize:

- One major, high quality comparative study in 2002 concluded Atenolol is 'inefficient'
- A large meta study in 2004 concluded 'no outcome differences' as compared to a placebo and cast doubts on Atenolol as a suitable drug for hypertensive patients.



- At least one article in a professional publication in 2005 seriously questioned the use of Atenolol.
- Five years later, docs wrote 36 million Atenolol prescriptions and nine years later Atenolol achieved \$161 million in annual sales.

Medically literate folks – the ones who ask the questions in this book – could have saved those millions of dollars by avoiding Atenolol.

Would they have made wise decisions?

In January 2017, Cochrane released an update on beta blocker research. Cochrane researchers reviewed all relevant beta blocker studies published through June 2016, most of which focused on Atenolol. Their conclusions were entirely in line with the research discussed above, specifically that beta-blockers have little to no effect on heart attacks or mortality and are inferior to other anti-hypertension drugs.

I hope you're beginning to understand why you need to ask 'has it been tested for the outcomes that concern me?' about every medication. Even for medications that have been around for a long time.

**Ezetimibe, a cholesterol lowering drug.** Lower cholesterol is associated with fewer heart attacks. Ezetimibe, typically marketed as Zetia, blocks cholesterol absorption in the small intestine, unlike the more commonly prescribed statins that block absorption in the liver.

- Some patients can't tolerate statins.
- Others might not achieve their desired cholesterol reduction goals with statins and lifestyle changes alone.

Ezetimibe offers benefits to both types of patients. Consider this statement on Zetia's website, [zetia.com](http://zetia.com) from about 2011 – 2016.

Adding Zetia to a statin is proven to help reduce cholesterol more than a statin alone.

Zetia's sales exceeded \$3 billion annually from 2013 - 2016.

But read the next sentence on Zetia.com, this one in bold:

Unlike some statins, Zetia has not been shown to prevent heart disease or heart attacks.

The New York Times review of Zetia's 2008 clinical trial, for example, concluded that no trial has ever shown that it can reduce heart attacks and strokes.

Note the difference between cholesterol lowering (Zetia has been shown to be good at this) and heart attack prevention (Zetia has not been shown to be good at this).

Then in 2014, the IMPROVE-IT study showed a 'modest' though statistically significant benefit of Vytorin (combination of Zetia and Zocor, a statin) over a statin only, but just for a very select group: patients who had already suffered a heart attack or experienced chest pain.

This underscores the need to ask your doctor regularly 'Has it been tested for the outcomes that concern me?' Be clear about the outcomes that concern you – heart attack reduction or cholesterol lowering. They're not necessarily the same.

- Patients who conflated the two and focused on Zetia.com's first claim that Zetia reduces cholesterol might have opted to take the medication but then only have received the cholesterol lowering benefit, not the heart attack reduction one. On the other hand
- Patients who relied only on the website's second sentence 'Zetia has not been shown to prevent heart disease or heart attacks' - and who had previously had a heart attack - might have missed the heart attack prevention benefit discovered in 2014.

See why being medically literate is so important?

**Vertebroplasty to relieve back pain** Let's switch focus now from medications to procedures. Consider vertebroplasty, a procedure to inject medical grade cement into fractured vertebra (back bones) to reduce back pain.

In 2008, the US market for vertebroplasty was \$245 million.

Then in 2009 the New England Journal of Medicine published two studies comparing vertebroplasty to a control or placebo group that received lidocaine (a topical skin numbing agent), massage and aromatherapy to reproduce operating room smells.

- The Australian study found 'no beneficial effect' of vertebroplasty compared to the control group.
- The Mayo study concluded that patient improvements were similar in the placebo and experimental groups.

Vertebroplasty, in other words, worked as well as, but no better than, the safer and far cheaper placebo.

\$245 million on a procedure that works no better than a placebo?

See why asking the 'has it been subjected to comparative studies?' question is so important?

**Surgery for Knee Osteoarthritis** Knee osteoarthritis is a degenerative disease that causes pain, stiffness and decreased knee function.

Arthroscopic surgery, including lavage (removal of particulate material such as cartilage fragments and calcium crystals) and debridement (surgical smoothing of articular surfaces and osteophytes) was the widely used treatment in the early 2000s despite the fact that, according to the New England Journal of Medicine in 2008 'scientific evidence to support its efficacy is lacking'.

Estimates of the number of knee arthroscopies performed annually in the US vary, and not all address osteoarthritis so we'll have to estimate the size of this problem:

- A 2002 New England Journal of Medicine study estimated 650,000 procedures at \$5,000 each, creating a \$3.25 billion market.
- A 2014 NEJM study estimated the market at 500,000 knee arthroscopies at about \$20,000, generating a \$10 billion market.
- Vinay Prasad in his 2015 book Ending Medical Reversal estimated the market at 700,000 patients spending \$4 billion.

How poorly does the scientific evidence support the efficacy of arthroscopic surgery to treat knee osteoarthritis?

- A 2008 New England Journal of Medicine published study concluded that they 'failed to show a benefit of arthroscopic surgery for the treatment of osteoarthritis of the knee.'
- This followed a 2002 comparative study which concluded 'At no point did [the] arthroscopic-intervention group have greater pain relief than the placebo group.'
- The 2002 study concluded 'This study provides strong evidence that arthroscopic lavage with or without debridement is not better than and appears equal to a placebo procedure in improving knee pain and self-reported function.'

Those disagreeing with these study conclusions present the usual 'weak study methodology' case, primarily, I would suggest, to protect their incomes. Even at our lowest market estimate - \$3 billion – that's certainly a big incentive for lots of people to protect their turfs.

These studies raise some uncomfortable questions:

- Why, after the 2002 paper, did doctors continue to prescribe this procedure and patients have it?
- Why after the 2008 study did both parties continue to use it?

This is an extension of Prasad's Law that says treatments adopted absent testing are proven ineffective or harmful about half the time. Here we have treatments used even after studies showed no patient benefit, underscoring the need for you to ask this question and insist on a clear answer about every medication and procedure.

Asking encourages your doctor to check (again?).

Never hurts but may help.

A lot!

### **Rest after heart surgery, an historical example to tie all this together.**

We'll start in the early 1900s with Dr. James Herrick's advice then fast forward to today's protocols.

Herrick was an extraordinarily influential coronary care researcher who received impressive accolades from both the Association of American Physicians and the American Medical Association.

In his major 1912 paper, Herrick wrote that, after having a heart attack or heart surgery 'the importance of absolute rest in bed for several days is clear'.

Herrick's recommendations were adopted by most hospitals. Over time they extended Herrick's advice of absolute bedrest from several days to a few weeks.

Indeed, thirty four years after Herrick's paper, Dr. Thomas Lewis published his own coronary care textbook Diseases of the Heart and elaborated on Herrick's prescription:

Rest in bed should continue for 4 – 6 weeks to ensure firm cicatrisation of the ventricular wall ... Patients have lost their lives ... by neglect of these precautions.

Lewis' justification came from pathological studies showing that it can take 6 to 8 weeks for firm scarring of the lesion to occur. Rest for that amount of time was considered necessary to minimize ventricular rupture risks.

Dr. Paul Woods, another coronary care authority, reinforced that message in his textbook Diseases of the Heart and Circulation in 1959, 13 years later, recommending 3 – 6 weeks of bedrest or more depending on the severity of the heart attack.

Thus at least three medical textbooks written between 1912 and 1959 agreed: post heart attack and heart surgery, patients should rest, pretty much for as long as possible.

But by the 1960s medical opinion reversed. Eugene Braunwald, author of his own 2007 cardiology textbook, claims doctors began to realize that

Prolonged bed rest, which had been routine since Herrick's day, could actually be harmful in some patients by leading to venous thrombosis and fatal pulmonary thromboembolism. In uncomplicated cases, the duration of absolute bed rest was shortened to about five days.

Patients who asked 'what do you recommend doc?' in the 1940s and 50s would have received the long bedrest recommendation.

But patients who asked the same questions in the 1960s and 70s would have received the short bedrest advice.

And today, patients are advised to walk every day during the first 6 – 8 weeks post heart surgery, the exact opposite of Herrick's, Lewis's and Woods' recommendations.

How can 'rest' and 'don't rest' both be right? They obviously can't. At least one is wrong. Drs. Herrick, Thomas and Woods offered their best guesses backed up with biological justifications. In effect, they said 'our best guess is that the risk of ventricular rupture exceeds the risk of venous thrombosis and fatal pulmonary thromboembolism.'

Their guesses were really testable propositions which, apparently, weren't actually tested until relatively recently. When tested, they learned that thrombosis risks exceed ventricular rupture risks. Thrombosis and embolism risks are so high in fact that today's patients are advised not even to stand in one place for more than 15 minutes! The exact opposite of Herrick's, Thomas's and Woods' advice.

That's why wise patients don't research why a specific medical recommendation makes sense. Doctors and scientists can justify a wide range of (often conflicting) recommendations, just as we've seen here. Prasad's Law tells us that absent testing for specific outcomes of concern, those recommendations are wrong about half the time.

Instead of relying on theory, wise patients rely on test data, the facts.

The tragedy of this story is that some heart attack recovery patients presumably died in the last century from following the established protocols and textbook advice.

They didn't ask if the recommendations had been tested.

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Dozens, hundreds, perhaps even thousands of other 'makes sense but doesn't work' situations exist. Here are some relatively-easy-to-understand additional examples of Prasad's Law from his book Ending Medical Reversal.

- Estrogen replacement to reduce heart attacks in postmenopausal women. Testing showed no heart attack rate reduction.
- Coronary stent insertion to prevent heart attacks in patients with stable angina. Testing showed no impact on heart attack rates over time.
- Prophylactic antibiotics for people with persistent Lyme disease symptoms and a history of Lyme disease. Testing showed no symptom reduction.
- Lowering diabetic's blood sugar (A1c) below 7% to prevent heart attacks with an intensive drug regimen. Testing showed an increase in mortality rates.
- Calcium plus vitamin D to reduce the risk of hip fractures. Testing showed no hip fracture rate reduction but an increase in kidney stone risk.
- Withholding birth control pills for women with lupus to reduce the rate of lupus flares. Testing showed no increase in flares.

- Saw palmetto for benign prostatic hyperplasia. Testing showed no benefit measuring multiple outcomes despite more than 2 million men using it.

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ChoosingWisely, a program organized by the American Board of Internal Medicine Foundation to combat wasteful, unnecessary and harmful medical care lists 300+ more examples of medical practices that, according to testing, should not be used. ChoosingWisely is a wonderful resource for well informed patients. Here are a few examples for illustration purposes.

Don't automatically use CT scans to evaluate children's minor head injuries.

Avoid doing stress tests using echocardiographic images to assess cardiovascular risk in persons who have no symptoms and a low risk of having coronary disease.

Don't perform EEGs (electroencephalography) on patients with recurrent headaches.

Don't routinely treat acid reflux in infants with acid suppression therapy.

Don't recommend prolonged or frequent use of over-the-counter (OTC) pain medications for headache.

Don't routinely prescribe antibiotics for inflamed epidermal cysts.

Don't use systemic (oral or injected) corticosteroids as a long-term treatment for dermatitis.

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When you ask 'has it been tested for the outcomes that concern me?' you may learn how well it works. In that case you and your doctor can determine if the benefits are substantial enough, and risks low enough, for you to have the treatment. I'll show you how in the next section.

But you may learn that the treatment has not been tested in real life, on real people.

In that case, remember Prasad's Law.

### **Applying Prasad's Law to long term medication use**

Some medications may have been tested for 1 year, say, but be prescribed for longer. What are the 8, 15 or 20 year effects, both positive and negative? We often don't know.

This is a version of Prasad's Law. In this case, the untested treatment is the time horizon. A medication with few side effects over 6 months may have major side effects over 10 years.

You can rephrase the testing question to 'Has it been tested for the length of time that I'm likely to be on it?'

## **Summary of Question 1 What We Have Learned So Far**

Comparative tests tell us how well medical interventions work.

Wise patients ask ‘Has it been tested for the outcomes that concern me?’ and base their medical decisions on comparative test results. I’ll show you how in the next section.

Importantly, we also learned that interventions that make biological and anatomical sense are shown to be ineffective or harmful about half the time in comparative tests.

Patients who base their medical decisions on biology and logic – but not test results – are wrong about as often as they’re right.

## **Question #2 Out of 100 people like me, how many benefit and are harmed?**

Determining how well care works from medical tests

Once you learn that a treatment has been tested, you and your doctor can discuss the impact. Use this phrasing:

- Out of 100 people like me, how many benefit? And
- Out of 100 people like me, how many are harmed?

This tells you how well the treatment works in testing circumstances. We’ll discuss how well it may work in real life circumstances in the next chapter.

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Ask ‘out of 100’ to get a number for your answer. ‘16’ conveys more information than ‘some’, ‘many’, ‘a few’ or ‘quite a few’.

Some patients may decide that 16 people benefiting is good enough to have the treatment while others say ‘only 16? That’s not very many.’ Different people can reasonably disagree.

Statements like ‘this treatment cuts your risk by 36%’ don’t answer the question! 36% of what? Percentage answers may confuse more than they illuminate.

Remember that Prasad’s Law applies if your doctor can’t answer the ‘of what’ question above.

Ask about ‘people like me’ because treatments can have different impacts on different demographic groups. Consider these examples.

Age: The American Academy of Pediatrics recommends against prescribing cough and cold medications for respiratory illnesses in children under 4 saying ‘these products

offer little benefit to young children and can have potentially serious side effects'. They're apparently fine for 6 or 8 year olds though.

... out of 100 people ... these medications work, but

... like me ... not if you're under 4 years old

Gender: In 2014, the Food and Drug Administration cut the recommended dose of Ambien, a sleep aid, in half for women after determining that men and women metabolize it differently. Women, it turns out, have more of the drug in their bodies the next morning, putting them at higher risk of impaired driving.

... out of 100 people ... the medication works, but

... like me ... not so well for women

Other patient differences exist but we don't always know how frequently. You and your doctor may have to estimate the impact on people like you.

Identify the benefits of interest to you. If you take a heart attack prevention medication ask 'out of 100 people like me, how many avoid a heart attack by taking this medication?'

- Remember our discussion of Atenolol and Zetia in the last section.

If you want to reduce your back pain, ask 'out of 100 people like me, how many enjoy less back pain as a result of this procedure?'

- Remember our discussion of vertebroplasty and knee surgery in the last section.

Beware of listing 'lower my cholesterol' or 'lower my blood pressure' as the benefit you hope to achieve. We discussed earlier how these 'test benefits' may or may not correlate closely to 'patient' or 'event' benefits. Focus on the benefits you hope to achieve.

And be as specific as possible.

### **Some case studies to indicate the power of asking this question**

Out of 100 people like me, how many benefit and are harmed?

Consider antibiotics to treat pediatric ear infections, a quite common childhood problem. Ear infections can be painful to the child and frightening to the parents who, not unreasonably, want to do something to help.

Ear aches are sometimes viral and sometimes bacterial. Doctors often prescribe antibiotics.



This intervention – antibiotics to treat pediatric ear aches - has been studied so Prasad's Law doesn't apply.

A meta review – that's a compendium of several individual studies – of 15 studies on 4100 kids concluded that 6 in 100 who took antibiotics reported less ear pain after 2 – 7 days; 94 in 100 did not enjoy less ear pain as a result of the antibiotics. Most had a complete recovery within 2 – 7 days without the medication.

But 11 in 100 who took antibiotics suffered uncomfortable side effects like diarrhea.

- Out of 100 kids who take antibiotics to treat ear infections, how many benefit by enjoying less ear pain in 2 – 7 days? 6
- Out of 100 kids who take antibiotics to treat ear infections, how many are harmed by diarrhea or other uncomfortable side effects? 11

Now you have sufficient information to discuss this intervention with your pediatrician. Does it work well enough for your child? Some parents may decide yes, others no.

But in both cases, it's an informed decision made by a parent in light of the facts.

Dozens of similar cases exist. One website [www.TheNNT.com](http://www.TheNNT.com) lists about a hundred. ChoosingWisely [www.ChoosingWisely.org](http://www.ChoosingWisely.org) takes a slightly different approach and lists hundreds more. Both sites will provide good information for you to discuss with your doctor.

### **Out of 100 people like me how many benefit and are harmed?**

We already discussed how age and gender can impact outcomes. I'd like to explore a different, infrequently discussed but vitally important like me category: social status.

I'll define social status ambiguously as a combination of wealth, income and sense of control over your life, analogous to the way former US Supreme Court Justice Potter Stewart defined pornography: you know it when you see it.

The Whitehall studies in Britain first identified and quantified social status' impact on health. These studies tracked disease and death rates by job and rank in the British civil service and their conclusions have been reproduced in other studies, in other countries.

Whitehall found that low social status folks had higher disease and death rates than high status folks. Surprisingly – and this is the big deal - this was not only due to measureable factors like cholesterol, blood pressure, blood sugar, smoking, obesity or exercise rates.

After correcting for those factors, the lowest status folks were about twice as likely to have heart attacks, develop other diseases and die as the highest status ones.

Whitehall also found a gradient: the higher you are on the social status scale, the lower your disease and death rates and the reverse, the lower you are on the social scale, the higher your disease and death rates.

Over and above specific disease risk factors, Whitehall concluded, there is something about social status independently that impacts people's health. Harvard School of Public Health Professor Nancy Kreiger, whose own work affirms Whitehall's conclusions, put it this way:

An individual's health can't be torn from context and history. We are both social and biological beings—and the social is every bit as “real” as the biological.

In line with this analysis, a major 2016 study in JAMA, the Journal of the American Medical Association found that the life expectancy gap

between the richest 1% of Americans and the poorest was about 12 years on a gradient similar to Whitehall's. In an accompanying editorial, Nobel laureate Angus Deaton emphasized the impact of income and social status on health and castigated traditional medical thinking:

The finding that income predicts mortality has a long history... the mortality gradient by income is found wherever and whenever it is sought...but the medical mainstream emphasizes biology, genetic factors, specific diseases, individual behavior, health care, and health insurance.

Consider the medical impacts of your own social status. Imagine your doctor says ‘your cholesterol level is slightly high. The guidelines suggest lowering it. I'll prescribe a medication.’

- If you're a low status person (thus facing higher than average heart attack risks) you may be undermedicated, leaving you exposed to disease harms.
- But if you're a high status person (thus facing lower than average heart attack risks) you may be overmedicated, exposing you unnecessarily to medication harms.

Try to include social status factors in your ‘like me’ discussions with your doctor along with age, gender, general health status, family history etc. One good information source is the 2004 report ‘Work, Stress and Health: The Whitehall II Study’. Share it with your doctor. It's surprisingly easy to read and it may change the way you think about medical care.

It certainly did for me.

**‘Out of 100 people like me...’ or ‘The guidelines say...’  
Case study of hypertension**

The American Heart Association recommends that people over 60 years old begin treatment for high blood pressure when their readings exceed 150/90.

But out of 100 people like that, how many benefit by following those guidelines?

Some answers come from a 2009 Cochrane report that summarized 15 trials totaling 25,000 subjects over age 60 with moderate to acute hypertension followed for average 4.5 years.

Out of 100 people over 60 years old with moderate to acute hypertension, how many avoid cardiovascular disease or death over 4.5 years?

Answer: About 4

Here are Cochran's numbers:

- Risk of cardiovascular death or disease without taking hypertensive medication: 14.9/hundred. This is the control group.
- Risk of cardiovascular death or disease among patients taking hypertensive medications: 10.6/hundred. This is the test group.
- Medication benefit: 4.3 fewer deaths or diseased patients/hundred (4.3%)

I don't know how many, if any, were harmed by the medication.

Which question gives you the best information and best helps you make the wisest decision: 'Out of 100 people like me, how many benefit?' or 'What do the guidelines say?'

It's your call.

## **Summary of Question 2 What We Have Learned So Far**

Question 2 builds upon the lessons of Question 1.

Question 1 was 'Has it been tested for the outcomes that concern me?' We learned that comparative tests identify the benefits and harms of a medical intervention.

- Importantly, we also learned that medical interventions that have not been subjected to comparative testing are ineffective or harmful about half the time. We called this Prasad's Law.

Question 2 showed how to quantify the benefit and harm impacts. We learned to ask

- Out of 100 people like me, how many benefit? And
- Out of 100 people like me, how many are harmed?

We also learned

- Why to ask ‘out of 100’ and not to accept answers like ‘this treatment reduces you risk by 36%’.
- Why to ask about ‘people like me’, including about people in your socio-economic demographic.
- Why ‘patient outcomes’ always matter but ‘test outcomes’ may not.

### **Question #3** **Is it overused?**

Sometimes beneficial care is overused so may not benefit you

This question acts as a yellow warning light to wise patients: proceed but proceed cautiously.

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Testing sometimes shows that a treatment works well on a narrowly specified group of patients but, in the real world, doctors may offer it more widely, perhaps hoping to benefit even more patients.

Examples include mastectomies, back surgery, c-sections (I’ll discuss these three in some detail below), tonsillectomies, antibiotic prescription, prostate surgery, MRI use, coronary angioplasty and many more.

This results in treatment variation meaning that different doctors may treat similar patients differently.

Vast amounts of research into this phenomenon have identified three significant issues.

*First*, about 85% of the time, two or more treatments can generate the same patient outcomes.

Mastectomy or lumpectomy for early stage breast cancer, surgery or physical therapy for back pain, injections or physical therapy for frozen shoulder, etc. Though the outcomes may be the same, the process, pain, risk, recovery period, family impact and cost can vary widely.

*Second*, when faced with care options, many patients delegate decision making to their doctors. This forces the doctor’s preferences, not the patient’s, to define the treatment decisions and doesn’t always serve the patient’s best interests.

We’ll explore some implications in Question 4, the next section.

*Third*, the higher the supply of medical services in a region, the more frequently patients access those services: the more hospital beds, the more hospitalizations, the more MRI units, the more MRI tests, the more orthopedic specialists, the more orthopedic surgeries etc.

We'll discuss some implications in this section.

Excessive utilization raises costs and risks but doesn't improve patient outcomes. It may even worsen them since patients expose themselves only to potential treatment harms, not benefits.

We'll explore three case studies of treatment variation. Two are based on Dartmouth Atlas of Healthcare information: early stage breast cancer treatment in Massachusetts and Connecticut and back surgery in southwestern and southeastern Florida. The third is hospital baby delivery patterns, specifically c-section rates.

These are 3 of dozens I could have chosen. As you read them, consider how patients who have the more aggressive, excessive and overused treatments may actually end up worse off.

### **Case Study: Mastectomy Rates in Massachusetts and Connecticut**

Female Medicare beneficiaries in Connecticut, using Connecticut hospitals, get about 40% more mastectomies per 100,000 than do similar women in Massachusetts. This has been roughly constant since 2008.

How can we determine if these surgical rate differences are driven by patient health differences or physician treatment orientation differences?

We'll first consider patient differences. The American Cancer Society tracks cancer incidence and mortality rates by state. They show that the breast cancer incidence rates for 2011 per 100,000 women are virtually identical in both states:

Based on breast cancer incidence rates alone the treatment variation appears driven by physician orientation, not patient disease rate differences.

Did the Connecticut women benefit from more mastectomies?

The American Cancer Society also tracks breast cancer mortality rates in each state. That's the rate at which women die of breast cancer. Again, they're virtually identical in both states.

If the higher rate of mastectomies in Connecticut from 2008 – 2011 generated patient benefit, we would expect to see lower Connecticut breast cancer mortality rates in 2011-2012 than in Massachusetts. That didn't happen.

Women asking the standard treatment questions – is this a good treatment? Do you get good results? Would you recommend this treatment for your wife, daughter or sister? – would get the same answers in Massachusetts and Connecticut.

But the Connecticut women wouldn't avoid those additional mastectomies.

The higher mastectomy rate in Connecticut generates no patient mortality reduction benefit. It only raises patient risks and costs.

Asking the 'is it overused in this hospital or region' question would help motivate physicians and well informed patients to review these kinds of data.

Follow up with 'out of 100 women like me, how many benefit and are harmed by mastectomies?'

Really well informed women might also ask 'would most physicians make the same treatment recommendation or might some suggest something different?' I'll introduce that question in the next chapter.

### **Case Study: Back Surgery in Florida**

Medicare beneficiaries in southeastern Florida, around Miami, are about half as likely to have back surgery as Medicare beneficiaries in southwestern Florida, around Fort Myers.

Are retirees in Miami medically different from retirees in Fort Myers? John Wennberg, founder of the Dartmouth Atlas and professor emeritus at the Geisel School of Medicine at Dartmouth, answers with a resounding 'no' saying

There is no epidemiologic evidence that illness rates vary as sharply from one health care region to another as does surgery.

Do retirees in Miami prefer more aggressive care than retirees in Fort Myers? In other words, do Miami patients routinely ask for physical therapy for their back pain while Fort Myers patients typically ask for surgery?

Again 'no' but this time from Dr. James Weinstein, former Chairman of the Orthopedics Department at Dartmouth's Geisel School of Medicine who has studied treatment variation for years:

It's highly improbable that Medicare retirees living in Fort Myers prefer back surgery two times as often as residents of Miami.

What causes the treatment variation? Wennberg again provides the answer:

Doctors decide who needs health care, what kind, and how much.

And the key patient benefit question: Do retirees in Fort Myers benefit from the extra back surgeries? In other words, do Miami retirees suffer unnecessarily from receiving too few back surgeries?

Though I was unable to find solid academic studies that specifically answer this question (!), Dr. Elliott Fisher and his Dartmouth colleagues addressed this issue in general in their massive 2003 study, 'The Implications of Regional Variations in Medicare Spending'. One observation, paraphrased for readability here:

For every 10% increase in medical spending, the relative risk of death increased.

In none of the regions studied did the higher per capita expenditures lead to a statistically significant mortality decrease.

In other words more care, or care above the minimum available in any US region, led to more harm not more benefit.

Wise patients don't stop their questioning when they learn that a treatment is beneficial, as spinal surgery and mastectomy sometimes are.

Wise patients want to ensure that the treatment provides benefit to them. That takes additional questioning.

### **Acceptable and Unacceptable Answers to 'Is it overused?'**

Acceptable answers include 'yes', 'no' and 'I don't know'. All can lead to a useful, additional discussion.

Unacceptable answers include 'we never perform unnecessary back surgery.' Fort Myers orthopedists and Miami orthopedists would say this about as frequently!

So would Connecticut and Massachusetts oncologists.

See the somewhat-famous-party-trick discussion coming up for further explanation.

### **Case study: C-section delivery rates at different hospitals**

C-section rates vary tremendously among hospitals and regions. Some hospitals routinely deliver 40% or more of babies by c-section while others deliver 20% or less.

Similarly some states exhibit far higher average c-section rates than others.

We'll start our analysis with a 2011 New Hampshire Insurance Department study 'A commercial study of vaginal delivery and cesarean section rates at New Hampshire hospitals' that showed c-section rates varied between 15% and 47% of deliveries by New Hampshire hospital. That study concluded

There are no obvious reasons that explain why c-section rates are higher at one NH hospital than another ...

there does not appear to be a relationship between c-section rates and health status among hospitals ...

statistics show essentially no relationship between hospital population health and health status and c-section rates.

The NH study did not note outcome differences among hospitals suggesting similarity. (Major outcome differences would have been headline news and almost certainly included in this study.)

That raises the question: Do hospitals that perform more c-sections on similar populations generate healthier babies?

A second 2011 study addressed that, this time of 30,000 births at 10 upstate New York hospitals without specialized neo-natal intensive care units but with varying c-section rates. It found no difference in outcomes for babies born in the hospitals with the highest c-section rates and those with the lowest when outcomes are measured by Apgar scores, need for assisted ventilation, or need to move to intensive care hospitals.

Two studies, both showing different c-section rates by hospital without apparent patient health reasons or outcome differences.

Fast forward to 2013 and consider the conclusion of a Harvard School of Public Health study of 228,000 births in 49 different Massachusetts hospitals:

The same woman would have a different chance of undergoing a c-section based on the hospital she chooses ...

Certain hospitals' high rates of cesarean births have more to do with characteristics of the hospitals themselves than with characteristics of their patients.

Harvard goes on to issue this caution:

While c-sections can be a lifesaving procedure for an infant in distress, or when there are multiple births or other labor complications, c-sections that are not medically necessary can put mothers and babies at avoidable risk of infection, extend hospital stays and recoveries, and increase health costs.

Again a beneficial medical intervention is overused and when 'not medically necessary' (Harvard's words) puts patients at unnecessary risk.

The same year, 2013, a different study by Dr. Katy Kozhimannil and others of 817,000 births in 593 hospitals nationally arrived at the same general conclusion. Kozhimannil found that c-section rates varied from 7 to 70 percent of all deliveries by hospital and suggested that provider practice patterns were a key driver of this rate variation.

Surgical variation rates were not, according to Kozhimannil, explained by hospital size, geographic location or teaching status...

The scale of this variation signals potential quality issues that should be quite alarming to women, clinicians, hospitals and policymakers.

More or less like the New Hampshire study, the New York study and the Harvard study.

Four different studies arrived at the same conclusion: c-sections benefit some patients but are overused so may not benefit – and may even harm – others.

To summarize:



- The hospital that you choose has a significant impact on your likelihood of delivering by c-section.
- Hospitals with the highest c-section rates don't necessarily serve the sickest, most at-risk populations.
- C-section rates vary significantly even among low risk mothers.
- Hospitals performing the highest rates of c-sections do not generate better outcomes than hospitals performing lower rates.

These treatment variation situations get replayed for dozens of procedures including

- tonsillectomies
- coronary stent insertions
- heart valve replacements
- referrals for CT scans
- hip replacements
- radical prostatectomies, and others.

Dartmouth researchers estimate that if you add all the excesses above the minimum, for lots and lots of procedures, you'll arrive at about 1/3 of all medical spending. I'd recommend that anyone interested in this topic visit the Dartmouth Atlas website and click around. It's packed with fascinating, potentially life-saving information.

A somewhat famous medical party trick story  
showing that even great doctors in great hospitals practice differently

John Wennberg, more or less the godfather of treatment variation analytics in this country, performed a party trick of sorts to show how doctors practicing at highly regarded hospitals can treat similar patients differently.

He used Boston, home to Harvard Medical School affiliated teaching hospitals, and New Haven, home to Yale Medical School affiliated hospitals, as his case study.

Wennberg learned that Boston area patients spent about 40% more time in the hospital:

- A Boston patient suffering from gallstones would be 40% more likely to be hospitalized than a similar patient in New Haven.
- A patient hospitalized for surgery that required 1 night in a New Haven hospital would often have spent 2 nights in a Boston hospital.

He wondered if the New Haven docs felt they undertreated patients or if Boston docs thought they overtreated. When asked, doctors in both cities claimed to treat patients appropriately.

Which were right? They can't both be.

To answer that question, Wennberg presented his findings at New Haven and Boston medical conferences, but he accidentally-on-purpose switched the data!

He showed the Boston docs that their patients spent 40% less time in the hospital and therefore received less care than New Haven patients, and vice versa, and asked for explanations.

- The Boston docs came up with lots of reasons why the New Haven ones erred by overtreating their patients, admitting too many to hospitals and therefore exposing them to unnecessary treatment risks and financial costs.
- The New Haven docs explained why the Boston ones erred by undertreating their patients, admitting too few to hospitals and therefore exposing them to unnecessary disease risks.

Wennberg then admitted his data mistake and went through the (presumably uncomfortable) analysis of the doctors' faulty reasoning.

The bottom line: though doctors all want to treat appropriately – and claim to - they are often unaware of their own assumptions and treatment patterns.

That's why wise patients always ask our questions and demand answers...

Even from the most experienced doctors who graduated from the most famous medical schools and work at the most prestigious hospitals!

### Summary of Question 3 What We Have Learned So Far

Question 3 builds upon the lessons of Questions 1 and 2.

Question 1 was 'Has it been tested for the outcomes that concern me?' We learned that comparative tests identify the benefits and harms of a medical intervention.

- Importantly, we also learned that medical interventions that have not been subjected to comparative testing are ineffective or harmful about half the time. We called this Prasad's Law.

Question 2 showed how to quantify the benefit and harm impacts. We learned to ask

- Out of 100 people like me, how many benefit? And
- Out of 100 people like me, how many are harmed?

Question 3 moved us out of the laboratory and into the real world. We learned that sometimes beneficial medical interventions are overused. We learned to ask

- Is it overused?

Appropriate answers include 'yes', 'no' and 'I don't know'.

Inappropriate answers include 'we never perform excessive or unnecessary treatments.'

We'll move now to Question 4 'Would most physicians make the same recommendation or might some suggest something different?' This helps you identify your treatment options.

While always important to ask, this question is particularly critical for patients who learn that the answer to Question 3 is 'yes, we sometimes perform this procedure too often'.

#### **Question #4**

**Would most physicians make the same recommendation or might some suggest something different?**

#### **How to get and evaluate a second opinion**

We learned earlier that patients have care options about 85% of the time. Often two or more treatment processes generate the same patient outcomes.

But the treatment processes can involve quite different pain levels, family impacts, recovery periods, costs and other factors.

Researchers have learned that, for the 85% of care that allows for choice, wise and well informed patients may prefer treatments different from that recommended by their doctors.

And two different patients with the same medical problem can choose different treatments and both be right.

Unfortunately, since patients today often delegate decision making to doctors, physician preference rather than patient preference often determines which treatment patients ultimately receive. That's not always such a good thing.

Preference-sensitive decision making among patients with access to good information

Various studies have assessed the impact of patient education on preference-sensitive decision making and have generally arrived at the same conclusion: when provided with good information about both outcomes and processes, patients tend to prefer less invasive and lower risk care.

The general trend is about a 20 – 25% shift.

Coincidentally, less invasive / lower risk care tends to be less expensive.

One 2012 study in Washington State found that patients who went through a thorough treatment comparison process had 26% fewer hip replacement surgeries, 38% fewer knee replacements and cost about 15% less than patients who did not go through the same process.

Other studies have indicated

- 20% fewer stent insertions
- 40% fewer prostate removal surgeries
- 40% fewer spinal fusion surgeries for herniated disks

These studies and others suggest that physicians need to diagnose both the medical condition and the patient to prescribe the appropriate intervention. A classic analysis, Patient Preferences Matter, written by two medical school professors and one business school prof, highlights the impact:

Health care may be the only industry in which giving customers what they really want would save money.

Well-informed patients consume less medicine – and not just a little bit less, but much less.

When doctors accurately diagnose patient preferences, an enormous source of waste – the delivery of unwanted services – is eliminated.

In other words, when doctors assume they know which treatment process a patient wants, they substitute their own preferences for the patient's.

That's not always wise because there's a huge difference between advice giving and advice receiving. The advice recipient may or may not agree with the advice giver.

Here's a list of some potential preference-sensitive considerations that affect physician 'advice givers' differently from patient 'advice receivers'. It's not exhaustive. I didn't include 'success' since it's obviously the most important consideration of both doctors and patients.

| <b>Some physician issues and concerns</b> | <b>Some patient issues and concerns</b> |
|-------------------------------------------|-----------------------------------------|
| Regulations and guidelines                | Pain                                    |
| Fear of lawsuit                           | Recovery period                         |
| Local / regional / hospital norms         | Family impact                           |
| Income                                    | Self image                              |
| Experience with treatment alternatives    | Personal preference (e.g. religious)    |
| Avoid feeling guilty                      | Cost                                    |

The question ‘what would you do if you were me, doc?’ is unfair. The physician-advice-giver can’t remove him or herself entirely from the constraints imposed by that role.

#### How to proceed after getting a second (or even third) opinion

Once you’ve had a second (or third) physician make treatment recommendations, use this chart to compare benefits and harms. Try to fill in as many boxes as possible. Include Treatments C and D as appropriate

|                                        | Treatment A | Treatment B |
|----------------------------------------|-------------|-------------|
| Benefits and harms at intervention     |             |             |
| Benefits and harms over the short term |             |             |
| Benefits and harms over the long term  |             |             |

Each patient can define benefits and harms as those most important to him or her, as well as the short and long term. Typically short term means the first few months and long term 3 – 5 years, though you can modify these definitions as you see fit.

Here are some issues in a hypothetical comparison of surgery and physical therapy for illustration purposes only. You may have different concerns.

First, benefits and harms of the intervention.

| Surgery                                     | Physical therapy                                      |
|---------------------------------------------|-------------------------------------------------------|
| How long will I be hospitalized?            | How many sessions will I need?                        |
| How much pain will I feel and for how long? | How much pain is associated with the therapy process? |
| How much work will I miss?                  | When will I know if the therapy is working?           |
| How long will I be incapacitated?           |                                                       |
| How likely is an infection or complication? |                                                       |

Second, benefits and harms over the short term.

| Surgery                                                                     | Physical therapy                                                 |
|-----------------------------------------------------------------------------|------------------------------------------------------------------|
| How long before I regain my strength and range of motion?                   | How often do patients report satisfaction at 3 and 12 months?    |
| How many patients report satisfaction with the outcomes at 3 and 12 months? | How many patients quit PT and opt for surgery in the short term? |
| How often do patients need a second surgery?                                |                                                                  |

Third, benefits and harms over the long term

| Surgery                                                              | Physical therapy                                                                     |
|----------------------------------------------------------------------|--------------------------------------------------------------------------------------|
| How many patients need a second surgery within 48 months?            | How many patients report satisfaction with the PT outcome at 48 months?              |
| How many patients report satisfaction with the outcome at 48 months? | How many patients who start with PT ultimately end up with surgery within 48 months? |

This comparative process isn't limited to surgery and PT: you can use it to compare any medical interventions, though the specific questions in each box may differ.

Try to format your treatment comparisons this way. It will help you focus on the most critical issues and streamline your decision making process.

Feel free to show a chart like this but with your own questions to your doctor. It may facilitate your discussions.

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Case Study: How John decided on physical therapy for his torn rotator cuff

John, a 69 year old insurance broker, walked up to me in a lecture hall one day with his arms high in the air, smiling and saying 'my shoulder feels fine'.

Odd behavior and greeting in a professional setting. I hadn't seen or talked with him in the previous year or two.

His right shoulder had been so weak, he said, that he couldn't shift gears in his pick-up: he had to reach over the steering wheel with his left hand to shift.

His scans clearly showed a torn right rotator cuff and his orthopedic surgeon recommended surgery. All fairly routine.

But his story then took a surprising turn. I'll quote him:

'I probably would have said yes to surgery prior to hearing your lectures. Instead I asked your questions and decided to try PT first.

I regained 95%+ range of motion without pain in same time period as surgical recovery.

Same outcome as surgery at far lower cost, risk and hassle.'

The key questions:

Out of 100 people like me, how many benefit from, and are harmed by, rotator cuff surgery?

Would most physicians recommend rotator cuff surgery or might some suggest something different?

Interestingly John, a well-educated, knowledgeable, regular attendee at insurance seminars, wouldn't have asked those questions absent specific instruction and a script.

I suspect a similar situation exists for most patients like the Fort Myers back surgery folks and Connecticut mastectomy women we discussed earlier.

They all might have made different choices had they simply been taught to ask the right questions.

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Another patient's experience asking the 'out of 100 people like me' and the 'would most physicians agree' questions.

'Preference-sensitive' applies to physicians too!

A fellow called me with this poignant story one day, completely out of the blue. He had attended a lecture and read my book Transparency Metrics.

I have a good relationship with my cardiologist, so I felt comfortable asking your 'out of 100 people like me' questions. So I did.

He put down his pen, looked at me and said 'no one has ever asked me that. I don't know the answer. Let's figure it out' and he started typing on his computer.

The process of finding answers got me involved and I ended up feeling more comfortable with his treatment recommendations as a result. I feel like I now have an even better working relationship with him than I did before.

I'm also more inclined to comply with his recommendations.

I asked a few questions then he announced 'now I have to tell you about my next experience'.

I asked my dermatologist the same questions including 'would most physicians agree with your recommendation?'

His response: 'you come into my house and ask me those questions? If you don't trust my judgment, I think you should get another dermatologist.'

Different doctors for different patients.

Preference sensitive works for physician choice also.

Choose the doctor whose style and professional demeanor work for you.

#### Summary of Question 4: What We Have Learned So Far

Question 4 builds upon the lessons of Questions 1, 2 and 3.

Question 1 was 'Has it been tested for the outcomes that concern me?' We learned that comparative tests identify the benefits and harms of a medical intervention.

- Importantly, we also learned that medical interventions that have not been subjected to comparative testing are ineffective or harmful about half the time. We called this Prasad's Law.

Question 2 showed how to quantify the benefit and harm impacts. We learned to ask

- Out of 100 people like me, how many benefit? And
- Out of 100 people like me, how many are harmed?

Question 3 moved us out of the laboratory and into the real world. We learned that sometimes beneficial medical interventions are overused and learned to ask

- Is it overused?

The answer helps identify at least one critical reason for asking Question 4 'Would most physicians make the same recommendation or might some suggestion something different?'

There are several additional reasons for posing this question to your physician including:



- It helps you get a second opinion that differs from the first thus exposing you to a range of treatment options.
- It helps you differentiate personal preferences from medical imperatives.

Once you identify the treatment option that you prefer, you'll want to identify the physician and hospital that does it the best. Ask Question 5 'How many patients like me do you treat annually?'

#### Question #5:

#### How Many Patients Like Me Do You Treat Annually?

The more experience a specialist or hospital has treating patients with your medical condition, the better your likely outcomes

Research has identified a pretty strong (but not perfect!) correlation between the volume of similar patients treated by a specialist or hospital and the outcomes for those patients: The higher the volume, the better your chances.

This is not a perfect predictor but it's about the best predictor currently available.

One classic study on the impact of hospital volume on mortality rates was published by Dr. John Birkmeyer of the Dartmouth-Hitchcock Health System and his colleagues. They analyzed the impact of hospital volume on mortality rates for 2.5 million patients who underwent 14 different medical procedures over a 5 year period.

Patients, they concluded, can significantly reduce their operative mortality risk by choosing a high volume hospital. Though the specific mortality rate reduction varied by procedure, Birkmeyer and his colleagues identified a surgical quality gap between high and low volume hospitals.

They concluded three things about this gap:

First, it is large enough to concern patients.

Second, it is consistent across different medical specialties and research studies, and

Third, it makes sense. High volume hospitals, they reason, tend to have more consistent processes for postoperative care, better-staffed intensive care units, and greater resources for dealing with postoperative complications.

Other research pretty strongly supports Birkmeyer's conclusions:

A 2011 study of heart failure patients estimated that 20,000 lives could be saved annually if patients at low volume hospitals switched to high volume hospitals.

A study of bariatric surgery found that hospitals treating more than 100 patients annually had shorter lengths of stay, lower mortality rates and decreased costs. In particular, bariatric surgical mortality rates at low volume hospitals were up to 3x higher than at high volume hospitals for patients over 55 years old.

A 2013 study of high risk patients found those undergoing aortic valve replacement at high volume hospitals enjoyed better outcomes.

Studies of breast cancer treatment, knee surgery and other medical care finds pretty much the same things.

By contrast, studies comparing patient outcomes from newer vs. older technologies, or from academic medical centers vs. other hospitals, do not always find such a gap.

One such newer vs. older technology study found that physicians need to perform 1600 robotic assisted prostate removal surgeries to achieve excellence. Experience with the technology, often more than the technology itself, correlates with quality outcomes.

We find the same thing for surgeons – the higher their volume of a particular type of surgery, the better their outcomes. Dr. Paul Ruggieri summarized the literature on this topic in Chapter 5 of his book *The Cost of Cutting*:

The message is becoming clearer with each published study. High volume surgeons operating out of high volume hospitals give patients the best chance for quality outcomes.

Based on the data, the high volume surgeon part of the equation seems to be the most important factor.

Ruggieri, a surgeon, might be slightly biased.

But Birkmeyer, the Dartmouth physician, agrees with Ruggieri's assessment, concluding that patients can improve their chances of survival substantially, even at high volume hospitals, by choosing high volume surgeons.

### Thresholds

Some organizations publish 'thresholds' or recommendations for the minimum experience a surgeon or hospital needs to achieve excellence. Treating fewer than the threshold number of patients tends to increase mortality rates but treating more doesn't decrease those risks.

The Leapfroggroup, for example, has developed hospital threshold recommendations for several procedures such as

- Coronary artery bypass graft, minimum 450 procedures/year.
- Abdominal aortic aneurysm repair, minimum 50 procedures/year.
- Percutaneous coronary intervention, minimum 400 procedures/year.

Johns Hopkins, Dartmouth-Hitchcock and the University of Michigan go one step further and have developed minimum hospital and surgeon requirements for their affiliated hospitals including

- At least 20 pancreatic cancer surgeries per hospital per year, and at least 5 for each surgeon.
- At least 50 knee or hip replacements per hospital per year, and at least 25 per surgeon.
- At least 10 carotid stent insertions per hospital per year, and at least 5 per surgeon.

John Birkmeyer, the leader of the Dartmouth effort, suggests the impact. If all US hospitals adopted this standard, he says, about half the hospitals that perform many of these procedures would be prohibited from continuing to do them.

Wise patients choose specialists and hospitals working at or above the recommended threshold.

### Why is experience so important?

The common sense answer that 'practice makes perfect' is only part of the reason, and the least important part. Physicians learn the process of cutting, suturing, etc. relatively quickly. Though these mechanical skills may improve slightly over time, this doesn't address the significant mortality reduction evidenced by high volume surgeons and hospitals. Few patients, it seems, die from faulty incisions.

Instead, I suggest that the true benefit of dealing with high volume surgeons and hospitals comes from their ability to identify patients who are 'out of bounds' more quickly and address their problems more appropriately. With volume a surgeon can sense, almost even without testing, that something is wrong.

Without the experience that volume brings, the surgeon is unsure if the patient's blood loss or reactions are within the normal range. This applies at a systemic level to hospitals also: nurses and technicians can develop the same sense from experience.

Atul Gawande wrote insightfully about this process in his article 'The Computer and the Hernia Factory', a study of Shouldice Hernia Hospital in Canada. Shouldice only performs hernia surgeries. Each Shouldice surgeon performs about 700 annually or, over their medical career, perhaps 20,000 similar surgeries. Gawande estimated, in 2002, that Shouldice's hernia surgery failure rate was 'an astonishing 1.0%.' He revised that figure in 2008 to 'closer to 0.1%'.

By comparison, some studies suggest an average 10-year hernia repair failure rate outside of Souldice at around 11%.

With repetition, Gawande found, 'a lot of mental functioning becomes automatic and effortless, as when you drive a car'. This allows experienced practitioners to focus on novel or abnormal situations and essentially ignore all that is normal and routine. A surgeon, he writes, for which most activities become automatic has a significant advantage.

He described a Shouldice operation:

- The surgeon performed each step ‘almost absently’
- The assistant knew ‘precisely which issues to retract’
- The nurse handed over ‘exactly the right instruments; instructions were completely unnecessary’
- The doctor slowed down only once, to check ‘meticulously’ for another hernia. He found one that ‘if it had been missed, would almost certainly have caused a recurrence’

This ‘almost absent attention to routine features’ but intense focus on potential abnormalities comes only from experience. That’s why higher volumes identify better quality surgeons and hospitals.

Just like why more experienced drivers have fewer car accidents!

When you consider hiring a specialist or using a hospital, be sure to ask the volume question. It just may save your life.

### Summary

Let’s review what we’ve learned:

Patients who follow the Goldilocks principle enjoy better outcomes than patients who do not.

- Too little medical care can expose you unnecessarily to disease harms
- Too much medical care can expose you unnecessarily to treatment harms
- Inappropriate medical care can expose you to more risks, higher costs and lower satisfaction than optimal

We introduced 5 questions to ask all doctors about all medical interventions.

- Has it been tested for the outcomes that concern me?
- Out of 100 people like me, how many benefit and are harmed?
- Is it overused?
- Would most physicians make the same recommendation or might some suggest something different?
- How many patients like me do you treat annually?

You can, of course, ask plenty of your own questions too: you may have specific concerns about pain, cost, time off from work, impact on your family, etc.

But I hope you ask the questions listed here. They'll help you differentiate better from poorer care, reduce your chance of receiving unnecessary and non-beneficial care and increase your likelihood of satisfaction with your own medical care.

## **Review Questions**

Answers on next page

1. What is a comparative study?
  - a. A study that compares two very similar groups of people, one of which gets the medical intervention and the other of which does not
  - b. A study that looks at only 1 group of people
  - c. A study that predicts outcomes based on biological theory
  - d. A study that compares the biological and physiological make up of different people
2. What is a well informed patient according to the medical definition of 'well informed'?
  - a. Understanding how well care works, what treatment options exist and which provider generates the best outcomes
  - b. Understanding deductibles, insurance regulations and prices
  - c. Understanding the biological processes in each treatment option
  - d. Someone who reads lots of articles online
3. Which do doctors generally worry about the most?
  - a. Performing too few tests and undertreating patients
  - b. Having patients wait longer in their waiting rooms
  - c. Providing interesting magazines for patients to read
  - d. Performing too many tests and overtreating patients
4. Which is the cheapest?
  - a. Good health
  - b. The lowest cost knee surgeon
  - c. A hospital-based MRI
  - d. A free-standing MRI
5. Which strategy is generally the cheapest after factoring in all costs including patient out-of-pocket, deductibles, insurance premiums, time off of work, productivity losses and rehab expenses?
  - a. Getting the best treatment outcomes
  - b. Getting care from the lowest cost surgeon
  - c. Paying cash for your treatment
  - d. Negotiating the best deal you can with each provider
6. Why would a wise patient ask a physician if a proposed treatment has been subjected to comparative testing?
  - a. Because treatments that have not been subjected to comparative testing are ineffective or harmful about half the time

- b. Because it makes you sound smart to your doctor
- c. Because you want to show your doctor who's really running the meeting
- d. Because you want to waste time before making an important decision

7. What is Prasad's Law?

- a. Medical treatments that have not been subjected to comparative testing are ineffective or harmful about half the time
- b. A hospital room built is a hospital room occupied
- c. The most expensive surgeon is the best
- d. The most expensive hospital generates the best patient outcomes

8. Which benefits more people?

- a. A treatment that prevents heart attacks 3 out of 100 people
- b. A treatment that cuts the heart attack rate by 25%
- c. A treatment that reduces total cholesterol levels by 10 points
- d. We have insufficient information in (a), (b) and (c) above to answer the question

9. Which benefit interests a wise patient the most?

- a. A reduction in heart attacks
- b. A reduction in cholesterol levels
- c. A reduction in blood pressure levels
- d. An improvement in blood oxidation rates

10. This chapter suggests that patients who base their medical decisions on biology, physiology, anatomy and logic – but not comparative studies – are what?

- a. Wrong about as often as they are right
- b. Wise and thoughtful
- c. Using the best possible information
- d. Likely to enjoy the best outcomes

11. As the number of medical services in a community – like MRI machines, vascular surgeons or hospital beds – rises, what tends to happen?

- a. More patients use those services
- b. Fewer patients use those services
- c. Service prices tend to fall
- d. Care quality tends to decline

12. Wise patients sometimes ask if a particular treatment is overused. Which below is an inappropriate answer to that question?

- a. Yes
- b. No

- c. I don't know
- d. I never provide unnecessary care

13. What is a 'preference sensitive' medical decision?

- a. A decision that's right *for you*. Different patients with the same medical condition can choose different treatments and all be right.
- b. A decision that your doctor would prefer that you make, not him or her
- c. Delegating your decisions to your doctor
- d. Delegating your care decisions to your hospital

14. What is the general trend among patients who explore their treatment options?

- a. They tend to choose less risky, less invasive and consequently less expensive care by about 25 – 30%
- b. They get confused
- c. They ultimately do what their doctor tells them to do
- d. They cost the most

15. What is the main purpose of second opinions?

- a. Expose patients to a range of treatment alternatives
- b. Waste time
- c. Increase physician billing opportunities
- d. Confuse patients

16. Which surgeon generally generates the best patient outcomes?

- a. The surgeon who does a specific type of surgery most frequently
- b. The surgeon who graduated from the most prestigious medical school
- c. The surgeon who charges the most
- d. The surgeon who uses the newest technology



## Review Questions

Correct answers in bold

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## Price transparency and CDH Plans

Dr. Clifton Meador, former dean of the University of Alabama Medical School, issued this caution about the role of financing and prices in American medicine: (references available offline)

Solutions to the high costs of medical care are almost exclusively financial or payment based [but] the underlying causes are based on misdirected clinical and diagnostic thinking

In other words, Meador cautions us about using financial tools like price lists to address clinical problems.

Dr. Andy Lazris, geriatrician and author of Curing Medicare, agrees, decrying our medical care system that

pushes the most aggressive care, often despite a paucity of evidence to support that approach ...as little as 15% of what doctors do is backed up by valid evidence

Prices can vary dramatically for the same service throughout our healthcare system. 'Transparency' means 'making prices public so people can choose the most economical alternative'. Some say this increases systemic value.

I'm not so sure.

### Some pricing examples

Here are some graphic examples of price differences within a relatively small geographic region for the same services. These prices come from the New Hampshire medical price website, nhhealthcost.org, downloaded in 2013 for arthroscopic knee surgery. I chose this website because it was public and easy to use.

| <u>Facility</u>                   | <u>Total Cost</u> |
|-----------------------------------|-------------------|
| Concord Ambulatory Surgery Center | \$3,431           |
| Franklin Regional Hospital        | \$5,118           |
| Cheshire Medical Center           | \$6,644           |
| Parkland Medical Center           | \$7,717           |
| Weeks Medical Center              | \$9,873           |

Pretty wide variation for the same service. Here are some prices for a pelvic MRI, same website.

| <u>Facility</u>              | <u>Total Cost</u> |
|------------------------------|-------------------|
| Derry Imaging Center         | \$1,486           |
| St Joseph Hospital           | \$2,574           |
| Exeter Hospital              | \$2,758           |
| Speare Memorial Hospital     | \$3,381           |
| Monadnock Community Hospital | \$3,868           |

Impressive differences. The same situation occurs for dozens of tests and treatments throughout our healthcare system.

### **Why prices matter (a lot)**

Paying too much for a test, medication or treatment directly affects two groups of people: individuals / families with high deductible health plans and self insured companies. Both, in an economic sense, function the same way – they spend their own money on medical care. Each dollar saved drops directly to their own bottom line.

Paying too much indirectly affects us all by raising overall costs and therefore health insurance premiums.

Thus, the argument goes, considering price generates benefits for us both individually and collectively.

### **Why prices don't matter (much)**

Prices do not tell us

- If we will benefit from the medical care
- If we will be harmed by the medical care
- If we use excellent, average or mediocre providers and treatments.

In short, shopping for medical care primarily based on price can lead patients to cheaper unnecessary or poor quality medical care. And, since it's cheaper, perhaps to *more* unnecessary or poor quality care.

### **How much unnecessary and poor quality care exists in the US?**

The standard estimate of unnecessary care quantity in our healthcare system today is about 1/3. That comes from the Dartmouth Atlas of Healthcare and is based on the amount of geographic treatment variation identified by studying Medicare intensity levels by geographic region. Some regions routinely provide more care to residents while others routinely provide less. The Dartmouth researchers added up all the differences and concluded that the variation equaled about 1/3 of all medical spending.

With our total healthcare expenditures approaching \$3 trillion annually, this '1/3' estimate accounts for about \$700 billion annually and perhaps as much as \$900 billion. Aetna claims the actual amount is at least \$765 billion.

**But I think this a low estimate**, and perhaps a very low one based on two analyses that we'll discuss in some detail later in this chapter.

- First, Dr. Vinay Prasad and his team from the National Cancer Institute and National Institutes of Health, in a very rigorous, detailed study, estimated that about half of all established treatments are ineffective or harmful.<sup>188</sup>

If we cut geographic 'low intensity' utilization rates by about half to account for Prasad's findings, **we might double the Dartmouth waste estimate to \$1.5 trillion or more**...potentially well over half of all medical spending.

- Second, Dr. Al Mulley and his team from Dartmouth Medical School estimated the potential systemic savings from incorporating patient preferences into treatment designs at about 20%.<sup>189</sup> Mulley's insight, along with others who have studied the same phenomenon, was that patients who understood their options tended to choose less medical care – both a lower number of procedures and less intense / aggressive / expensive ones.

If we cut geographic 'low intensity' utilization rates by 20% to account for Mulley's findings, **we increase the Dartmouth waste estimate to about 40% of all medical spending**.

Add the Prasad and Mulley numbers to Dartmouth's original waste estimate and you get a very large number. I think a perfectly reasonable, even conservative estimate is 40% of all medical spending.

But I won't argue with higher estimates.

### **Overestimating treatment benefits**

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<sup>188</sup> Prasad, A decade of reversal, Mayo Clinic Proceedings, August 2013

<sup>189</sup> Mulley, Patient Preferences Matter, The King's Fund, 2012  
[http://www.kingsfund.org.uk/sites/files/kf/field/field\\_publication\\_file/patients-preferences-matter-may-2012.pdf](http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/patients-preferences-matter-may-2012.pdf)

Patients typically overestimate the benefits of medical care and underestimate the risks. Sometimes they think all the tests, drugs and treatments are crucial to maintaining their health. Other times they discount the risk and side effect warnings. Still other times they think the care quality is all equally good from all providers.

In general, patients seem to think that medical care is always – or, at least *almost* always - beneficial and necessary.

But patients often miss on their benefit estimates and overstate them by quite a bit. One study, for example, found that women without the BRCA genetic mutation overestimated their cancer risk reduction benefit from prophylactic bilateral (double) mastectomy 4 fold or more.<sup>190</sup>

- The average estimated risk reduction was 65%. Most women in the study group estimated their chance of developing breast cancer *without* surgery at 76%, and their chance of still developing breast cancer *with* the double mastectomy at 11%.
- Meanwhile, the real risk of developing breast cancer without surgery was 17%. Whatever the prophylactic mastectomy benefits, they were no greater than 17%, far less than the estimated 65% risk reduction anticipated by most patients.

Another study found that 80% of patients overestimated the benefit of hip fracture prevention medications, 90% overestimated the benefits of breast cancer screening and 94% the benefits of bowel cancer screening.

Clifton Leaf, assistant managing editor of Fortune magazine, makes pretty much the same point in his upsettingly insightful analysis of the war on cancer, *The Truth in Small Doses*. Most patients seem to believe that ‘the newest cancer fighting drug, or at least the next one after this one, will certainly provide terrific treatment benefits, so I have to have it.’

Unfortunately, as Leaf shows in almost excruciating detail, those apparent benefits are often illusory or statistical manipulations. Take our war on breast cancer, for example, and consider all the ‘newest and greatest’ drugs developed since 1970, then see the impact on both our actual number of female breast cancer deaths and our national breast cancer death rate per 100,000 women:<sup>191</sup>

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<sup>190</sup> These examples come from *If Patients Only Knew How Often Treatments Could Harm Them*, Austin Frakt, New York Times, March 2, 2015. Frakt summarizes 30+ studies of patient expectations of medical care benefits, based largely on *Patient’s Expectations of the Benefits and Harms of Treatments, Screening and Tests* by Hoffman and Del Mar, JAMA Internal Medicine, Feb 2015

<sup>191</sup> Leaf, *The Truth in Small Doses*, page 127. Data from the National Center for Health Statistics (CDC) and National Vital Statistics System

| Year | Actual Number of Breast Cancer Deaths | Crude Breast Cancer Death Rate (deaths per 100,000 women) |
|------|---------------------------------------|-----------------------------------------------------------|
| 1970 | 29,652                                | 28.4                                                      |
| 1975 | 32,158                                | 29.4                                                      |
| 1980 | 35,641                                | 30.6                                                      |
| 1985 | 40,093                                | 32.8                                                      |
| 1990 | 43,391                                | 34.0                                                      |
| 1995 | 43,844                                | 32.2                                                      |
| 2000 | 41,872                                | 29.2                                                      |
| 2005 | 41,116                                | 27.3                                                      |
| 2010 | 40,996                                | 26.1                                                      |

I did my own 'back of the envelope' analysis of breast cancer mortality gains over the past 20 or so years and found equally unimpressive improvements. I learned that from the mid-1990s to 2006 our national age of breast cancer death remained the same: 68, despite improved technologies, treatments, access and more widespread screening.

|                                         | Mid-1990s         | 2010 <sup>192</sup> |
|-----------------------------------------|-------------------|---------------------|
| Average age of breast cancer diagnosis  | 62 <sup>193</sup> | 61                  |
| Average age of breast cancer death      | 68 <sup>194</sup> | 68                  |
| Number of survival years post-diagnosis | 6                 | 7                   |

<sup>192</sup> 2006 data from National Cancer Inst, SEER Stat Fact Sheet: Breast downloaded Oct 2012

<sup>193</sup> Glockler, Cancer survival and incidence, The Oncologist, Dec 2003

<sup>194</sup> Saenz, Trends in Breast Cancer Mortality, Population Reference Bureau, Dec 2009



My concern: frightened patients may, under the influence of myth, ads, hope or hype, make unwise medical care choices, 'unwise' in the sense that the care probably won't benefit them much and may harm them some. But they may justify their choices based on relative prices: 'it cost \$5,000 from Supplier A and only \$1,000 from Supplier B. I'll give it a try. Saves me / my employer / my HSA \$4,000!'

Would they have 'given it a try' for \$5000?

We often think, as behavioral economists like to point out, in relative, not absolute terms. That \$4,000 savings seems pretty good, a motivation to buy. That's why so many consumer products advertise '\$500 off this weekend only' without telling the actual price. It's a good deal *relatively*, perhaps especially appealing to scared patient consumers.

That's why I find studies that indicate patients would opt for less, or at least very different care if they had better information about the likely benefits and harms, critically important.<sup>195</sup>

With these types of benefit overestimates and harm underestimates in mind, I'd like to propose a 4-Step Decision Making paradigm.<sup>196</sup> I suggest that patients who follow this process will make better medical decisions, end up more satisfied with their outcomes and save some money along the way.

Perhaps quite a bit of money.

### **How to make a wise medical decision**

I suggest that wise patients use the following decision criteria when considering and accessing medical care. Price considerations are 4<sup>th</sup> on this list of 4, meaning they're relevant but that other factors are far more important.

**First** decide if medical care will help you. You can learn this from comparative studies of patient outcomes.

Care may not benefit you for a two main reasons.

- You may not be 'sick' even though some indicator or other shows you to be 'at risk'. Our sickness indicators change overtime, with some becoming more expansive and others more restrictive. Someone, for example, with blood sugar of 130 mg/dl was 'not sick' prior to 1997 but 'was sick' after, when a new threshold definition was adopted.

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<sup>195</sup> Frakt, op cit

<sup>196</sup> This is the 2<sup>nd</sup> or 3<sup>rd</sup> time I discuss this in this book. My excuse: seems like a pretty worthwhile approach to medical decision making. Hope repetition serves to reinforce the message rather than bore readers.

Similarly, a 65 year old with blood pressure of 145/90 'was sick' prior to new definitions adopted in 2013, but was 'not sick' after.<sup>197</sup>

As a general rule, medical care cannot improve your health if you're not sick.

- You may be sick but treatments may not work. We learn from comparative studies which treatments work most of the time, which some of the time and which infrequently.

Sometimes simply waiting for the 'sickness' to heal itself is the best strategy. This seems the case for pediatric ear aches - the NNT of antibiotics to reduce pain caused by Otitis Media in the first 7 days is 20, for example<sup>198</sup> - and most back pain. ChoosingWisely states that 'back-pain sufferers who had an MRI in the first month were eight times more likely to have surgery, and had a five-fold increase in medical expenses—but didn't recover faster.'<sup>199</sup>

In your own case, unfortunately even if you're sick, medical care may not be able to help you.

Once you determine that medical care can help you - *if* that's what you determine and *if* you determine that it can help you *enough* - then **second**, decide which care *process* you prefer. You almost always have options: mastectomy or lumpectomy for early stage breast cancer, spinal fusion surgery or physical therapy for back pain, acupuncture or injections for a sore shoulder and many others.

- The various options sometimes (often?) generate similar outcomes though the treatment, risk and recovery processes may differ significantly.
- There's often no one 'right' answer for everyone, only 'right' answers for each individual

Once you decide which process you prefer, then, **third**, determine which medical provider gets the best outcomes.

- One spinal surgeon, for example, may generate far better patient outcomes than another so, if you've already decided you prefer spinal fusion surgery to physical therapy, choose the better surgeon. Ditto for hospitals.
- A good indicator of likely outcomes is the annual volume of patients like you that each physician and hospital treats. Though this is not foolproof – far from it, in

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<sup>197</sup> <http://www.webmd.com/hypertension-high-blood-pressure/news/20131218/new-blood-pressure-guidelines-raise-the-bar-for-taking-medications>

<sup>198</sup> See Otitis Media evaluation on [www.TheNNT.com](http://www.TheNNT.com)

<sup>199</sup> Imaging tests for low back pain on [www.ChoosingWisely.org](http://www.ChoosingWisely.org)

fact – it's about the best indicator we currently have to predict likely patient outcomes.

Finally, **fourth**, *after* you determine that medical care can benefit you, and *after* you decide which treatment process you prefer, and *after* you decide which provider gets the best results for patients like you, consider prices.

- You may find that two equally good providers charge different prices for your preferred treatment process. In that case and ***only in that case***, the wise patient chooses the low cost provider.

Be sure to follow these steps in order and rigorously. That will ensure you get the best outcomes, from the process you prefer, at the lowest cost. Don't short circuit this decision tree or you risk getting sub-optimal outcomes, from a process you really don't like, from a provider who's not very good and perhaps overpaying along the way.

### **Why this decision making process is so important Part 1**

#### **The story and legacy of J. Alison Glover: physicians rely on hunches too much**

Dr. Glover was a British physician and researcher, perhaps the first to identify the role that physician 'hunches' had in medical care. Glover studied tonsillectomy procedure rates and impacts in the 1920s – 30s.<sup>200</sup> He learned that in Scotland between 1931 and 1935, 60 people died from enlarged tonsils and 513 from tonsil removal including 369 children under 15 years old.

- In this case, even though people were sick, the available medical care couldn't help them much.
- Had they applied Step 1 above, many would have opted against having tonsillectomies and, perhaps, lived as a result.
- Had they applied Step 4 only, the dismal results would have been the same, but some people would have saved money in the process, a Pyrrhic victory if ever there was one.

The US healthcare system, during the same years, was expanding its rate of tonsillectomies in children. Knowing the Scottish experience, however, the Americans tried a different approach, radiation to treat tonsillitis between the 1930s and 50s. This was both unnecessary and ubiquitous, according to the Chicago Tribune's 2004 analysis.<sup>201</sup> The treatments led to increases in thyroid, salivary gland and jaw cancer.

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<sup>200</sup> See In pursuit of the Glover phenomenon <http://the-141.blogspot.com/2012/05/in-pursuit-of-glover-phenomenon-what.html> and John Wennberg A debt of gratitude to J. Alison Glover <http://ije.oxfordjournals.org/content/37/1/26.long>

<sup>201</sup> Goldman, Radiation Babies, Chicago Tribune, Nov 14, 2004

- Patients rigorously using our 4-step process above would, again, have learned in Step 1 that medical care would possibly generate more harm than good.
- They may also have determined in Step 1 that they really were not sick. As such, medical treatments could not make them ‘better’. See below.
- They might also have determined, in Step 2, that tonsillectomies were less risky than radiation.

Glover hypothesized that physician preferences, rather than patient need, drove tonsillectomy rates. He tested this hypothesis by reviewing tonsillectomy rates at the Hornsey Borough School in north London, in the late 1920s.

British children in those days got their medical care through the local school with the school physician acting, more or less, like a Primary Care Physician does today in the US, while sometimes even performing surgeries like an American specialist would. As such it was the school’s responsibility to diagnose and treat tonsillitis, along with lots of other illnesses.

Glover found that in 1928, an unnamed Hornsey school physician performed 186 tonsillectomies. A new doctor named Garrow arrived in 1929 and the number of tonsillectomies fell to 12.

- The average number of tonsillectomies per year from the previous physician, 1921 – 1928: 169
- The average number of tonsillectomies per year after Garrow took over, 1929 – 1933: 13
- The percent of apparently unnecessary tonsillectomies between 1921 and 1928: about 92%.

Glover identified no outcome differences or population changes during this time. It appeared, though, that some 156 children received unnecessary tonsillectomies annually from the previous doctor. They were not, in our terms, ‘sick’.

- Again, to tie this back to our price transparency discussion, wise Hornsey parents would have determined whether or not tonsillectomies provided benefit first and then considered price (if that was a factor in 1929 Britain. I’m not sure it was.)
- Unwise parents would have assumed something about the procedure benefits then jumped to our Step 4 and compared prices from available providers.

OK, one might say. The Hornsey situation happened a long time ago, in a country far away. It doesn’t apply to American medicine today.

### **John Wennberg follows in Glover’s footsteps**

Wennberg, then a young researcher at Dartmouth Medical School, built on Glover's ideas and tracked tonsillectomy rates in Vermont in the 1970s. He found exactly the same thing as Glover did in Hornsey:

- 7% of children under age 16 had tonsillectomies in Middlebury Vermont, while
- 70% did in Morrisville, despite these two communities being demographically similar.

Wennberg identified a similar treatment variation rate when comparing Waterbury Vermont to next door Stowe, again two socio-economically and demographically similar towns (among the full time residents though not necessarily the ski vacationers who didn't generally have tonsillectomies there anyhow).

Parents choosing the cheapest tonsillectomy provider in Morrisville or Stowe would have received less expensive though still unnecessary care about 80% of the time. Not a vast improvement over the 92% unnecessary rate discovered by Glover in Hornsey, years before.

'Too long ago' you still might say. 'My doctor uses the most up-to-date technology, so this wouldn't happen to me. Those Vermont studies are 50 years old.'

In 2013, Wennberg, now an elderly senior researcher and his colleagues at Dartmouth published a tonsillectomy rate analysis among kids in Northern New England during the period 2007 – 2010. Here's what they found in each Pediatric Surgery Area, per 1000 children:

| <b>Rates per 1000 children by Pediatric Surgery Area</b> |             | <b>Surveys of New Hampshire, Vermont and Maine by Dartmouth affiliated researchers</b> |            |
|----------------------------------------------------------|-------------|----------------------------------------------------------------------------------------|------------|
| Middlebury, Vt                                           | <b>5.6</b>  | Burlington, Vt                                                                         | <b>2.9</b> |
| Berlin, NH                                               | <b>10.4</b> | Lewiston, Maine                                                                        | <b>5.2</b> |
| York, Maine                                              | <b>7.3</b>  | Portland, Maine                                                                        | <b>4.0</b> |
| Presque Isle, Maine                                      | <b>5.8</b>  | Bangor, Maine                                                                          | <b>2.7</b> |
| Dover, NH                                                | <b>8.1</b>  | Waterville, Maine                                                                      | <b>3.6</b> |
| Manchester, NH                                           | <b>8.1</b>  | Ellsworth, Maine                                                                       | <b>3.8</b> |
| Exeter, NH                                               | <b>8.4</b>  |                                                                                        |            |

The average rate in Burlington Vermont and Bangor Maine was about 3 tonsillectomies per 1000 children while the average rate throughout New Hampshire was about 9, a 3-fold rate difference. The unnecessary tonsillectomy rate in New Hampshire between 2007 and 2010: about 68%, better than Glover's Hornsey example 80 years before but still awfully high.

The Dartmouth researchers could not identify population health differences that explained this treatment rate difference, just as Glover had been unable to in Hornsey. Nor could they identify population health gains from the excessive tonsillectomies.

Throughout this story, the treatment rate differences appear due to physician preferences, not patient need.

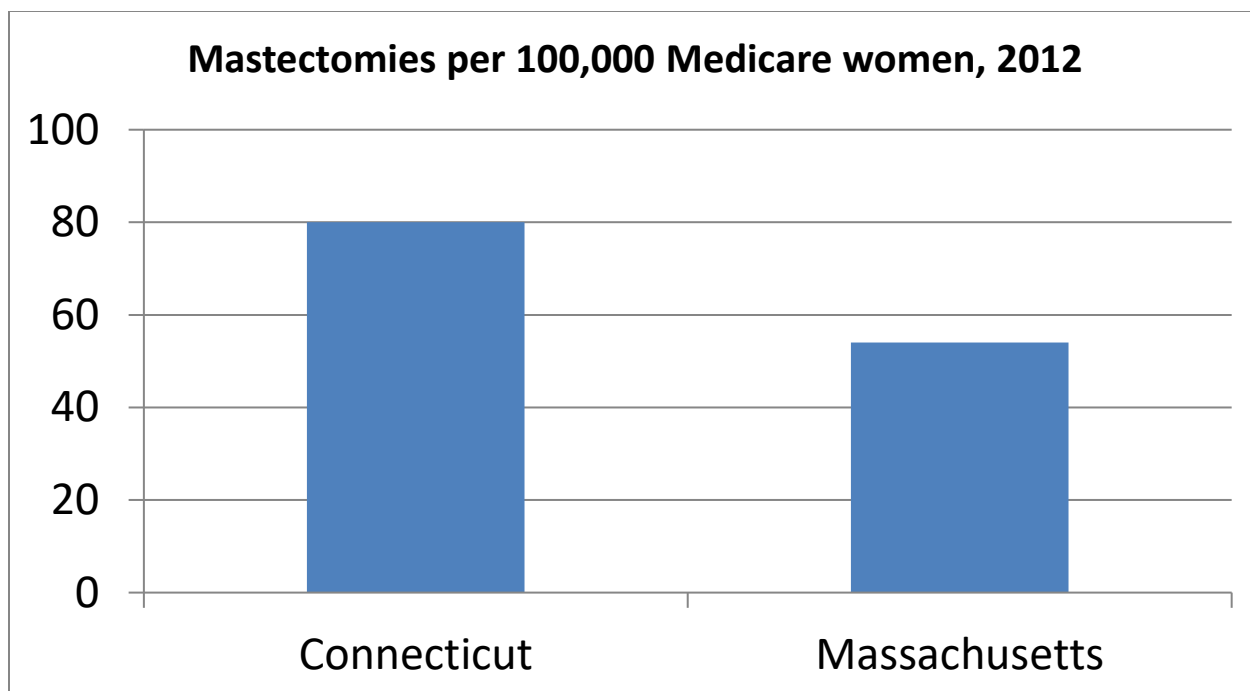
- The appropriate mechanism to avoid unnecessary care remains consumer education and use of our 4-Step Program, not price lists and not google searches.
- Parents choosing the cheapest tonsillectomy providers in New Hampshire would have received less expensive unnecessary care for their children 2/3 of the time...just like the parents in Stowe or Morrisville 50 years earlier or Hornsey 80 years before. Not much systemic evolution over the years.

Physicians appear, according to Wennberg, to rely on 'hunches' too often, rather than data and scientific outcome evidence from comparative studies when making treatment recommendations to patients, just as they did in Hornsey and Morrisville many years before.

But perhaps the most shocking treatment variation example comes in the mastectomy rate differences among Massachusetts and Connecticut Medicare beneficiaries. Note that both Massachusetts and Connecticut patients have access to outstanding medical care in facilities affiliated with Harvard and Yale medical schools respectively. It just doesn't get any better than that!

I say 'most shocking' because in this breast cancer treatment case we have disease incidence rates, disease treatment rates and patient outcome rates. This puts to bed the 'population difference' justification for treatment variation rates.

Here's a chart showing mastectomy rates in both Massachusetts and Connecticut, per 100,000 Medicare beneficiaries, from the Dartmouth Atlas of Healthcare, 2012.



Connecticut women are about 50% more likely to have mastectomies than Massachusetts women.

This raises the ‘sickness’ question: are Connecticut women sicker than Massachusetts women? Do they get breast cancer 50% more frequently?

The answer is no, according to breast cancer incidence rate data from the American Cancer Society.<sup>202</sup> The breast cancer rates are virtually identical.

**Breast cancer incidence rates per 100,000 women**

|               | Non Hispanic White | African American | Hispanic |
|---------------|--------------------|------------------|----------|
| Connecticut   | 139                | 113              | 127      |
| Massachusetts | 137                | 109              | 104      |

Now, if women in both states were equally sick but received different treatments, did Connecticut women benefit from the additional mastectomies?

Again the answer is no. Breast cancer mortality rates are almost identical in both states.<sup>203</sup>

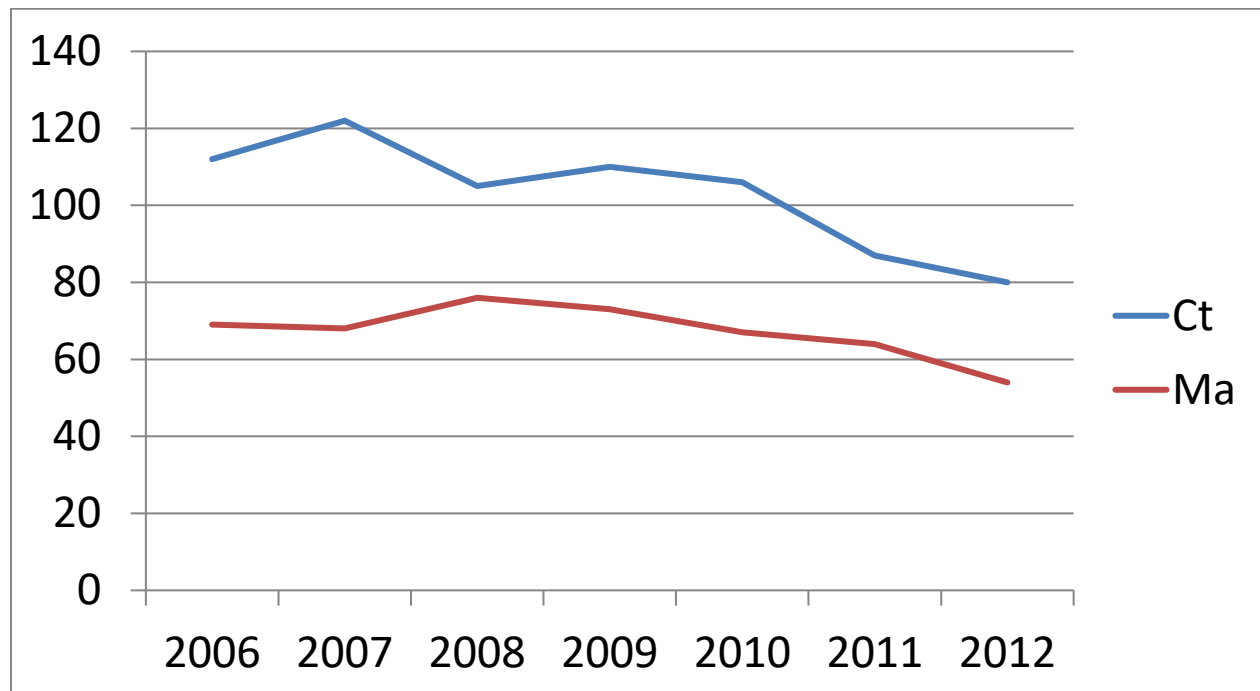
<sup>202</sup> American Cancer Society, Cancer Facts and Figures, 2011-2012

<sup>203</sup> <http://www.cancer.org/acs/groups/content/@epidemiologysurveillance/documents/document/acspc-030975.pdf>

### Breast cancer mortality rates per 100,000 women

|               | Non-Hispanic White | African American | Hispanic |
|---------------|--------------------|------------------|----------|
| Connecticut   | 24.0               | 27.4             | 12.1     |
| Massachusetts | 23.5               | 27.3             | 12.1     |

This treatment variation situation has existed for years. Connecticut always has more, per thousand women. Here are the rates from 2005 – 2012, again using data from the Dartmouth Atlas:



That 50% more in Connecticut rate has existed for many years.

If the additional mastectomies Connecticut women received over time had any benefit, then we would see breast cancer mortality rate differences that approximate the treatment differences. That is not the case.

Rate discrepancies like these exist for dozens of medical tests and treatments.

These situations – tonsillectomy rates in Vermont in the 1970s and northern New England from 2007 – 2010, and mastectomy rates in Massachusetts and Connecticut in the 2000s – are exactly the same as Glover identified in Hornsey in the late 1920s.

- Knowing treatment prices would no more help a Connecticut women in 2010 avoid an unnecessary mastectomy – or a Scot in the 1920s avoid dying from a



botched procedure or an American in the 1940s avoid radiation-induced thyroid cancer - than a Hornsey child in 1928 avoid an unnecessary tonsillectomy.

- Most likely, price transparency would only have helped that Hornsey child or Connecticut women get cheaper unnecessary care.

An underlying cause of this problem, according to many who have studied it: physicians like to use the newest available technology <sup>204</sup> and patients generally believe that more medical care is better medical care. Wennberg put it this way: <sup>205</sup>

- Few surgeons are hesitant believers in the efficacy of the operations they perform, nor do they doubt their clinical necessity.
- Most patients are convinced that the benefits of surgery exceed the risks by a wide margin.

Yet, as we have just seen, these two certainties do not add up to patient benefit as often as either doctors or patients would like. Knowing prices adds nothing to the patient's chance of benefit.

### **Why this decision making process is so important Part 2**

#### **The impact of Vinay Prasad's research:**

**half of established medical interventions are found to be useless or harmful when subjected to comparative studies**

Dr. Prasad, Senior Fellow at the National Cancer Institute and National Institutes of Health, was lead author in an extraordinary, though little discussed, study published in the Mayo Clinic Proceedings in 2013, *A Decade of Reversal*. <sup>206</sup> Prasad and his team reviewed every article published in the New England Journal of Medicine between 2001 and 2010 and found that 363 studied an 'established' medical practice, meaning a commonly used medical protocol.

Of those, 146 studies or 40% reversed the practice.

In other words, 40% of comparative studies on existing, established, routine medical practices showed those practices were ineffective or harmful. The actual percentage is probably closer to 50% being ineffective or harmful when Prasad's 'inconclusive' group, 139 practices or 22% is included.

Stated differently, about half of what doctors do doesn't work. As Prasad told the New York Times

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<sup>204</sup> See Dr. Lazris's comment at the beginning of this chapter.

<sup>205</sup> <http://ije.oxfordjournals.org/content/37/1/26.long>

<sup>206</sup> <http://www.mayoclinicproceedings.org/article/S0025-6196%2813%2900405-9/abstract>

They all sound good if you talk about the mechanisms... the nuts and bolts, what does it do, how does it work....but the real question is: Does it work? <sup>207</sup>

Or, as he said in his fascinating You Tube summary: <sup>208</sup>

Of all those things we're doing currently that lack good evidence, probably about half of them are incorrect.

Patients who are embarking on procedures, screening tests, diagnostic tests should really try to ascertain whether or not those are based on good evidence. By good evidence, I mean randomized controlled trials powered for hard endpoints such as mortality or morbidity and not surrogate endpoints.

Consequences of medical reversal are quite dire. All the people who were subject to the intervention during the years it fell in favor... in retrospect, we realize, received no benefits

These are practices that should never have been instituted, that were instituted in error...even for things that make perfect sense.

The take away message from our paper is that a large proportion of medical practices which are based on little to no evidence are probably incorrect. Their continued use jeopardizes patient health and wastes limited healthcare resources.

Remember Prasad's definition of *evidence*: randomized controlled studies powered for hard endpoints, not biological, anatomical or physiological explanations of why some intervention makes sense. Wise patients discuss outcome evidence with their doctors; unwise discuss anatomy and physiology. Prasad clearly explains why the latter approach doesn't work.

Here are some of Prasad's examples of medical reversals. You can find the entire list on the Mayo Clinic Proceeding website. As you review this list, ask yourself if you would like to have the *cheapest* of the reversed procedure or test. My guess: you don't want it at all, regardless the price.

I tried to choose relatively non-technical discussions. Many of Prasad's 146 reversals are very technical, specialized interventions and his discussions are often aimed at a medically trained audience.

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<sup>207</sup> <http://well.blogs.nytimes.com/2013/07/26/medical-procedures-may-be-useless-or-worse/>

<sup>208</sup> <https://www.youtube.com/watch?v=fB1qEoDO2nE>

|                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Intensive Blood Glucose Control and Vascular Outcomes in Patient with Type 2 Diabetes                            | A target A1C of 7.0% or less was the guideline for most patients with diabetes. However data were inconsistent how glucose control played a role in vascular disease. In the Action in Diabetes and Vascular Disease (ADVANCE) trial, the effects of glucose control on major vascular outcomes were evaluated. There was no evidence of reduction in macrovascular events and intensive glucose control was associated with increased risk of severe hypoglycemia and increased rate of hospitalization.                                                                                            |
| A Randomized Trial of Arthroscopic Surgery for Osteoarthritis of the Knee                                        | Arthroscopic surgery is widely used for osteoarthritis of the knee even in the face of scant evidence of its efficacy. This failed to show a benefit of arthroscopic surgery for treatment of osteoarthritis of the knee as assessed by WOMAC scores                                                                                                                                                                                                                                                                                                                                                 |
| Effects of Combination Lipid Therapy in Type 2 Diabetes Mellitus                                                 | Fibrate therapy has long been used in the treatment of dyslipidemia in type II diabetes. Though statins are considered primary therapy to reduce the risk of cardiovascular events, rates remain elevated despite use. Two large previous studies of fibrate therapy in type II diabetics conflicted with regard to their effect on cardiovascular events. The Action to Control Cardiovascular Risk in Diabetes (ACCORD) Lipid study demonstrated here that statin and fibrate combination therapy did not differ in outcomes compared with statin therapy alone at similar levels of serum lipids. |
| Two Controlled Trials of Antibiotic Treatment in Patients with Persistent Symptoms and a History of Lyme Disease | Many patients with persistent symptoms of Lyme disease receive prolonged courses of antibiotics, although the effectiveness of this practice remains unknown. This randomized, placebo-controlled, double-blinded trial failed to show any significant improvement in                                                                                                                                                                                                                                                                                                                                |

|                                                                  |                                                                                                                                                                                                                                                                                                                                                                                      |
|------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                  | symptoms after a prolonged 90- day course of antibiotics in patients with persistent symptoms.                                                                                                                                                                                                                                                                                       |
| Calcium plus Vitamin D Supplementation and the Risk of Fractures | Observational evidence and data from randomized clinical trials suggested that calcium or vitamin D supplements or both may slow bone loss and reduce the risk of falls. However, in this randomized clinical trial involving 36,000 postmenopausal women, calcium with vitamin D supplementation did not significantly reduce hip fracture, and increased the risk of kidney stones |

Consider our mastectomy data from Connecticut and Massachusetts above. Rates are down in both states, more dramatically in Connecticut, even though Medicare enrollment is up. Does this mean 20 or 30% of the Connecticut mastectomies performed in 2006 – 2010 (and earlier – I didn't include those data to keep the above chart easy-to-read) were performed in error (Prasad's term)?

That's in addition to the rate discrepancy between Connecticut and Massachusetts.

### **Why this decision making process is so important Part 3**

**Al Mulley and the problem of patient preference misdiagnosis:  
well informed patients often prefer treatments that differ from what their doctor  
thought they would want**

Dr. Albert Mulley and his team from Dartmouth's Geisel School of Medicine evaluated the phenomenon and impact of physician attempts to diagnoses patient treatment preferences.<sup>209</sup> Patients who learn of all their treatment options, it turns out, often choose very differently from their physicians, or indeed, from what their physicians would expect them to choose.

Mulley summarizes his conclusion this way:

Well-informed patients consume less medicine – and not just a little bit less, but much less. When doctors accurately diagnose patient preferences, an enormous source of waste – the delivery of unwanted services – is eliminated. It is particularly notable that when doctors accurately diagnose the preferences of patients struggling with long-term conditions, those patients are far more likely to

<sup>209</sup> [http://www.kingsfund.org.uk/sites/files/kf/field/field\\_publication\\_file/patients-preferences-matter-may-2012.pdf](http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/patients-preferences-matter-may-2012.pdf) . See especially page 9, source of quote in the next paragraph

keep their conditions under control, leading to fewer hospitalizations and emergency department visits.

But rushed doctors treat as *they think* the patient wants. This ‘silent misdiagnosis’ harms both patients and the system:

- It harms patients by providing care to them that they would not have chosen had they been better informed. Patients, according to Mulley, can suffer just as much from a missed *preference* diagnosis as from a missed *medical* one.
- It harms the entire system when doctors select more aggressive, invasive and expensive treatments than the patients themselves would, thus increasing overall costs. ‘Patients choose fewer treatments when fully informed’ according to Mulley, a conclusion reached in other studies.<sup>210</sup>

This echoes Wennberg’s suggestion above about specialist enthusiasm for surgery and Lazris’s about the system promoting the more aggressive care far too often.

Mulley estimated the overall system savings from better patient preference diagnoses at 15 – 20%, but this comes with a huge caveat. He and his team evaluated the impact of improved patient preference diagnosis in the Britain’s National Health Service. The UK averages spending less than half per capita on healthcare as we do, about \$3,400 per person compared to over \$9,000 per American. The potential savings for our healthcare system is enormous, possibly well over that 20% estimate.

Dr. Sandeep Jauhar, cardiologist and author of ‘Doctored’ agrees with Mulley’s thesis, suggesting that healthcare reforms

will have to focus less on payment models and more on education...better-informed patients might be the most potent restraint on overutilization ...Shared decision making would be more likely to get patients the treatments they want [while helping them avoid unnecessary or inappropriate care]

Adding to this whole line of thinking, Atul Gawande, one of the key thought-leaders in this field, suggests a new role for doctors that builds on Glover, Wennberg, Prasad, Mulley and Jauhar’s thinking:

**the ideal modern doctor should be neither paternalistic nor informative but rather interpretive, helping patients determine their priorities and achieve them**<sup>211</sup>

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<sup>210</sup> See the Dartmouth Atlas of Healthcare, sections on Preference-Sensitive Care and Reflections on Variation

<sup>211</sup> Sheri Fink, New York Times Book Review of Gawande’s Being Mortal, November 6, 2014

I think this is a brilliant summary of the doctor's role. But it takes time to 'help patients determine their priorities and achieve them'; it's not a role one can play in a time compressed environment.

### **What this means for price transparency**

Step 1 of our 4 step 'how to make a wise medical care decision' really matters. This step, in case you forgot, is 'determine that medical care can benefit you'.

That, I think, is where our medical care system should point patients first. Prices are where our medical care system should point patients last.

Dr. Andy Lazris summarizes the problem nicely:

an idea has blossomed within our medical thinking that equates aggressive, specialized care with good care ... with enough perseverance, our healthcare delivery system is capable of virtually anything...the perception that science and technology can cure everything ...[but] as little as 15% of what doctors do is backed up by valid evidence ... [instead] technology is king

the public – from patients and their families to doctors and experts and politicians and journalists – perceive that more is better <sup>212</sup>

Knowing prices does nothing to fix this problem.

When I think of the various healthcare problems we face, and of price transparency as the solution, I am reminded of a quote I heard at a convention some years ago – sorry, can't remember exactly where or when – about healthcare: Never have so many bright and talented people worked so incredibly hard to achieve so little.

That quote and the energetic price transparency movement also remind me of Ronald Reagan's famous campaign response to a tried-and-failed political initiative of an opponent: *There you go again*.

In healthcare '*there you go again*' means yet another attempt to solve clinical problems with financial tools. It never works. Dr. Meador told us that in the beginning of this chapter.

### **The problems raised by attempting to solve clinical problems with financial tools**

Our healthcare financing tools, commonly called 'health insurance', focus almost exclusively on 'financing' and almost totally disregard 'health'. David Dranove of Northwestern University summarized the impact of this fallacy in his book *The*

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<sup>212</sup> Lazris, *Curing Medicare*, page xviii

Economic Evolution of Managed Care on cost control reforms in the 1980s and 90s: they ‘utterly failed, on all accounts’.

Though there are many reasons for this, I think the two fundamental are:

- A primary financial focus almost inevitably reduces the amount of time each physician has for each patient. Time is the physician’s primary inventory, one which he or she must use wisely to maximize his or her income. As the payment for each inventory unit – i.e. each minute – decreases, physicians need to maximize their income per unit. Hence, they see more patients per hour or day.

Michael Porter, Harvard Business School’s great business strategy professor, put this succinctly in his 2006 book *Redefining Healthcare*: Without the discipline of value-based competition on results, carriers have incentive to reduce the time physicians spend with patients.<sup>213</sup>

Price lists and price transparency programs take us exactly where Porter warned we don’t want to go. We need to focus on outcomes, not prices, to improve outcomes. We cannot improve value (outcomes per dollar spent) otherwise and we’ll probably end up decreasing it.

- Financial / price based solutions lead to ‘simplistic actions such as across-the-board cuts in expensive services, staff compensation, and head count’ according to Porter.<sup>214</sup> More succinctly, he says,

‘It is a well-known management axiom that what is not measured cannot be managed or improved’<sup>215</sup> meaning financial solutions to clinical problems may lead to cuts that negatively impact care quality. Rather than managing some critical but unquantifiable care components, market pressures may lead to across the board cuts.

That was, more or less, our experience with HMOs in the late 1990s and early 2000s: fairly brutal cuts and cost controls that led, among other things, to the Patient’s Bill of Rights. Might we simply re-create the same experience, only this time motivated by price lists?

I’ll let some physicians express all this in their own words.

Dr. Vikas Siani, President of the Lown Institute, suggests that publishing prices lists will put more pressure on clinicians to improve their efficiency. This will limit the amount of

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<sup>213</sup> I wrote this quote in my notes while reading Porter and Teisberg’s *Redefining Healthcare*, but can’t find the exact reference. This article in the Harvard Business Review says pretty much the same thing.  
<https://hbr.org/2011/09/how-to-solve-the-cost-crisis-in-health-care>

<sup>214</sup> Ibid

<sup>215</sup> <https://hbr.org/2011/09/how-to-solve-the-cost-crisis-in-health-care>

time for each patient's care and serve to erode, not enhance, the doctor-patient relationship.<sup>216</sup>

Dr. Joshua Fenton of UC Davis Medical School, lead author of a study that concluded "Patient satisfaction is linked to higher healthcare expenses and mortality, study of 50,000 people over 7 years' claims <sup>217</sup>

Doctors may order requested tests or treatments to satisfy patients rather than out of medical necessity, which may expose patients to risks without benefits. A better approach is to explain carefully why a test or treatment isn't needed, but that takes time, which is in short supply...

...and which may decrease in supply under the increased billing pressures that result from excessive price considerations.

Publishing prices absent the critical and, as yet poorly developed quality metrics may make this situation worse, not better. The net result may be *more* unnecessary tests and treatments, not fewer according to Dr. Jauhar who says

There is no more wasteful entity in medicine than a rushed doctor.<sup>218</sup>

To save time, he says, doctors order more tests or refer to more specialists. This adds costs and risks; it doesn't decrease them.

Time compressed physicians have less time to develop personal relationships with each patient. This leads, according to a study of 20,000 diabetics and their care givers, to less empathy for patients and poorer outcomes. <sup>219</sup>

- Patients of high empathy doctors had about 35% fewer metabolic complications like hyperglycemia or diabetic comas.
- Empathy means sharing feelings with other people, not belittling, undermining or judging, according to Dr. Rana Awdish, a critical care physician at Henry Ford Hospital who's involved in hospital's empathy program. These skills can be taught and practiced, she says, but this requires emotional availability on part of physician, something he or she needs time with patients to develop.

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<sup>216</sup> <http://www.doconomics.com/blog/?p=4647>

<sup>217</sup> <http://www.ucdmc.ucdavis.edu/publish/news/newsroom/6223>

<sup>218</sup> Jauhar, New York Times, 7/20/14

<sup>219</sup> Bakalar, NY Times, Doctor Empathy a Factor in Diabetes Care



- Dr. Jauhar addresses the empathy issue from a typical physician's point of view: 'Among my colleagues I see an emotional emptiness created by the relentless consideration of money.'<sup>220</sup>

Kaplan and Haas, in their 2014 Harvard Business Review article 'How Not to Cut Health Costs' give an example:

- Starting kidney dialysis with a fistula (a surgical procedure to connect to an artery or vein) rather than catheter generates better outcomes, meaning longer lives with fewer complications.
- Patients starting at optimal times in their disease progression cost tens of thousands of dollars less per year than otherwise.
- One nephrologist said that spending 30 minutes more per patient with advanced kidney disease could dramatically improve rate of fistula or graft starts, *but there was no time or compensation for the discussion*.
- Publishing nephrology office price lists will, suggest these authors, take us in the wrong direction, generate more patient harm and ultimately cost our system more.

Actions like helping patients choose doctors based on price destroys healthcare system value.

But actions that (1) increase the amount of time physicians have with patients and that (2) enhance the doctor-patient relationship, that (3) help doctors diagnose preferences better and that (4) help patients choose effective care based on their preference and high quality outcome studies, add value.

### **How to turn price transparency from value-destroying to value-creating**

Our definition of value includes two components: costs and outcomes, value being measured as outcomes per dollar spent. Focusing only on spending will probably decrease systemic value by reducing outcomes, for all the reasons above.

Including critical outcome factors along with prices can turn this positive, into a value creating exercise. I'll list some components below as examples. The chapter on Decision Aids goes into this in much more detail.

Consider first **birthing**, about 10% of non-Medicare hospital income. Along with price lists by hospital, an informed patient would need to know

- Infant mortality rates by hospital

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<sup>220</sup> Jauhar, Doctored, page 170

- Infant and maternal readmission rates
- C-section rates
- Plus have some indication of whether or not each hospital's catchment area population was abnormal in some critical respect.

For **preventive care**, a wise patient would need to know

- Mortality and morbidity rates both with and without the preventive care
- Harm rates from the preventive care such as false positives and test and treatment harms
- Plus have an ability to understand what all these numbers and statistics really mean.

For **hospital choice**, patients need to know

- Infection rates
- 30 and 60 day readmission rates
- Tendency / process information by hospital per 1000 people in each hospital's catchment area, similar to Dartmouth Atlas information
- Volume of similar patients treated annually. Though an imprecise metric, care quality correlates relatively well with care quantity, and the hospitals performing the highest number of similar surgeries annually tend to generate the best patient outcomes.

For **surgeon choice**, patients need to understand

- Infection rates, complication rates, mortality rates, return-to-operating room rates and hospital readmission rates by surgeon / by procedure
- It does not seem fair that hospitals should be privy to this important information while prospective patients, whose health could be influenced by it are not, says Dr. Paul Ruggieri, general surgeon and former clinical instructor at Harvard Medical School.<sup>221</sup>
- Absent that information, patients need volume rates by surgeon. 'Patients can improve their chances of survival substantially – even at hospitals with high volumes of a procedure - by selecting surgeons who perform the operations frequently,' according to Dr. John Birkmeyer, former Chief of General Surgery at Dartmouth – Hitchcock Medical Center in New Hampshire.

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<sup>221</sup> Ruggieri, The Cost of Cutting, page 127

For **pharmaceuticals**, note that the Americans average about 13 prescriptions / capita / year, double other OECD countries that generate similar or better population statistics.

- Several new Decision Aid reference sources provide useful drug information though in different forms. I particularly like Number Needed to Treat and Harm analyses. I'll discuss much more of this in the chapter on Decision Aids

Patients who know this quality information can use their doctors as 'interpreters' (Gawande's term) to help them determine which care they really want and which process they prefer. Prices can have a role in those discussions but, I suggest, probably a relatively limited one.

## Conclusion

Good health is cheaper than poor health. That's both axiomatic and true.

Activities that get patients healthier are almost always less expensive than activities that either keep people unhealthier or do not positively impact health.

Well informed patients who understand their options tend to cost less than poorly informed patients. Well informed patients who use our 4-Step Decision Process will choose care wisely by balancing the likely benefits against the likely harms. They will use outcome data from comparative studies to help them make their decisions, consult with their physicians about options and alternatives and ultimately end up healthier.

Poorly informed patients assume that more medical care is better medical care, tend to assume higher likelihoods of benefit and lower of risk than are true, and are ultimately somewhat less likely to end up in good health.

Turning patients from poorly informed to well informed saves money. Shopping by price, especially for medical interventions that do not benefit patients, does not.

I conclude that Price Transparency is value-creation neutral:

- Listing prices alone, absent the critical quality indicators discussed above and in detail elsewhere in this book, probably destroys value.
- But listing prices *along with* those critical quality metrics, and using prices to engage patients in a discussion of care quality can increase system value.

It's too early in this process to know where this is headed and to issue a definitive conclusion.

<sup>1</sup> Richard Harris, Rigo Mortis and John Wennberg, Tracking Medicine for example.

<sup>1</sup> See the Dartmouth Atlas of Healthcare for example on this.

<sup>1</sup> State of Washington 2018 report First Do No Harm. I used this source for the other examples in this section also.

<sup>1</sup> Wennberg, Tracking Medicine. He estimates that patients have options about 85% of the time.

<sup>1</sup> See the Dartmouth Atlas of Healthcare and various research papers from the Dartmouth Institute for Health Policy and Clinical Practice, for example. Also David Cutler's estimate in The Quality Cure, page 20.

<sup>1</sup> See Wennberg, Tracking Medicine, Chapter 1

<sup>1</sup> HHS, Quick Guide to Health Literacy,  
<https://health.gov/communication/literacy/quickguide/factsbasic.htm>

<sup>1</sup> Mulley, et al, Patient Preferences Matter, Kings Fund and the Dartmouth Center for Health Care Delivery Science, 2012, page 9

## **Review Questions**

Answers on next page

1. Do prices among vendors vary much for the same medical service?
  - a. Yes
  - b. No
  - c. Only in New Hampshire
  - d. Rarely in New Hampshire
2. Can you determine which vendor provides the highest quality medical services from price lists?
  - a. Yes
  - b. No
  - c. Only in New Hampshire
  - d. Rarely in New Hampshire
3. Can a patient determine if he or she will benefit from a specific medical service by learning its price?
  - a. Yes
  - b. No
  - c. Only in New Hampshire
  - d. Rarely in New Hampshire
4. About how much ineffective or harmful medical care exists in this country?
  - a. About 2% of medical care is ineffective or wasteful
  - b. About 40 – 50% of medical care is ineffective or wasteful
  - c. About 97.8% of medical care is ineffective or wasteful
  - d. Well over 100% of medical care is ineffective or wasteful
5. This text suggested 3 reasons that explain why medical care is sometimes ineffective or wasteful. Which below is NOT one of those reasons?
  - a. Physicians rely on hunches, not science, too often
  - b. Medical care that has not been subjected to comparative studies is proven ineffective or harmful about half the time when subjected to those studies
  - c. Physicians too frequently treat patients according to physician preference, not patient preferences
  - d. Doctors are poorly trained in this country
6. This text suggested a Four Step Process for making wise medical care decisions. Which below is Step 1 of that process?
  - a. Determine if medical care provides more benefits than harms or than doing nothing

- b. Pray
  - c. Ask a trusted friend or relative what to do
  - d. Learn as much as you possibly can about the anatomical and physiological causes of your medical problem
7. Which below is NOT an element of the Four Step Process?
- a. Determine which treatment process you prefer
  - b. Determine which doctor and hospital generates the best outcomes for your preferred process
  - c. If two providers generate the same outcomes from your preferred process, consider prices
  - d. Pray
8. Which, below, is *most likely* to happen if medical prices become widely known to patients?
- a. Doctors will spend less time with each patient
  - b. Our national 30 day hospital readmission rate will drop
  - c. Our infant mortality rate will drop
  - d. Americans will live longer
9. Which, below, is *least likely* to happen if medical prices become widely known to patients?
- a. Care quality will improve
  - b. Prices for many ineffective treatments will fall
  - c. Doctors will advertise the prices of their (often ineffective or harmful) services
  - d. Hospitals will advertise the prices of their (often ineffective or harmful) services
10. Americans seem to perceive that more medical care is better and that higher technology care is better than lower. How will posting prices affect these perceptions?
- a. It won't
  - b. It may reduce moral hazard when people understand what care costs
  - c. It may induce more moral hazard when people learn true care costs
  - d. It may incent people to drop insurance coverage

### Review Questions

Correct answers in bold

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## Why Private Sector Healthcare Reforms Always Fail to Control Costs

We have a 40+ year history of healthcare system reform, and a 40+ year history of reform failures to control costs. Harvard Business School Professor Michael Porter explains why:

With the wrong diagnosis, the attempts to treat the system have addressed the wrong issues or offered piecemeal, ultimately ineffective solutions aimed at symptoms rather than causes. <sup>1</sup>

Harvard Business School's Michael Porter, along with his colleague Elizabeth Teisberg, have written the Big Book About Healthcare, 400+ pages, titled **Redefining Healthcare**. Chapter 2 provides a litany of competitive dysfunctionalities. We'll use some of Porter and Teisberg's categories to articulate why we have expensive, fragmented, inappropriate and dysfunctional forms of healthcare competition.

Note when reading this: Porter is a business school professor, primarily interested in improving healthcare value. 'Value' for Porter means 'outcomes per dollar spent'. Good surgical outcomes at low cost are high value medical services, for example, while similar outcomes at higher costs represent less value.

Porter and Teisberg see as dysfunctional many healthcare regulations because these are designed to treat healthcare purchasing as different from purchasing other goods and services in our economy. **The clash between appropriate business strategies to promote patient value, and inappropriate regulations to control competition, comes through quite clearly.**

### Dysfunctional Competition in the Wrong Geographic Market

We know that some hospitals provide better value than others. The Cleveland Clinic, for example, is nationally recognized as an outstanding cardiac center, and the Mayo Clinic wins accolades for its patient care. Both provide outstanding patient value – excellent outcomes at moderate prices. From Porter's point of view, we could increase overall American patient value by allowing more patients to access these, and similar, outstanding medical facilities.

But regulations often prohibit people insured in one state from getting treatment in another state, at least, without paying hefty 'out of network' costs (essentially fines). A Massachusetts small group employee, for example, who has Massachusetts based health insurance, must pay this fine – in the form of out-of-network costs - to access the Cleveland Clinics' outstanding care.

This makes no sense. We don't do this in other economic arenas. We are not restricted from purchasing cars made in other states, or computers, or food, or clothing. That's one reason why we have a history of quality improvements and cost reductions in these products.

But in healthcare, we charge patients **more** to get better care – meaning often quicker and cheaper care.

What would happen if, for example, Massachusetts insureds could use out of state facilities without these extra charges? The short answer: it would be a win-win for the carrier, employer and employee:

- The carrier would save money;
- The employer would thus have reduced premiums;
- The employee would save money and – as an added bonus – receive better care.

The only losers – perhaps – are the Massachusetts providers who lose a patient to an out-of-state competitor. (I say lose ‘perhaps’ because competitive pressures from out-of-state providers might actually improve the value at Massachusetts hospitals, so they will get more insureds from other states than they lose. Inter-state competition might reward them with more patients.)

This type of geographic restriction may make no sense to people who believe that purchasing healthcare is the same as purchasing other goods and services.

But it may make perfect sense to folks who believe that purchasing healthcare is **different** from purchasing other goods and services. These people may see the state as a protector of its citizens.

Massachusetts, for example, may have significantly more stringent licensing requirements than some other states. As such, it’s the Massachusetts state regulator’s responsibility to dissuade its citizens from leaving the state to receive – potentially – inferior care. Yes, some people may not be able to access the Cleveland Clinic. But they are protected from receiving shoddy care in lots of other states.

Regulators, thus, may restrict people from getting the **upside** of out-of-state providers, but they also save people from getting the **downside** – shoddy treatment. That, apparently, is the justification.

Are they right? Are they wrong? The answer depends on how you define healthcare. If it’s like other goods and services, then the regulators interfere with market competition to the detriment of us all. But if it’s unlike other goods and services, then regulators provide a valuable function.

Regulators think that purchasing healthcare is different from purchasing other goods and services, so they regulate accordingly.

Whether or not we agree with them, we all pay the price in the form of higher costs than any other advanced industrialized country.

## Dysfunctional Competition over the Wrong Time Horizon

We know that most diseases, especially the chronics ones, last longer than 1 year. Lupus, multiple sclerosis and cystic fibrosis, for example, last a lifetime. Yet we finance healthcare treatments with one year health insurance policies.

These policies, underwritten by different carriers, may have different provider networks, different drug formularies and different approval criteria for various medical treatments. A patient may need to change physician, hospital, medications and treatment protocol when the employer decides to change plan.

Conceivably some patients may need to change provider, medication and treatment protocol annually. This makes no medical treatment sense - people with chronic conditions need, above all, continuity of care. This allows the treaters to monitor progress, tweak protocols as necessary and take a long term view of patient improvement.

But short term health insurance policies – i.e. 1 year plans - incent carriers and providers to seek quick hits, like eliminating certain expensive drugs or failing to invest in world-class hospital IT systems. This can be counter-productive: a patient responding to one drug may develop problems when that drug is discontinued due to a formulary difference.

Some drugs may, for example, be more expensive in the short term but reduce long term costs significantly. The VA has found this sometimes to be true. Our 1 year policy horizon and associated restrictions, however, may dissuade physicians from using the better / lower-long-term cost medication. The patient may receive sub-optimal care and the total disease treatment costs may ultimately increase.

Yet we allow, and indeed require, 1 year long insurance policies because of our weird employer based funding system. Employers, loath to take on appreciating long term liabilities, balk at committing to longer term insurance policies.

This short term funding mechanism treats healthcare purchasing as **different from** other goods and services. Your employer doesn't buy your food or auto insurance, for example. We don't subject other products designed for long term use – like automobiles – to the same short term financial review. Imagine if we purchased cars using the same 1 year time horizon as we use when purchasing healthcare!

The historical quirks that led to our employer based insurance system have generated many regulations that protect employers from potentially harmful financial obligations...sometimes to the detriment of patients, and often to the detriment of employer's own long term financial interests.

In the meantime, we choose our health insurance policies based largely on premium price. We shop for health insurance like we shop for other goods and services. But we finance healthcare very differently, using this artificially imposed 1 year time horizon.

Thus we have a financing system absurdly designed to treat healthcare purchases as **different** from other goods and services, while we try to apply routine business practices to medical treatments – restricting costs to remain within a budget, for example. This is a huge disconnect.

### **Dysfunctional Competition over the Wrong Unit of Measure**

We currently shop for providers, when we shop at all, seeking the ‘best’ doctor, the ‘best’ surgeon or the ‘best’ hospital. We typically have no clear definition of ‘best’.

Some people define the best hospital as the name hospital, the research facility associated with a famous university. Some define the best doctor as the head of a department or research institute, or a graduate of a famous medical school. Others define the best surgeon as the one most frequently recommended by other doctors.

None of these definitions, typically, includes a quantification of outcomes, as in ‘Dr. Smith is the best surgeon because 97% of his patients fully recover within 30 days’. We typically lack this data.

But there’s a more insidious underlying issue here. Dr. Smith is but one component of a large team that provides care to a patient. The team consists of diagnosticians, nurses, pre-op professionals, surgeons, assistants, post-op professionals, rehab professionals, IT specialists, therapists, psychologists, etc. Good patient outcomes require the entire team to work together as a well oiled machine for a failure of any one component may doom the patient.

In other words, the appropriate unit of measure for medical care is **the medical condition itself** – not the individual surgeon or hospital. A great surgeon with a poor rehab team may generate poor results.

A specific hospital may be outstanding at orthopedic care, but lousy at cardiac. Or the hospital may be outstanding at certain surgical procedures but poor at chronic care. Or have a poor IT system that fails to follow patients post-discharge, leading to a high readmission rate. Or perhaps have poor post-op patient counseling that fails to prevent self destructive behavior.

A brilliant surgeon with a poor post-discharge team may generate outcomes as poor as those from a crummy surgeon with an excellent post-discharge team.

We need cost and outcome information **by medical condition** for competing hospitals in order to make wise purchasing decisions. We also need this information to make wise healthcare reform decisions. Yet this information is virtually nonexistent.

The costs and value of each individual treatment component cannot be assessed in isolation, as each component is but a part of the larger team effort. Our attempts to control a portion of the treatment costs – surgical costs, for example, or rehab therapy costs – backfire as a result.

Healthcare reforms that consider any unit of measure other than the specific medical condition will almost certainly also fail.

### **Dysfunctional Competition to Amass Wealth**

Our various medical care providers – primary care physicians, specialists, hospitals, diagnosticians, allied medical professionals, etc – all share a client who is not their patient. Their real client: the insurance carrier who pays the bills!

I have no doubt that medical care professionals would each, personally, like to help their patient's get better. Many went into the profession to help people.

But I equally have no doubt that medical professionals also seek to maximize their incomes, as do all rational business people in a capitalist environment. In the healthcare field, we call this 'supply induced demand'. It correlates with moral hazard – the healthcare problem we discussed in Chapter 8. Here's how it works:

Physicians know that someone besides the patient – i.e. an insurer - will ultimately pay the bill. The physician also knows the criteria that each insurer uses to approve payments. It's a simple step – and probably unconscious for most medical professionals - then, to design a treatment plan that generates the highest payments.

Take this process one step further. Each hospital has an economic self interest in providing the most reimbursable treatment to each patient. Providers also have economic interests in not referring that patient out. This would mean that another provider benefits economically.

Providers – both specialists and hospitals - compete to provide the most care to each patient and refrain from referring patients to other providers. Again, probably not even consciously.

Now add one more step. Providers assemble themselves in networks, often affiliated with hospital systems. When referrals are necessary, they refer 'in-network'. Not to the 'best' specialist or, necessarily, to the cheapest. Instead, to an in-network affiliate, to keep the carrier's payments within their group. Compensation, bonuses, etc may rest on physicians' abilities to keep patients in-network.

And add a final step. Provider groups negotiate rates against carriers. The carriers want to pay less; the providers want to earn more. The larger and more powerful the provider group, the higher the rates.

Rates become a function of negotiating power, not of outcomes, not of efficiency, and not of patient satisfaction.

Providers thus compete with carriers and with each other to amass wealth. Whether or not patients get good treatment or enjoy good outcomes becomes a side issue in the compensation competition.

Hospitals typically do not support their claim for higher payments with data showing that their 30-day readmission rate is lower than another's. Nor do they show that their diabetic patients reduce their blood sugar levels more in a given time period. They generally don't argue that they should get paid more because their treatment quality is better.

Instead, they threaten not to accept a carrier's payment schedule. Here's Rick Weisblatt, Senior Vice President for Health Services at Harvard Pilgrim Health Care in Massachusetts, describing how geographically isolated hospitals (for example, on an island) negotiate fees. They use their geographic monopoly

To leverage higher reimbursement. The employers in that community generally want that hospital in the network. And the hospitals are not shy about threatening termination [of the carrier's contract] <sup>1</sup>

The competition is to amass wealth, not provide better value.

Healthcare competition is like competition in other arena where the parties negotiate fees and prices to maximize their wealth. But it is different from other goods and services which compete on value – in our case, cost per patient outcome.

Instead, in healthcare, the parties compete simply via power relationships.

### **Dysfunctional Competition over the Wrong Hospital Strategies**

Most American hospitals are General Hospitals, providing all medical services from ER to cancer treatment to open heart surgery, to all patients in a geographic area. These broadline general hospitals compete with each other.

Yet numerous studies have demonstrated that specialty hospitals – orthopedic, cardiac, etc – generate better outcomes at lower prices. The literature is full of case studies of this. <sup>1</sup>

Indeed, Harvard Business School Professor Regina Herzlinger – who has taught accounting to budding MBAs for years – claims bluntly:

Specialty hospitals generally provide better, cheaper healthcare than the everything-for-everybody general hospital. <sup>1</sup>

General hospitals, rather than competing with specialty hospitals on **value** (best outcomes per dollar spent) instead obtain political redress.

Some states – about 35 currently – have Certificate of Need regulations on the books. CON laws restrict hospital expansion or construction unless the hospitals can demonstrate a ‘need’ for the additional services to government regulators – at a public hearing. A new specialty hospital looking to enter a market must similarly face this requirement.

Imagine the hearing. I, for example, want to open Gary’s Coronary Hospital, perhaps in conjunction with an out-of-state hospital (or even, heaven forbid, a foreign hospital). I think I can provide better value – better outcomes at lower costs – than the current hospitals in my region. I’m willing to invest my money in this venture.

I make my proposal at the public hearing. ‘Why,’ I wonder, ‘do I need to convince regulators about the validity of my proposal? I wouldn’t have to go through this if I wanted to open or expand a shoe store. Or if I was a university president and wanted to expand my business school or chemistry department. I’m looking for the same tax treatment as the university, but I have a far more difficult regulatory hurdle to overcome.’

After I outline my business plan, the local incumbents speak in turn. They all explain to the regulators that there is no ‘need’ for my new coronary facility. They all, it turns out, have sufficient capacity to cover all the cases that I’m hoping to get. They try to convince regulators that there is no need for my services.

I, in this case, see purchasing healthcare as **like** purchasing other goods and services. I’ll invest my money and take my chances. If I’m wrong about the need for my service, I’ll fail and go out of business. I’m willing to take that risk.

But the regulators see purchasing healthcare as **different from** most other economic activities. They perceive a need to avoid wasting resources – potential tax losses from another non-profit entity, perhaps. They may want to avoid generating excess expensive medical capacity, so seek to protect hospitals from themselves. They may want to prohibit me from ‘cherry-picking’ profitable services from existing broadline general hospitals, using the totally fallacious argument that hospitals need the profitable patients to subsidize the unprofitable ones.<sup>1</sup>

Regulators may also perceive a need to protect the local incumbents, perhaps on the theory that ‘they do such good work’ for the local community - even if this raises medical costs to state inhabitants. In Michael Porter’s terms, CON laws serve to

Protect local incumbents from competition that could drive improvements in the diagnosis and treatment of specific medical conditions.<sup>1</sup>

Hospital systems tend to be very large local employers, often the largest or second largest in a local market. Physician and hospital campaign contributions are also

generally quite significant, especially at the local level. One wonders the impact of this electoral and campaign contribution clout in the Certificate of Need decisions.

This situation played out at the national level in, for example, the Medicare Modernization Law of 2003. That Law prohibited establishment of new specialty hospitals for 18 months. Congress passed a second 6-month ban in 2005.

Now that's a good way to stifle competition!

Note the tension between those who see healthcare as like, and unlike, other economic activities. Contrast the regulations governing private hospital expansion with the regulations governing private college expansion. A private college (also generally a non-profit, like a hospital) can open a new department or expand an existing one without receiving state permission. But a hospital cannot....to our cost disadvantage.

### **Dysfunctional Competition Based on the Wrong Information**

Wise shoppers need quality information – both price and outcomes – about the products they're considering. Neither is available in healthcare.

Contrast the purchase of a tennis racquet with the purchase of any medical service, even one as simple as an MRI.

You can comparison shop for tennis racquets. You can determine price, weight, color, string tension, hand grip size and construction material. You might even – depending on where you purchase – hit a few balls with it. You can get all this information about a product that costs a couple hundred dollars and plays a minor or inconsequential role in most people's lives.

Contrast this with available medical provider information. We'll use an MRI example, because this is a relatively straight-forward, discrete test.

You can't determine the MRI price – it's a function of carrier discounts, which in turn are a product of power negotiations. You can't determine radiologist quality. You can't learn how many misdiagnoses have been generated from this facility – either false positives or false negatives. You can't determine if this particular machine is the most current incarnation of MRI. You can't even learn how many people with your medical condition have used this radiological facility.

In short, you can't learn anything about this procedure's cost or quality, even though it may have life impacting consequences for you.

Not only is this type of quality information unavailable to shoppers, but it's also typically unavailable to physicians. Indeed, according to Porter, 'most physicians lack any objective evidence of whether their results are average, above average or below average...they generally lack information on their own efficiency.' <sup>1</sup>



Imagine lacking quality feedback about your own competence and outcomes in other profession! Porter goes even further:

The information that is available – health plan overviews, subscriber satisfaction surveys, and reputation surveys...has modest value. Much more relevant is information about...results.<sup>1</sup>

The hospital rankings currently available, in, for example, US News and World Report or Money magazine 'fall far short of the types of information really needed to support comparisons of value'.<sup>1</sup>

This differs, of course, from auto, food or other product information.

Why is medical information so unavailable? One short answer: government regulators treat healthcare differently from the way they treat providers of other goods and services. They don't require it.

We require auto manufacturers to publish lots of information about their products, including crash test ratings. But not hospitals. Why?

Some claim that hospital lobbies are too powerful. This seems an unsatisfactory answer, for the auto industry also has lobbyists, is also powerful and would probably be delighted to avoid publicizing crash test ratings and other comparative information that might cast them in a poor light. Ditto for the food industry.

Instead, I think, regulators see medical service provision as essentially different from provision of other goods and services, and thus subject to a different set of rules. They allow medical providers to withhold comparative information from the public, apparently with the justification that ordinary people would not be able to understand this data. (OK, political pressures and lobbying are a consideration here also.)

Interestingly, regulators have no problem mandating certain kinds of services for sick people – minimum nursing staffing ratios, for example, or mental health parity. They do this because they believe that the market alone will not provide adequate services to sick people. They typically regulate based on political influences – the nurses lobby, for example, demanding certain minimum staffing rates – rather than on rigorous, extensive studies comparing various nurse-to-patient ratios and patient outcomes.

But regulators balk at requiring price and outcome transparency. They require it for autos, but not for healthcare. They require it for food products, but not for healthcare. They require it for financial services, but not for healthcare. They even require it, more or less, for life, homeowners and auto insurance – but not for healthcare.

The best way to understand these discrepancies? Understand that many regulators see healthcare as essentially different from other goods and services.

This conflict – between regulations based on one set of assumptions, and competition based on another – leads to dysfunctional competition that raises medical service prices without simultaneously improving patient outcomes.

Porter and Teisberg note several other kinds of inappropriate and dysfunctional competition in the healthcare arena. We've presented enough above to make our underlying point: our lack of consensus about whether healthcare is like or not like other goods and services leads to a poor regulatory framework and dysfunctional, costly competition.

### **Our Lack of Consensus Is Expensive**

As our medical providers compete for business in this poorly regulated, dysfunctional marketplace, we have more and more people administering our healthcare. In 2006, for example, we had some 470,000 health insurance employees – that's 1 for every 2 physicians! <sup>1</sup>

These numbers don't include the number of hospital and physician office employees who coordinate with these insurance employees. Surveys find that both doctors and nurses spend between one-third and one-half of their time on paperwork and that health insurance administration alone is a staggering 30% of all healthcare spending. <sup>1</sup>

Why are these costs so astonishingly high? Because we lack a consensus on whether healthcare is like or dislike other goods and services. As a result, we have an overly complicated, confused and often internally contradictory regulatory and administrative system.

We could reduce administrative costs, complications and confusion if we all agreed that healthcare is like other goods and services – or dislike.

If, for example, we let the market alone dictate healthcare system evolution, then we could eliminate many mandates and healthcare access restrictions, referral costs and requirements and inappropriate geographical competition. We could probably eliminate the expensive and inappropriate medical arms race by focusing on outcomes per dollar.

Alternatively, if we agreed that healthcare is a government function – not a market function – then we could eliminate many of our current costly types of provider competition, like individual underwriting and pre-existing condition exclusions and network restrictions. We could also eliminate the massive private insurance overheads that serve no useful economic function in a public healthcare system.

But since we lack consensus, we have the worst of both worlds. We have expensive private insurance overhead. We have expensive provider overheads whose only function is to deal with the various insurance carriers and complications. Yet we don't have the benefits of true market competition that would lower costs and improve outcomes.

Indeed, our current convoluted healthcare billing system is so complex and confusing that carrier and provider *billing offices themselves* often cannot understand the process. Errors and double billing abound. <sup>1</sup> Partially as a result, insurers find reasons to reject up to 30% of all the bills they receive from physicians and hospitals <sup>1</sup> – leading to more administrative time and expense to straighten all this out.

Our lack of consensus about how to treat healthcare – is it like or dislike other goods and services? – is hugely expensive for all of us.

## Overview of Health Insurance Reforms Since 2000

The US has enjoyed spurts of health insurance reforms for the past 60 years at least. Medicare and Medicaid, the first major public health insurance programs since World War II, passed Congress in the 1960s. Nixon's HMO Act of 1973 followed, presenting a major private sector reform about 6 years later. Both dramatically changed our health insurance landscape for years to come.

After 3 decade major healthcare reform lull, the W. Bush administration passed the Medicare Modernization Act in 2003 and the Obama administration the Affordable Care Act 7 years later. Both also dramatically changed our health insurance landscape for years to come.

But did either the MMA or Aca have the impacts their authors desired? Did either improve the health status of Americans? Did either cut medical costs? Did either dramatically expand coverage? This chapter will address those questions and propose some startling and perhaps unsettling answers. It will then suggest some changes to our healthcare system, already in the works, that *could* have the dramatic systemic impacts that the healthcare reformers had hoped to have.

### The Two Major Healthcare Reforms Since 2000

The Medicare Modernization Act of 2003, passed by the George W. Bush administration, represented the **market based** reformers vision of an improved healthcare system. Among its key components, this legislation enhanced the so-called 'consumerism' movement in American health insurance by codifying Health Savings Accounts and Health Reimbursement Accounts into our income tax and health insurance systems.

- Health Savings Accounts (HSAs) allow insured folks to invest tax deductible money into special accounts called Health Savings Accounts that they own personally. This money grows tax free until needed, when it can be withdrawn tax free to spend on medical care. HSAs are the only triple tax free investments available under the IRS code; they're tax deductible when initiated, grow tax free and are not taxed when withdrawn for qualified medical expenses. HSAs have grown tremendously, totaling over \$80 billion by 2022 with some individual accounts reaching \$100,000 or more.

Health Savings Accounts are closely tied into high deductible health plans, both legislatively and economically. Insured people could originally only invest an amount equal to their annual health insurance deductible into their HSA. Overtime, this requirement has changed; in 2021, the contribution limits were \$3600 for an individual plan and \$7200 for a family plan.

Economically and philosophically, these accounts were designed to help medical care consumers think of medical payments as being made with their own money. The Medicare Modernization Act authors hoped that this change in consumer attitude – from thinking of medical payments as someone else’s money (the health insurance company’s) to thinking of medical payments as their own money – would motivate patients to shop more wisely for medical care, compare prices and choose the least expensive care, in other words, act like purchasers of other consumer products. This consumer driven movement would, in turn, force medical providers to cut prices and therefore reduce healthcare spending by billions of dollars.

That, at least, was the theory.

- Health Reimbursement Accounts (HRAs) are funded by employers. These were designed, originally, to cushion the impact of high deductible plans on employees by covering all or part of the deductible. Operationally, the employee pays for a medical treatment, then submits a receipt to his / her employer for reimbursement. Overtime this became mechanically simpler, with employees paying for medical services with their HRA card. HRA payments are tax deductible to the employer and tax free to the employee.

HSAs and HRAs have become integrated into our health insurance landscape since 2003 and have also become far more complicated and intricate than outlined here. My purpose in this chapter is simply to introduce them as components of the Medicare Modernization Act of 2003.

The Medicare Modernization Act also introduced Parts C and D of Medicare.

Medicare Part C, often called Medicare Advantage, operates like an old-fashioned HMO. These plans are offered by private insurance companies under Medicare’s guidance and with Medicare’s approval. Medicare pays a fixed amount to the companies that offer Medicare Advantage Plans. These companies must follow rules set by Medicare. However, each Medicare Advantage Plan can charge different out-of-pocket costs, have different rules for how to get services like specialist referrals or specific hospital and physician networks, and sometimes include additional benefits. That introduces additional consumerism into the marketplace; different Medicare beneficiaries can choose different Part C plans according to their own different insurance plan preferences.

The MMA authors hoped that competition among health insurers – the folks who actually offer various Part C plans – would force prices down. Part C subscribers would, again in theory, choose the lowest cost / most attractive insurance options. As these plans grew in popularity, the offering insurance companies could negotiate lower and lower prices with participating doctors and hospitals.

Again, in theory.

- Medicare Part D covers outpatient prescription drugs, previously not covered by Medicare.

Our purpose in this chapter is less to describe components of the Medicare Modernization Act or, later, the Affordable Care Act, but more to discuss their impacts on the American healthcare system. To that end, we'll move now to commentaries on the state of American healthcare post-MMA. I'll use summaries from well known academics representing various disciplines – medicine, business, economics and public policy – to make my points.

In 2005 – two years after passage of the MMA – two Harvard Medical School professors, Jules Richmond and Rashi Fein representing for our purposes the medical school perspective, called our healthcare system a 'mess' in the title of their lengthy book on the state of American healthcare entitled 'The Healthcare Mess'. Interestingly Richmond was a former US Surgeon General and exceptionally well placed to understand the issues he discussed.

In 2010 – seven years after passage of the MMA – Regina Herzlinger, a well known Harvard Business School professor and, for our purposes representing the business school perspective, called our healthcare system 'insane'. That was at a Boston area lecture I attended, though my notes are somewhat confusing on this point; she may have called our system 'stupid'. The distinction doesn't matter.

Others from various academic disciplines offered similar commentaries.

Seven years after passing the Medicare Modernization Act and seeing an obvious need to correct some perceived fatal flaws in our healthcare system, the Obama administration passed the Affordable Care Act, a set of government based health insurance reforms. These differed markedly from the market based reforms encompassed in the 2003 Medicare Modernization Act. The ACA's primary goal was to expand insurance coverage, not to enhance consumer / patient power. Among the key ACA provisions, it

- Introduced income based subsidies for health insurance premiums, so lower income folks could afford to purchase private plans,
- Introduced health insurance exchanges or online marketplaces, where consumers could view all health insurance plans available in their area and comparison shop based on price and benefits,
- Introduced employer mandates, requiring employers to offer health insurance to their employees under various circumstances and conditions,
- Introduced an individual mandate, requiring everyone to have health insurance, again under various circumstances and conditions,
- Introduced community rating, so everyone in the same area paid the same amount for health insurance with some minor condition differences, like age and smoking status. This ended 'individual underwriting' where the insurance carrier priced policies differently based on a host of individual risk factors. Individual

underwriting made health insurance unaffordable to very sick people, a situation the Obama administration wanted to avoid.

- Eliminated annual or lifetime policy payment ‘caps’ or amounts of money a person could receive in insurance payments per year or per lifetime. Caps protected insurance carriers from extremely high payouts but, again according to ACA authors, did not serve severely sick patient interests as well.
- Medicaid expansion in which the Feds paid states to cover more low income people.

The commentators continued.

In 2014 – four years after passing the ACA and 11 after passing the Medicare Modernization Act, Ezekiel Emanuel, perhaps the primary author of the ACA and brother of President Obama’s Chief of Staff Rahm Emanuel, called our healthcare system “terribly complex, blatantly unjust, outrageously expensive, grossly inefficient and error prone”. Remember – this summary came from a supporter of healthcare reform.

In 2016 – six years after passing the ACA and 13 after passing the MMA, Jonathan Engle from Columbia University’s School of Public Health called our system “uniquely dysfunctional”.

In 2020 – ten years after passing the ACA and 17 after passing the MMA, Angus Deaton and Anne Case, two Princeton economics professors, called our system a “calamity”. Deaton won the Nobel Prize for Economics in 2015 for his work in this field.

Other academics and healthcare commentators chimed in along the same general lines.

The summary of our selected healthcare commentaries above, described US healthcare system evolutions through 2 major reforms – the Medicare Modernization Act of 2003 and the Affordable Care Act of 2010 – as moving from a ‘mess’ to a ‘dysfunction calamity’. Not a ringing success by any means.

Interestingly, this fiasco (my word) is taxpayer subsidized since employer paid premiums are tax deductible to the employer and not taxable to the employee - the biggest tax break allowed by the IRS. This raises questions to me, at least, about the purpose of our healthcare system. Is it designed to get people healthy? Is it designed to be benefit sick people? Or is it primarily a jobs program designed to keep well educated, well compensated people happy? Read on and decide for yourself.

#### Success and failure defined and demonstrated

Let’s now define healthcare reform success and failure. Success in any business, economic, or public policy reform means better products at lower cost and with wider access. This applies to activities ranging from internet expansion to educational reforms, from air conditioning utilization to automobile safety and emission standards and from cell phone use to consumer product sales: better products at lower cost and

with wider access. By this definition, we can see internet success as an example – many more people have internet access today, at higher speeds, greater reliability and lower costs, than in 2003. Ditto cell phone use and automobile evolution and a host of other services and products.

A quick note on car costs as an economic cost methodology example: we'll use the same approach to healthcare costs in a few pages.

The average new car cost \$24,770 in 2003, the average hourly wage then was \$13 so the average person, working at the average wage, had to work 1905 hours to purchase a new car. (People generally financed new cars over time.)

But in 2022, the average new car cost \$47,150, the average hourly wage was \$32 so the average person, working at the average wage, had to work only 1468 hours to purchase a new car. The 2022 new cars had a host of features that the 2003 cars lacked, including back up cameras, voice activated controls, onboard navigation, Wi-Fi and, increasingly, electric motors.

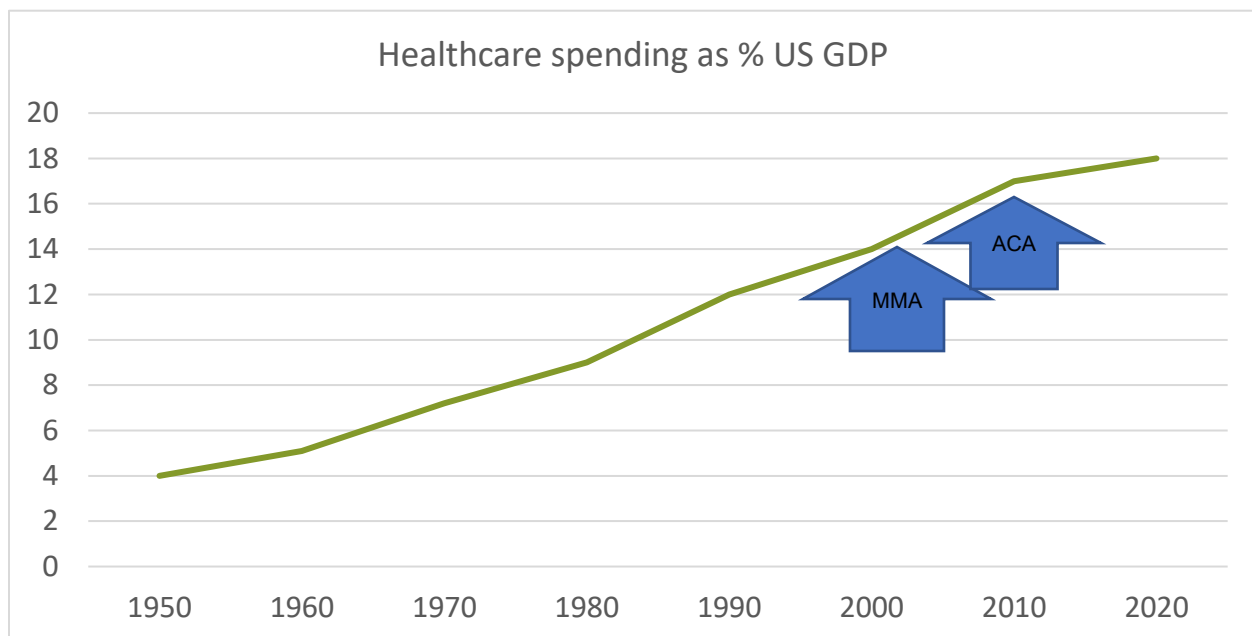
Thus, despite the higher 2022 sticker price, the average 2022 new car, with all those additional safety and other features, cost less economically than the 2003 ones.

In healthcare, our reform definition means better health outcomes at lower costs for more people. Failure is the opposite: healthcare costs more, doesn't work any better than in the past and remains inaccessible to many.

How have we done on these metrics since 2003?

**Healthcare spending** as a percent of our total economy has risen since 1950 at about a constant rate. See the chart below. As healthcare spending grows, it consumes more and more of our economic resources. It inflates, in other words, more quickly than the economy as a whole. You can see that the Medicare Modernization Act had no impact on the rate of healthcare spending growth, while the Affordable Care Act has a minor impact. After both reforms, healthcare spending continues to grow faster than the overall economy and continues to consume more and more of our economic resources.





As a side note, ‘consume more and more of our economic resources’ means that we have fewer resources to invest in other parts of our economy as a percentage of our economy. Thus, as healthcare spending grows, other sectors – education, national defense, infrastructure development, etc. – have fewer resources available, again as a percentage of our total economy.

Phrased differently, this means that, as healthcare spending grows, we either spend less in these other sectors or borrow more to fund them fully.

**Healthcare outcome improvements**, though, do not demonstrate this same growth. See the chart below showing average life expectancy since 1950. I use life expectancy as the care quality metric since the fundamental function of a healthcare system is to keep people alive.

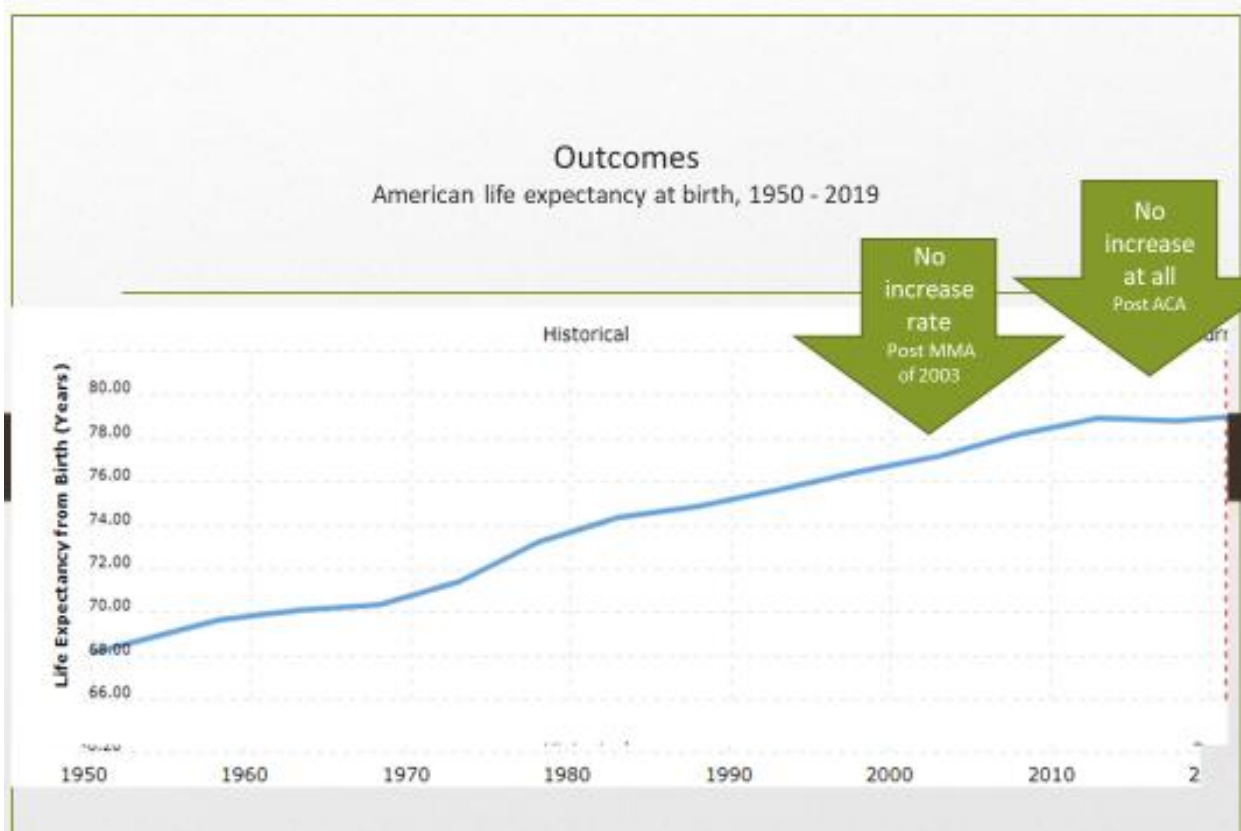
In economic / public policy terms, if our healthcare system keeps people alive longer, then it is arguably worth more funding; but if it does not, then I question whether the additional costs provide any value.

Yes, I know that factors outside the healthcare system can impact longevity: wars, pollution, genetics, individual behaviors...a long list. But my point is that a healthcare system exists to keep people healthy and alive for longer. If a society identifies harms that limit longevity, then a good healthcare system will adapt and develop programs and treatments to ameliorate those harms. Take smoking, for example. Once identified as a cancer causing / life limiting agent, our healthcare system developed treatments – surgeries, early disease identification programs etc. – and preventive measures – patient education, smoking session programs,

medications to reduce smoker cravings, etc.- to combat smoking's negative effects. That's how a good healthcare system works.

A poor healthcare system limits the definition of 'healthcare' to functions it can perform well – knee surgeries and cataract removals for example - focuses on those, and claims that life extension is someone else's problem. A good healthcare system adapts and extends life. Is our healthcare system, post 2 reforms and by this definition, 'poor' or 'good'? See below.

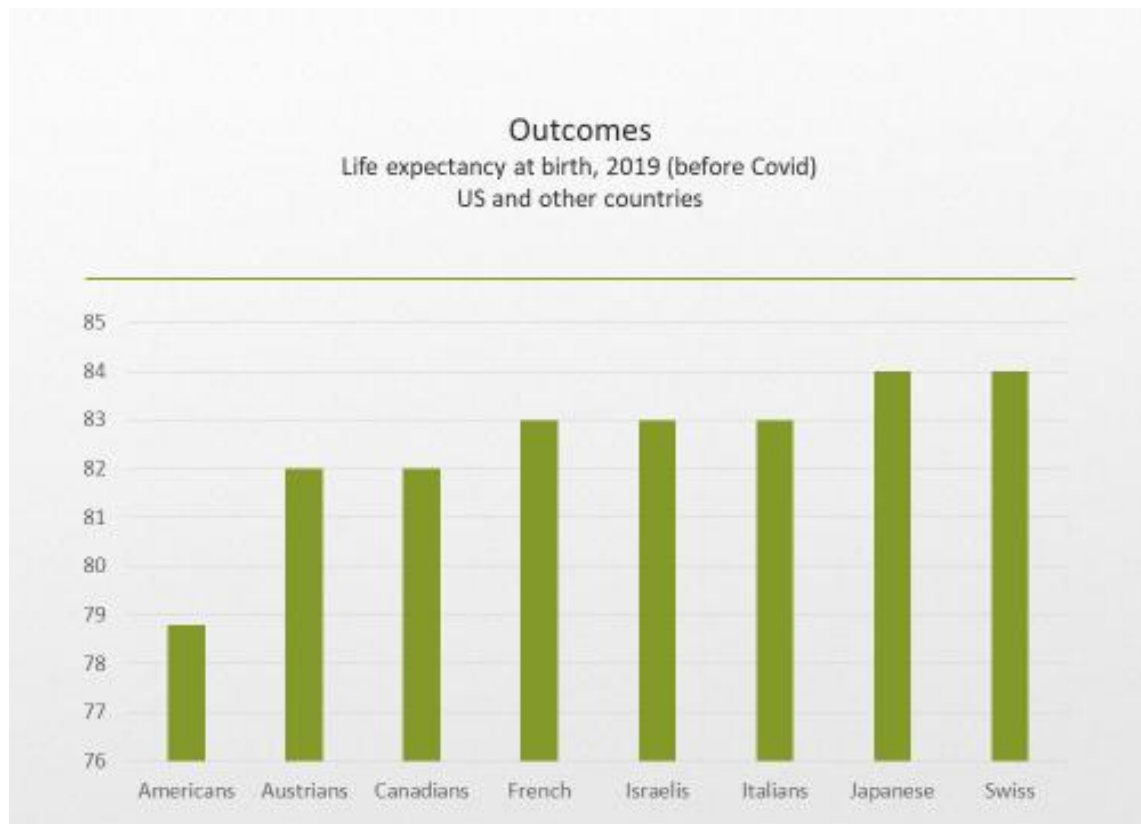
The chart below showing American average longevity at birth ends in 2019 on purpose: I did not want any Covid issues to interfere.



Four things to note here: first, the life expectancy annual increase is basically linear; we gained about as many life years in the 1950s as in the 1990s. Second, the biggest life expectancy gains occurred in the 1970s when we passed various public health measures like the Clean Water and Clean Air Acts. Third, the Medicare Modernization

Act had no impact on the rate of life expectancy growth; it was irrelevant. Fourth, interestingly and for some reason that I cannot explain, we saw no life expectancy growth post passage of the Affordable Care Act, again irrelevant.

In 2019, the last full year before Covid struck and all these metrics became murkier and more confusing, Americans lived less long than people in many (most?) other developed countries. See the chart below, generated **16 years** after passing the Medicare Modernization Act and **9** after passing the Affordable Care Act.



Neither the Medicare Modernization Act nor the Affordable Care Act impacted American's longevity. The underlying trends that existed when those healthcare reforms passed simply continued. The trillions of additional healthcare spending dollars encompassed in those legislations were irrelevant from a longevity perspective.

Let's look at post-reform healthcare costs and outcomes as economists again, just like we looked at auto costs and quality a few pages ago. We'll use two different methodologies.

First, the methodology we used in auto costs a few pages ago. In 2003, the US spent about \$5,700 per capita on healthcare. The 2003 average hourly wage was about \$13 so the average person, earning the average wage had to work 438 hours to pay for healthcare.

In 2019, the year before Covid hit, the US spent an average of about \$11,500 per capita on healthcare. The 2019 the average hourly wage was about \$15.35, so the average person, earning the average wage had to work 749 hours to pay for healthcare.

The analysis above shows that healthcare was much more expensive in 2022. It doesn't tell us if the more expensive healthcare system in 2019 worked better than the 2003 version like in the auto example above, where today's cars are better and safer than the 2003 versions.

So our second approach to thinking as economists will incorporate a productivity and quality indicator to measure healthcare system improvement (or lack thereof) over time. We'll divide average per capita healthcare spending per year by average longevity and compare that number in 2003 – the last year before passage of the Medicare Modernization Act - and 2019, the last year before Covid.

In 2003, again, the US spent about \$5,700 per capita, we lived, on average, about 77 years, so our ratio of per capita spending to expected life years was 74. That doesn't mean anything in a vacuum but allows us to compare systemic quality and productivity over time.

In 2019, again, 16 years after passing the Medicare Modernization Act and 9 after passing the Affordable Care Act, we spent about \$11,500 per capita and lived, on average, about 79 years. Our 2019 ratio of per capita spending to expected life years was 147, about 73 points higher than our 2003 indicator.

Could this increase be due to overall inflation? One online inflation calculator suggests that \$1 in 2002 was equal to \$1.42 in 2019.<sup>222</sup> Applying this factor, our healthcare efficiency metric of 74 in 2003 would reasonably be expected to rise to 105 in 2019 due to inflation, a rise of only 31. But it increased by 75. More than half the increase in our metric was something other than inflation.

What was it? My presumptive answer: healthcare system inefficiency, defined as outcomes per dollar spent. Leaving inflation out, we spent far more for each life year in 2019 than in 2003. I'll suggest 4 types of inefficiency or system value reductions.

- One type revolves around prices. Healthcare providers, pharmaceutical companies, medical device manufacturers etc. raised prices far more than at average overall inflation rates because they could – an indicator of market strength. We'll discuss market consolidation later in this chapter.

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<sup>222</sup> CPI inflation calculator <https://www.in2013dollars.com/us/inflation/2002?endYear=2019&amount=1>

- A second type of inefficiency comes from patient coding. According to the HHS inspector general, “hospitals increasingly billed for inpatient stays at the most expensive level from FY2014 to FY2019...these stays are vulnerable to...upcoding.”<sup>223</sup> Upcoding means labelling a patient as sicker for financial and reimbursement purposes.
- A third type of inefficiency comes from the mix of medical services provided in 2019 vs. 2003. Providers in 2019 sometimes (often?) opted for more expensive treatments when less expensive ones existed, or new drugs that worked no better than older ones might dominate the marketplace, or new devices that worked no better than older ones.
- A fourth type of inefficiency might come from a changed patient population needing medical care. The 2019 folks might be older, sicker or more obese than the 2003 group.

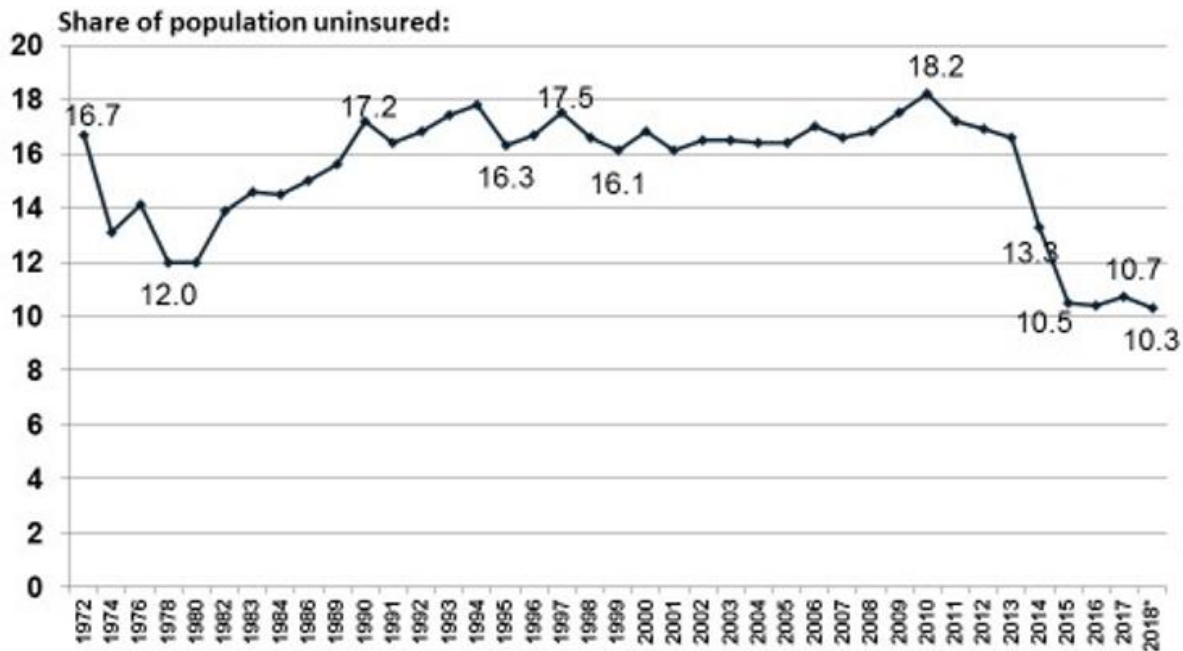
There is good evidence that all 4 factors combined in 2019 to describe that increase in our healthcare efficiency metric. We'll discuss some of this below. Regardless, though, of the exact cause, my underlying point here is that neither healthcare reform package – the 2003 Medicare Modernization Act nor the 2010 Affordable Care Act, nor both together – created a more efficient healthcare system that provided better outcomes at lower costs. Both reforms failed on that efficiency scale.

Let's turn now to coverage expansion, one of the 3 goals of any economic reform program. Post-Medicare Modernization Act – the legislation that was supposed to reduce healthcare costs and thus stimulate higher coverage rates due to the lower costs of health insurance – our **national uninsured rate** did not decrease. But post-Affordable Care Act the national uninsured rate did decrease, from about 18 to 10% of our total non-elderly population, or from about 50 to 30 million people. See the chart below.

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<sup>223</sup> HHS Inspector General Data Brief, **February 2021** OEI-01-18-00380

## Uninsured Rate Among the Nonelderly Population, 1972-2018\*



Source: CDC/NCHS, National Health Interview Survey, reported in [http://www.cdc.gov/nchs/health\\_policy/trends\\_hc\\_1968\\_2011.htm#table01](http://www.cdc.gov/nchs/health_policy/trends_hc_1968_2011.htm#table01) and <https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201808.pdf>.  
 \*Note 2018 data is for Q1 only

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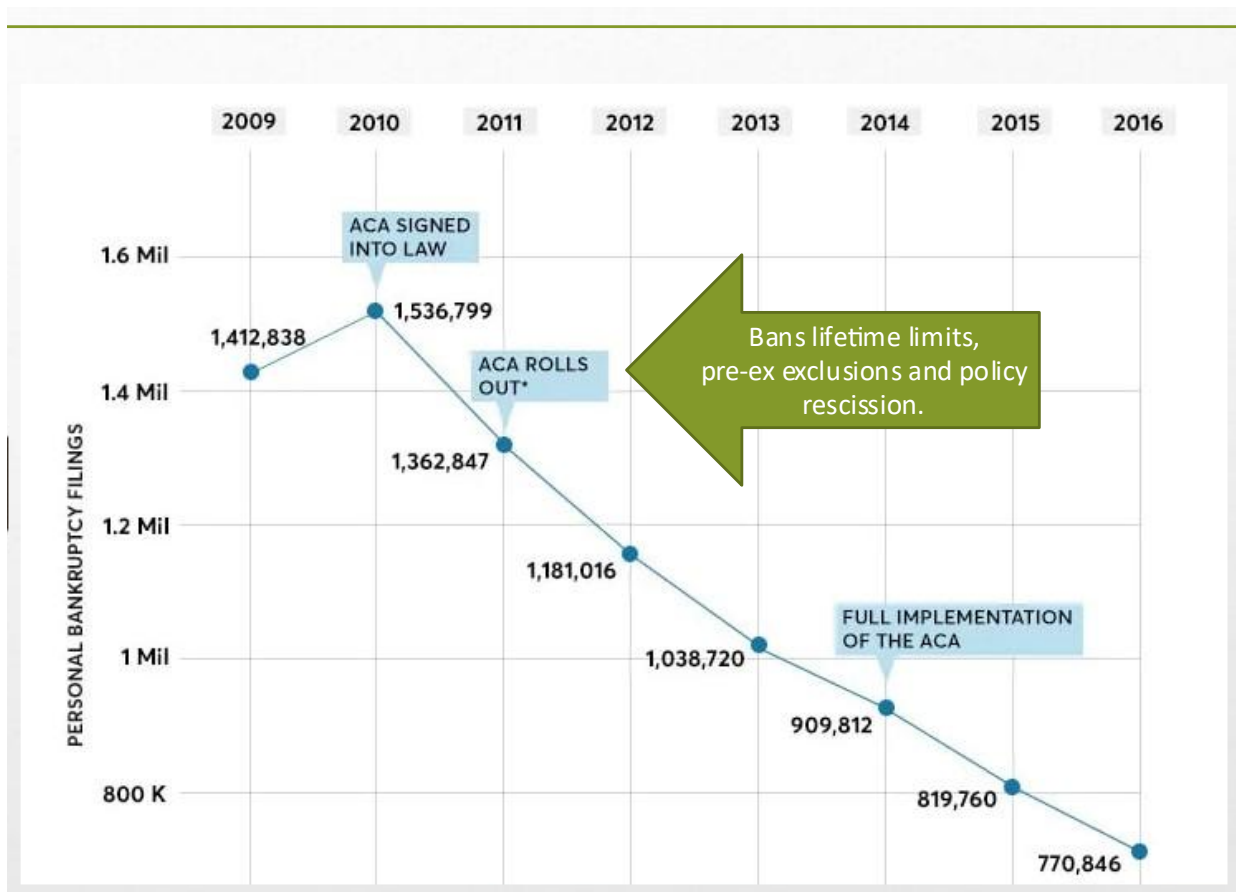
Wider health insurance coverage post-Affordable Care Act but no life expectancy gain. We'll discuss why below, but this initial analysis raises an interesting question: should we grade healthcare reforms *only* on coverage rates? After all, coverage rates are something we can control fairly easily (nothing in healthcare is easy but expanding coverage is mainly a political issue while extending longevity includes medical, economic, social, genetic, educational, behavioral and other issues.)

Some people say 'yes', that the government's role should only be to ensure coverage while the private sector – doctors, hospitals, pharmaceutical companies etc. - should focus on care quality and cost. The government's role is only to promote access; the private sector's is to promote quality. Thus 'good healthcare reform' by this definition, brings down the uninsured rate. Period.

I find this a strange argument. Extending it to the logical conclusion, it makes the Canadian or British healthcare systems better than ours. After all, they cover everyone while we only manage to insure about 90% of Americans. Few brokers, in my experience, and fewer politicians I suspect, would embrace that conclusion.

All this supports my skeptical position about healthcare reform, that Americans have no clear national vision of what a good healthcare system actually is. Yet each of us, working in the healthcare arena, claims to using our own, parochial one: a good healthcare system is one that pays me well. Odd but, unfortunately I suspect, true.

There is, though, one unequivocal, clear winner from healthcare reforms since 2000 – people declaring bankruptcy from medical expenses. Our national bankruptcy rate has fallen by about half since passage of the Affordable Care Act, from about 1.5 million to 750,000 annually. See the chart below. Many, if not most bankruptcies in the US are caused by medical bills.



While reducing the number of personal bankruptcies is clearly a good thing, I wonder if there might be alternative strategies available to accomplish this goal – other, that is, than revamping the entire US healthcare system. Nonetheless, I take this as a healthcare reform win, the only one I see.

## Healthcare reform tools

Let's now consider the tools available to healthcare reformers.

Market based reforms, like the Medicare Modernization Act, focus on so-called 'bottom up' or consumer driven incentives. These market based folks like to deregulate so the market, i.e. the interactions between medical care suppliers and medical care purchasers, takes place as efficiently as possible. Market based reformers dislike mandates and requirements, seeing these are obstacles coming between clinicians and patients. They dislike, in other words, things like insurance coverage requirements or minimum benefit packages that, in their eyes, raise prices unnecessarily. The marketplace, they argue, would differentiate 'good' from 'bad' insurance policies more efficiently.

Classical economic theory holds that an unencumbered buyer with access to all available information, will choose the highest quality / lowest cost products available. The market based reform team tries to apply this economic principle to healthcare.

Market based reformers like competition, figuring that more competition will force medical care suppliers (providers, clinicians, physicians, pharmaceutical companies and insurers) to find better / less expensive ways to treat sick patients. This becomes, they hope, a virtuous circle in which each product improvement / price reduction move stimulates others in the same direction.

Market based reformers like association health plans, seeing them as competition to large insurance companies. They like price lists and reference pricing figuring that patients will use price as a choice consideration, purchase lower priced care and therefore exert downward pressure on medical prices.

Reference pricing means that an employer or insurance policy will pay a stipulated amount for a specific treatment, say \$5000 for knee surgery for example. If the patient wants the \$6000 treatment, or prefers the \$6000 surgeon, then he or she pays the additional \$1000. In theory, reference price lists reflect the lowest priced medical providers in an area, thus stimulating other providers to lower their own prices to compete.

Market based reformers like Health Savings Accounts and HRAs, both of which put money into patient hands, on the theory that patients will spend their money more wisely than a huge, bureaucratic, bulky insurance carrier.

Government based reforms, on the other hand, use more top-down tools. This team likes regulations that force medical providers and carriers to act in certain ways. They don't trust the market to work its magic in healthcare. These folks like mandates, for example, that require employers to provide health insurance to employees. They like



the individual mandate that requires everyone to have health insurance, this to avoid so-called 'insurance death spirals' in which only sick people purchase insurance.

Insurance death spirals occur when healthier people don't purchase health insurance, but sicker people do. This drives up premiums, so 'slightly sicker' people stop purchasing and only the sickest remain on the insurance books. This makes premiums too expensive for most people, uninsured rates skyrocket and the system collapses.

Insurance operates on the law-of-large-numbers principle and needs lots of healthy people enrolled to counter the costs of sick people. That is why the Affordable Care Act instituted the individual mandate.

Government based reformers also like a required minimum set of benefits in any ACA compliant policies. They worry that carriers might lower their policy prices by leaving out important benefits. Policy holders, either unsophisticated purchasers or victims of unscrupulous sales tactics, might not learn of the benefit gaps until they get a bill, potentially a huge one. In other words, government based reformers see a minimum benefit requirement as consumer protection far less than inflationary. Our market based reform friends, discussed above, see the situation very differently.

The Affordable Care Act created health insurance exchanges, or online marketplaces where individuals could shop for health insurance. Exchanges list all available policy options from all available carriers in a region, encouraging consumers to compare prices and coverages before purchasing. By and large, exchange offered plans cover similar benefits but with different cost sharing.

Cost sharing means that the policy holder and insurance company each pay a portion of the premium and medical costs. Some policies might cost less but force the insured to pay more at the point of service; others might cost more but have a lower annual deductible.

Which team of healthcare reformers is right - the market based or government based folks? Which approach will reduce healthcare spending, extend life expectancy and provide universal insurance coverage? The unsatisfactory answer is that no one knows for sure, but both teams are convinced of their own infallibility with almost religious zeal. The Medicare Modernization Act passed the Senate in 2003 with 45 Republican votes and only 9 Democrats; the Affordable Care Act passed with 60 Democrats and no Republicans. Given that neither reform reduced costs, extended life expectancy or provided universal insurance coverage, I suspect that the real purpose of healthcare reform is to fight the good fight, raise money from political supporters and stay in office rather than actually to solve any of our myriad healthcare system problems.

But that's just my own point of view.

## Why reforms always fail to reduce costs, extend longevity and provide universal access?

I would argue that all our healthcare reforms since 2003 have ignored the 3 elephants in the room: obesity, industry consolidation and so-called 'diseases of despair' a new term to describe suicide, alcoholism and drug abuse. Any one of these 3 elephants would have made true healthcare reform difficult; all three together make healthcare reform impossible and generate the dismal results we see today. Let's address each elephant in turn and do so in the classical economic terms of supply and demand. But in our case, we'll go in reverse order, demand and supply because this makes our story flow somewhat more logically.

Obesity on the demand side of our 'supply and demand' equation, suggests why Americans need so much medical care. High national obesity rates work in opposition to our 3 healthcare reform goals: obesity decreases life expectancy, increases healthcare costs and therefore exacerbates our uninsured problems.

As I researched the obesity data for this lecture, I found three examples of obesity costs that surprised even me, and I study this stuff for a living. First, as people become more obese, their need for knee surgery rises dramatically. For this analysis, remember that a normal or healthy Body Mass Index tops out at 25.

Body Mass Index or BMI is our standard weight and obesity metric. It divides someone's weight in kilograms by their height in meters squared. You can find lots of online BMI calculators. A BMI between 18.5 and 24.9 is considered healthy. Below 18.5 is considered underweight, above 25 overweight. A BMI above 30 is labelled obese. The chart below shows BMI rates for a 6 foot tall person at different weights, simply as an example:

- At 147.5 pounds, the 6 foot tall person has a BMI of 20
- At 184 pounds, the 6 foot tall person has a BMI of 25
- At 221 pounds, the 6 foot tall person has a BMI of 30
- At 258 pounds, the 6 foot tall person has a BMI of 35
- At 295 pounds, the 6 foot tall person has a BMI of 40

As the BMI increases, the need for knee surgery increases proportionally more. Here are estimates from the American Academy of Orthopedic Surgeons for the rate of total knee arthroscopy by BMI. Compared to a normal weight person,

- Someone with a BMI of 30 is 8.5 times more likely to need knee surgery;
- Someone with a BMI of 35 is 18.7 times more likely, and
- Someone with a BMI of 40 is 32.7 times more likely.

We'll label that example 'surprising cost impacts of obesity #1'.

Next, consider the need for bariatric surgery, or surgery to remove part of your stomach to reduce your weight. People generally opt for this procedure after diets and other

lifestyle changes have failed. The US annually spends about \$180 billion on bariatric surgery and related medical procedures, that approximation in 2020 dollars.

Compare that to our annual cancer treatment expenditures of around 200 billion or so. Almost as much. But note that virtually everyone in American who gets diagnosed with cancer gets treated. By contrast only about 1% of the eligible obese population has so far had bariatric surgery. That's a huge population appropriate for and needing the procedure. We'll label this 'surprising cost impacts of obesity #2'.

And third, consider the additional Covid costs of obesity, including more severe symptoms, longer hospitalizations, more costly treatments and poorer outcomes. (This section was written in early 2022. Over time Covid treatments have evolved so some of this might be out-of-date when you read it.) According to Dr. Dariush Mozaffarian, dean of the Tufts Friedman School of Nutrition Science and Policy, as quoted in the Boston Globe on November 22, 2021 in an article The Obesity Pandemic Has Made Covid Much More Deadly, "64 percent of all the hospitalizations from COVID could have been prevented, if we had a metabolically healthy population, without the rates of obesity and diabetes and hypertension that we have now."

Let's try to calculate the obesity costs of Covid using Dr. Mozaffarian's estimate above. First, we'll assume the average hospital cost of treating a Covid patient at \$100,000. Admittedly rough, this comes from the Becker's Hospital Review analysis by state.<sup>224</sup> To simplify, the average Massachusetts hospital costs of treating a complex Covid patient in 2020 – 2021 were \$209,200; the average Massachusetts hospital cost of treating a non-complex patient were \$62,900. Other states are basically in the same ballpark. \$100,000 per patient is 'not obviously absurd' to quote one of my old grad school professor's mantra.

Meanwhile, the American Hospital Association estimates over 80 million Covid cases and 4.6 million hospitalizations.<sup>225</sup> Multiplying those 4.6 million hospitalizations times \$100,000 per hospitalization comes to a whopping \$460 billion. Dr. Mozaffarian's 64% of Covid hospitalizations attributable to obesity is almost \$300 billion.

That's a huge cost! We'll label this 'surprising cost impact of obesity #3'.

I hope I've made the basic point that obesity is a key driver of healthcare spending and adds a huge amount to our healthcare costs. Which raises the critical question of how well we have done on the obesity front since we reformed healthcare 2003. Presumably

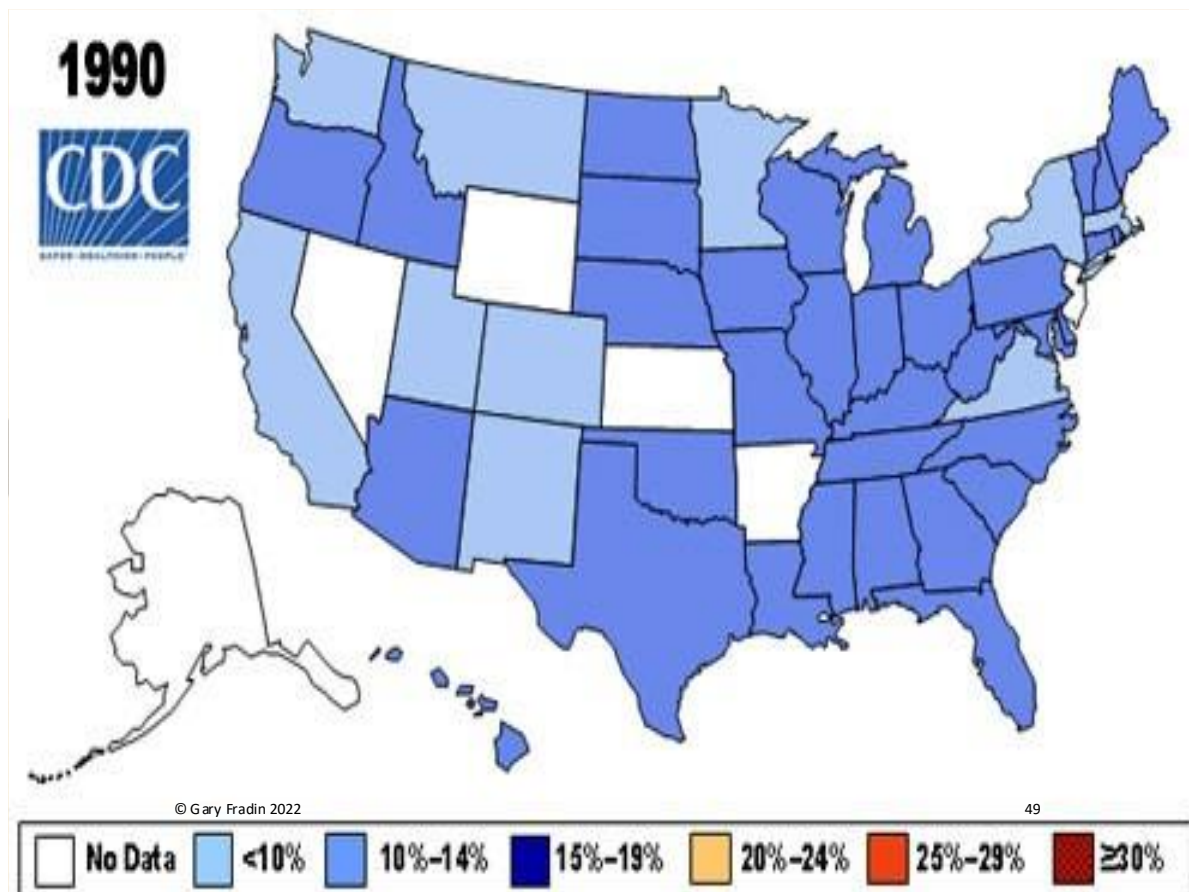
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<sup>224</sup> Average charge for Covid 19 hospitalization by state, Alia Paavola, Becker's Hospital Review, October 20, 2021

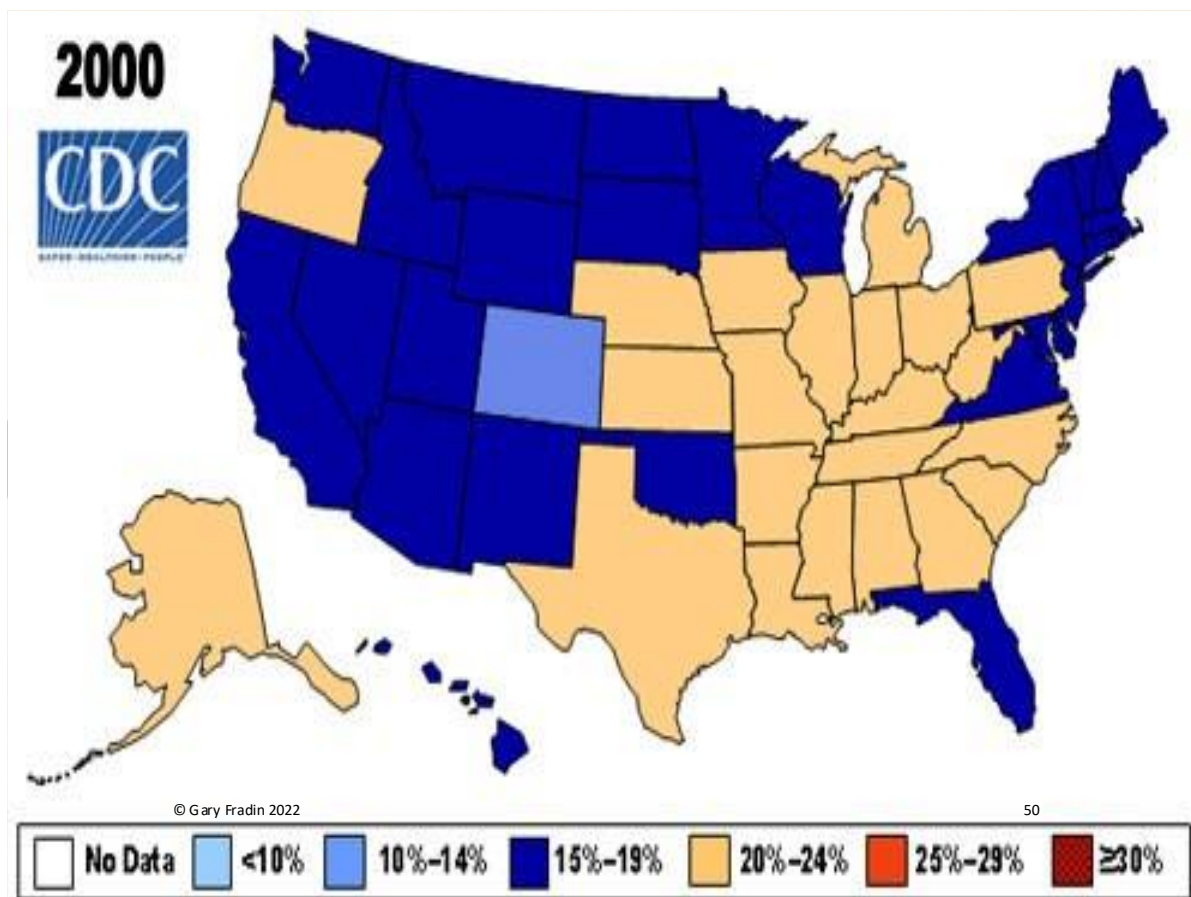
<sup>225</sup> Rising growth in expenses and rising inflation fuel financial challenges for America's hospitals and hospital systems, <https://www.aha.org/guidesreports/2022-04-22-massive-growth-expenses-and-rising-inflation-fuel-continued-financial#:~:text=Medical%20supply%20expenses%20grew%2020.6,%2C%20from%20pre%2Dpandemic%20levels.>

lower obesity would work toward our healthcare reform goals of better outcomes at lower costs for more people, which greater obesity would work in the opposite direction. In fact, I'll push this even further and suggest that healthcare reforms that fail to address or control obesity set themselves up for failure.

Let's see how we've done and use CDC charts as our guide. We'll start in 1990, before our healthcare reform packages, to set a baseline. The chart below shows obesity by state in 1990. The 4 white states mean 'no data', the 19 light colored states have less than 10% of their populations obese, and the remaining darker states have 10 – 14% of their populations obese. Note also that the CDC's grid at the bottom tops out at greater than 30% obese, a situation the CDC presumably figured unlikely to occur.

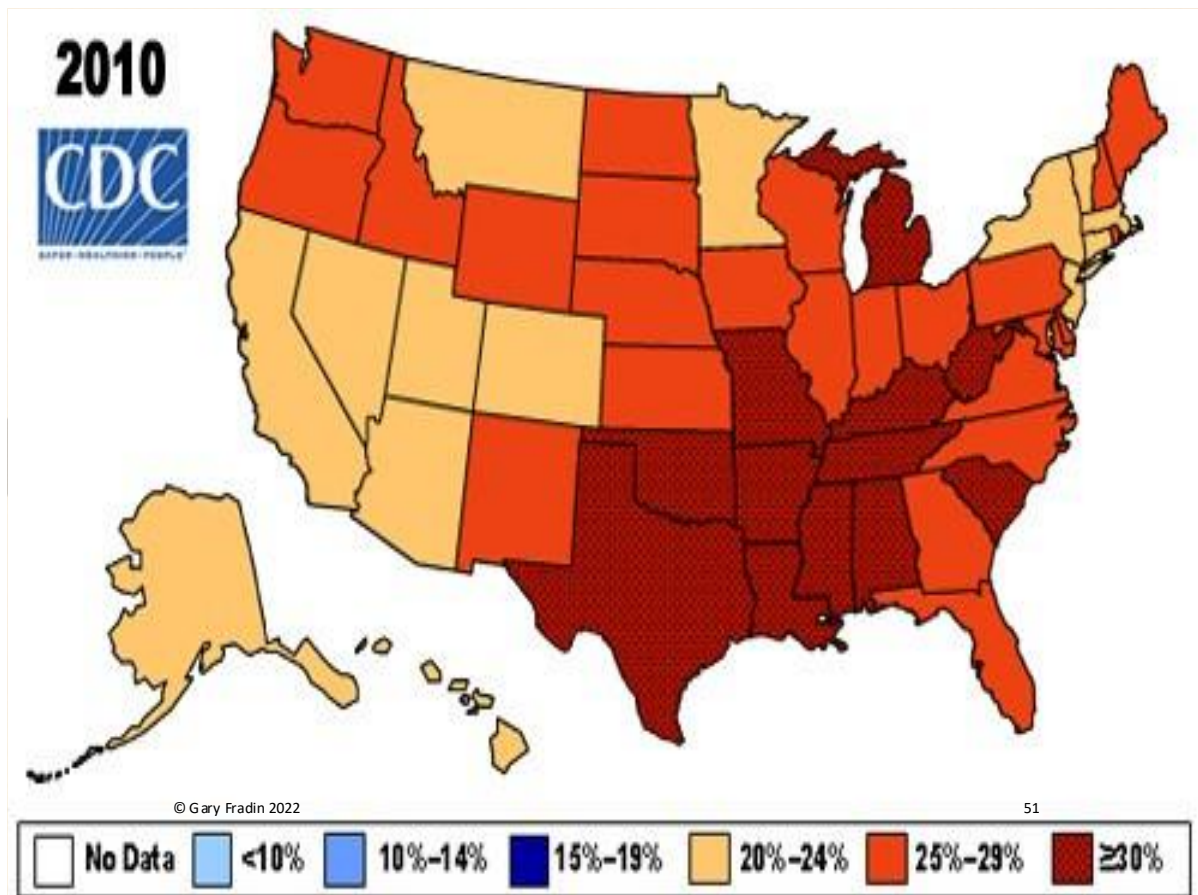


Then, 10 years later, our map changed. Same CDC methodology, same metrics, same format but a vastly different obesity map in only 10 years.



No state is less than 10% obese and only Colorado is less than 14% - the highest level of any state just 10 years before. Now, in 2000, over half the states are 20 – 24% obese, a level no one had reached in 1990.

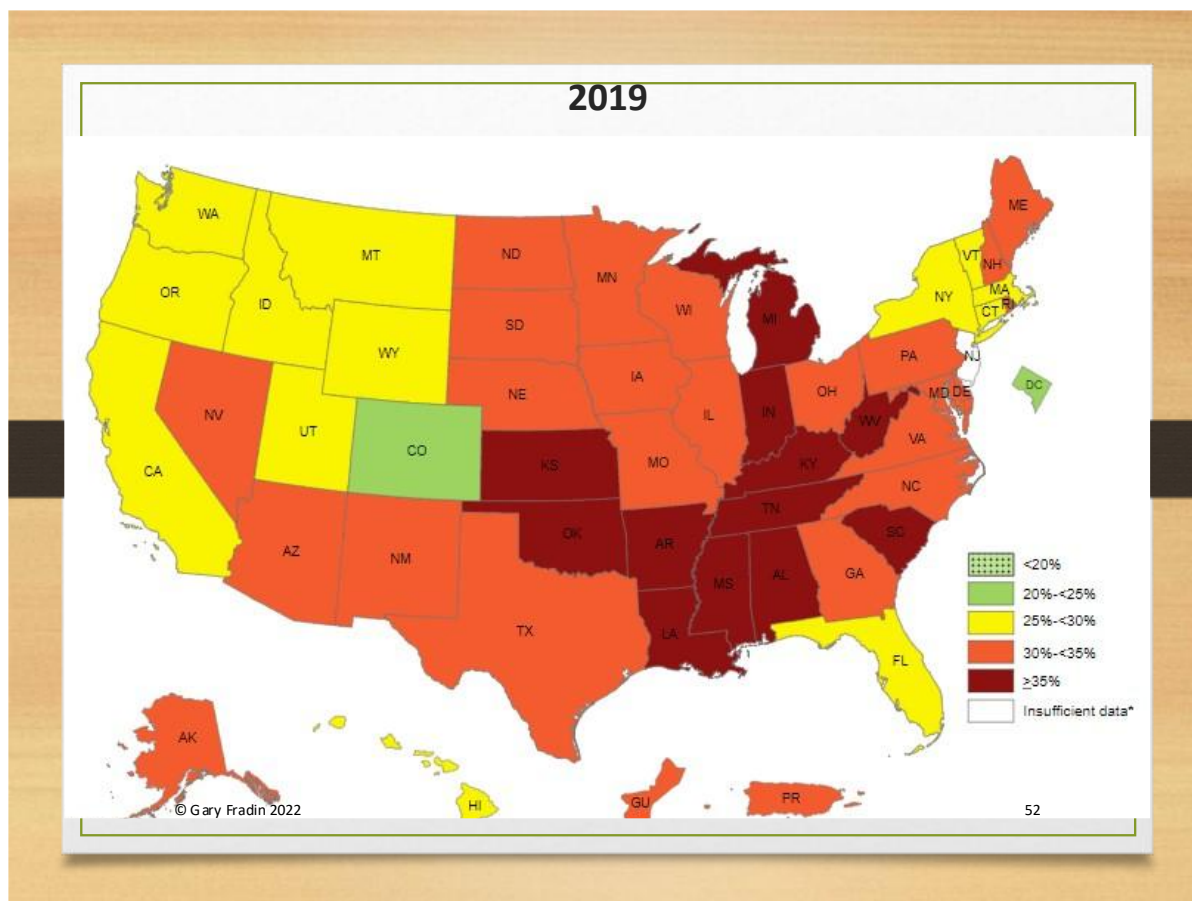
We then passed the Medicare Modernization Act and the Affordable Care Act...and our map changed dramatically again.



Forget about being less than 20% obese, a level no state had approached just 20 years before. Now no state is less than 20% obese and 11 states had hit the CDC's top limit of 'greater than 30%' obese, a situation the CDC thought unlikely just 20 years previously.

This led the CDC to rethink their format and methodology. In 2019, again the last year before Covid hit, the CDC had a completely different map.





Only 2 states were less than 20% obese and only 14 less than 30% obese. All the others were greater than 30% obese and a handful exceeded 35%. That's exceptional growth since passage of the Medicare Modernization Act and Affordable Care Act, one that makes achievement of those reform goals overly difficult.

A different CDC study estimated that 42% of us were obese in 2018 and Dr. Mozaffarian, our old friend from the Tufts School of Nutrition, estimated at 1 in 4 teenagers were pre-diabetic.

How, I wonder, can we reduce healthcare spending, improve healthcare outcomes and insure more people with a national obesity rate of 42% and 25% of US teenagers suffering from pre-diabetes. My short answer: you can't.

Let's now move from obesity on the demand side of our 'supply and demand' analysis to the supply side and discuss industry consolidation in the healthcare arena. As a basic economic principle, if you have increasing demand for services – which we have from obesity – and fewer medical care suppliers, then you will see prices rise. Let's examine our post-reform history.

First, hospitals have merged to create large hospital systems. Though they had been merging fairly actively prior to passage of the Affordable Care Act – in Boston, for

example, Brigham and Women's merged with Mass General in 1994 – mergermania continued in the hospital sector. Between 2011 and 2017, i.e. post passage of the Affordable Care Act, some 1587 hospitals or about 25% of the US total, merged. These merged hospital systems became the largest (or 2<sup>nd</sup> largest depending on Amazon) employer in most states. This middle class or wealthier employee population represented votes at the state level to promote the hospital system's interests. The hospital's coffers represented lobbying dollars to promote the hospital system's interests. The merged hospital system spoke with one voice in negotiations with health insurers. And the hospital's wealth funded high priced lawyers to defend the hospital system's interests against aggressive state attorneys general who wished to curb hospital dominance.

The net result was higher medical prices with, according to a 202 analysis in the New England Journal of Medicine, no significant change in 30 day readmission or mortality rates, i.e. no care quality improvement.<sup>226</sup> The Inspector General at the US Department of Health and Human Services phrased this differently in 2021 saying "hospitals increasingly billed for inpatient stays at the most expensive level from FY 2014 through FY 2019" because "these stays are vulnerable to ... upcoding".<sup>227</sup> (Upcoding means labelling the patient as sicker to get a higher insurance or Medicare payments.)

The net result: fewer hospitals, caused by the huge number of hospital mergers, used their market power to raise prices.

Hospitals not only merged together but also purchase physician groups to act as 'patient feeders', directing patients to specific hospitals. Between 2016 – 2019, hospitals purchased some 9000 physician practices, again constraining the supply of medical care providers in a region.

Then private equity groups entered the picture, purchasing about 22 physician practices between 2018 and 2019. Private equity purchasers had specific goals: either make a good return on their purchase investment or build an asset for future sale, or both. This motivated physicians to perform more procedures at higher prices. According to a 2022 American Medical Association study 'prices rose 26% in private equity-backed practices, while prices at similar practices without private equity investment grew by 12.9%'.<sup>228</sup>

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<sup>226</sup> Beaulieu et al, Changes in Quality of Care After Hospital Mergers and Acquisitions, New England Journal of Medicine, 2020

<sup>227</sup> HHS Inspector General Data Brief, February 2021 OEI-01-18-00380

<sup>228</sup> Zhu, Private Equity Acquisitions of Physician Medical Groups, JAMA Network Research Letter, Feb 18, 2020



Merged hospitals, combined with acquired physician practices, reduced the number of independent, competitive, healthcare providers dramatically post-healthcare reform. (The actual number of physicians did not decrease, just the number of businesses competing.) Faced with less competition, these large, merged businesses did what any large business would do in similar circumstances: they raised prices. How, I wonder, do negotiations go between a hospital system that controls 75% of the beds in a region and most of the physicians, and an insurer who has a 15% market share?

So far, I've suggested that demand for healthcare services rose post-healthcare reform due to obesity (among other factors) and the supply of healthcare providers available to deal with that increased demand fell due to industry consolidation. Now let's switch focus and discuss the environment in which all this took place. We'll introduce a new term: 'diseases of despair' or alcoholism, drug abuse and suicide combined.

People who die from alcoholism, drug abuse or suicide are said to die 'deaths of despair'. Some numbers to set the scene:

- Alcohol is linked to 95,000 annual deaths according to the CDC. This is about double gunshot deaths.<sup>229</sup>
- 500,000 Americans have died from drug abuse since 1999 including 107,000 in 2021.<sup>230</sup>
- 48,000 annual suicides.<sup>231</sup>

Note that neither the Medicare Modernization Act of 2003 nor the Affordable Care Act of 2010 ameliorated this mortality trend.

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AMA 2022 study, Robeznieks, 'Physicians warned of the pitfalls behind private equity promises, Aug 1, 2022 <https://www.ama-assn.org/practice-management/private-practices/physicians-warned-pitfalls-behind-private-equity-promises>

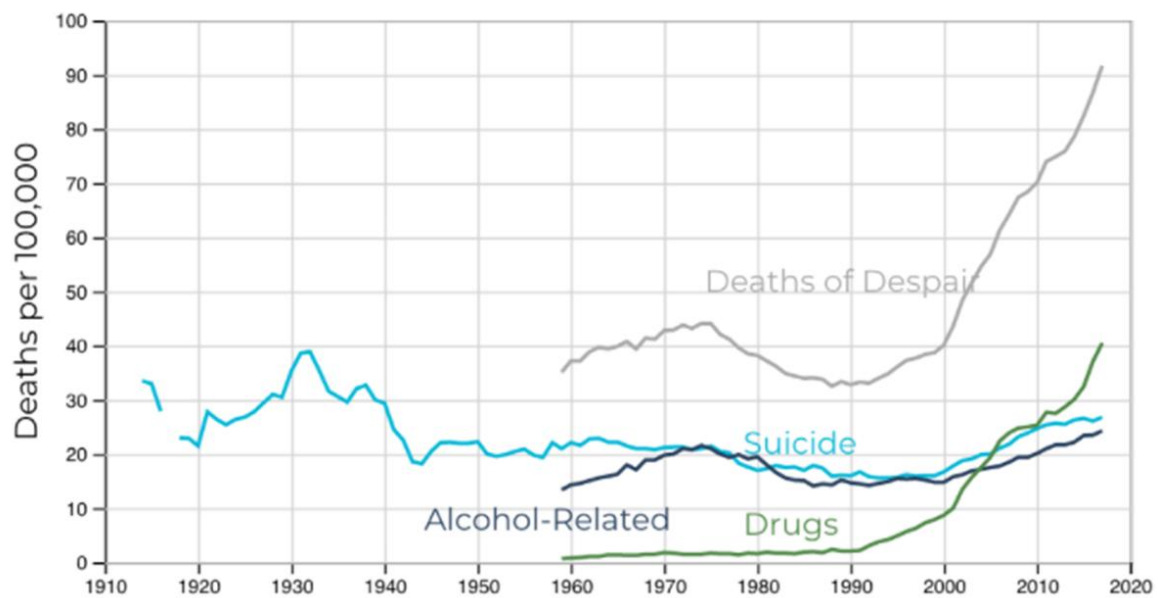
<sup>229</sup> Forbes <https://www.forbes.com/sites/joshuacohen/2018/07/19/diseases-of-despair-contribute-to-declining-u-s-life-expectancy/#277e57f0656b>, Gunshot deaths <https://www.cdc.gov/nchs/fastats/injury.htm>

<sup>230</sup> CDC estimate <https://www.cdc.gov/media/releases/2020/p1218-overdose-deaths-covid-19.html>

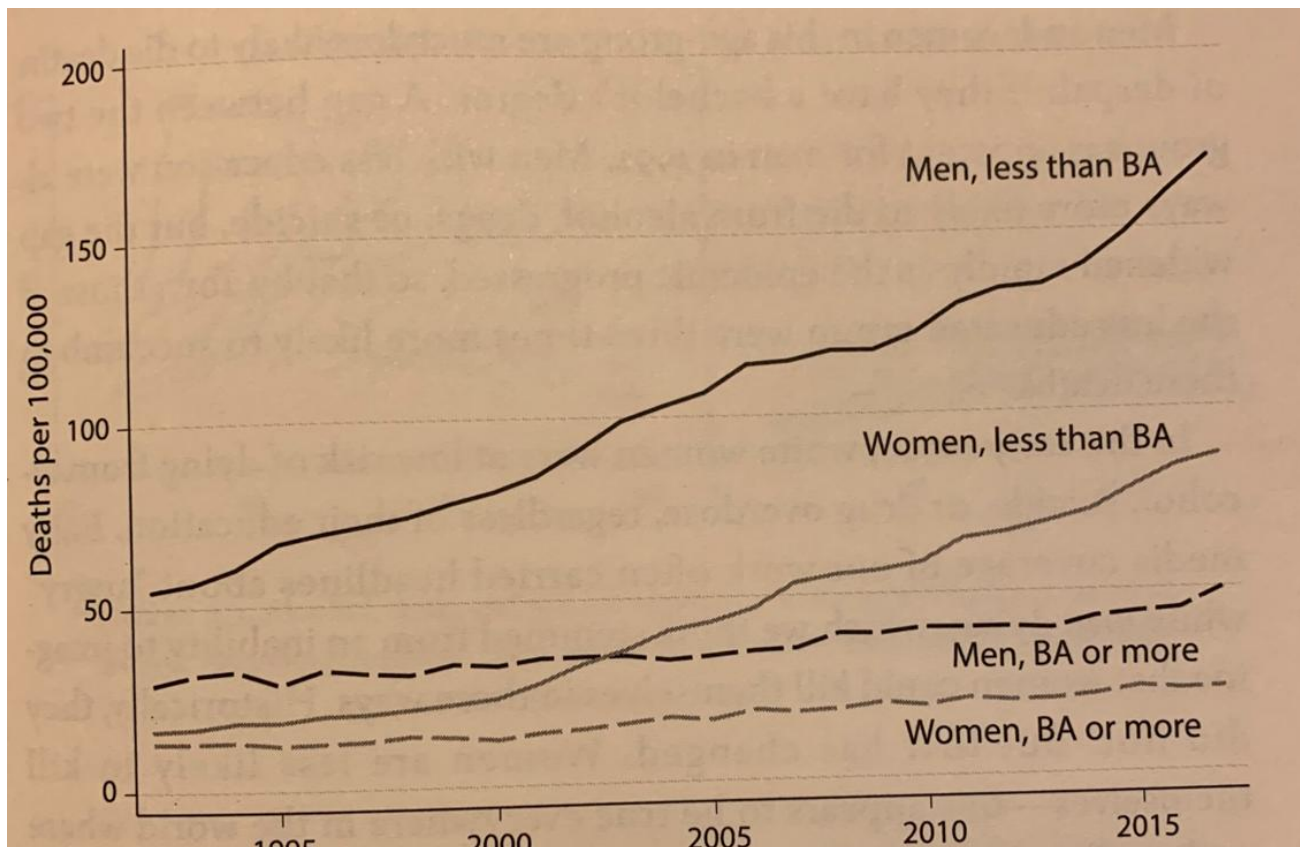
<sup>231</sup> Reference for Figure 3 chart **SEP 05** 2019 United States Congress Joint Economic Committee "Long term trends in deaths of despair"

<https://www.jec.senate.gov/public/index.cfm/republicans/2019/9/long-term-trends-in-deaths-of-despair>

**Figure 3. Deaths of Despair and Its Components, 1914-2017, Crude Rates, Non-Hispanic Whites Ages 45-54**



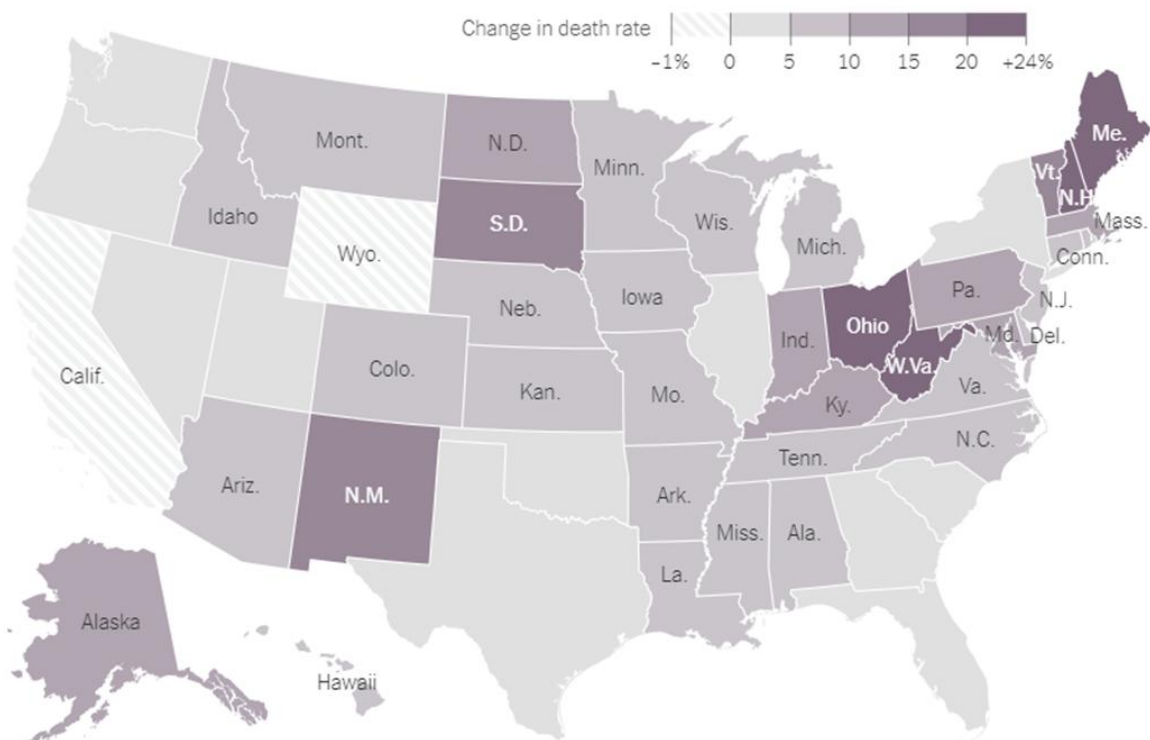
Deaths of despair fall disproportionately on middle aged, white, non-college educated men. The following chart, 'drug, alcohol and suicide mortality among white, non-Hispanics aged 45 – 54' shows this. It's from the 2020 book *Deaths of Despair* by Angus Deaton and Anne Case.



The next chart shows the net impacts of both healthcare reforms, the Medicare Modernization Act and Affordable Care Act. It shows the increase in mortality between 2010 and 2017 among people aged 25 – 64. These are the folks who should finish their education, begin and develop their careers, get married, have kids, build community and pay taxes. In all states except California and Wyoming, the death rate of this group has increased since passage of the ACA. In the darkest colored state, the death rate increase has been 20% or more.<sup>232</sup>

Death rate **increases** per state 2010 - 2017, people aged 25 – 64

<sup>232</sup> NY Times, It's Not Just Poor White People Driving a Decline in Life Expectancy, Kolata and Tavernise, Feb 18, 2021 <https://www.nytimes.com/2019/11/26/health/life-expectancy-rate-usa.html>



I understand the components of healthcare reform and what they are supposed to do. Health insurance exchanges are designed to help people shop more easily for health insurance policies. Eliminating annual and lifetime caps allow patients to receive more medical care. Health Savings Accounts combined with annual deductibles and price lists can help people purchase lower cost commodities like MRIs, X rays and a few other relatively low cost products.

But I don't understand how expanding HSAs, increasing insurance options or publishing medical prices reduce obesity, because they don't.

I don't understand how any component of healthcare reform helps people navigate through our 'insane' (Harvard Business School's Regina Herzlinger's term) or 'uniquely dysfunctional' (Columbia School of Public Health's Jonathan Engle's term) healthcare system when 1 hospital system controls 70% of the physicians and beds in a region, because they don't.

And I don't understand how any component of healthcare reform addresses deaths of despair because they don't.

In other words, I don't see any financial, political, insurance or payment format solution to our healthcare system problems. We've seen in the combination of Medicare Modernization Act and Affordable Care Act that incremental reforms don't work. And we know that dramatic, radical healthcare system reforms are politically impossible. The situation looks hopeless.

What might save us?

To answer this question, I propose a quick review of America's history of change, an analysis of how we have solved unsolvable problems in the past. By studying how we solved these problems in the past, we can see how we will likely solve our healthcare system problems in the future.

I am guided in this analysis by two thoughtful comments. The first comes from Herbert Stein, a well-known economist in the last century – Chairman of the Council of Economic Advisors to Presidents Nixon and Ford, for example – who famously observed that 'trends that can't continue, won't'. Something, in other words, always intercedes to avoid utter catastrophe. I suspect Stein is right about this.

The second comes from Mark Twain who equally famously observed that 'history doesn't repeat itself but it rhymes.' Historical examples, in other words, don't tell us exactly what will happen in the future but they suggest a direction.

Let's explore a non-healthcare problem from the late 1800s that could have destroyed civilization as we know it. The problem is horse refuse in major cities. We'll focus on New York since I have some data about this courtesy of the New York Times.<sup>233</sup>

Building technologies changed in the 1870s or so, with Andrew Carnegie's commercialization of steel. Buildings were no longer limited to 4 or 5 stories but could now reach 40, 50 or more. This led to more people living and working per acre.

At the same time, immigrants flooded to New York, increasing the city's population from 950,000 in 1870 to 3.4 million in 1900. More people jammed into tighter spaces meant more need for goods and services on, for example, Manhattan Island.

All these goods and services were transported by horse and buggy. In fact, according to the New York Times, there were more than 150,000 horses in New York in 1880. Each horse, according to their estimate, generated 22 pounds of manure per day. That's 1,650 tons! Plus, again the Times' estimate, 10,000 gallons of urine each day. Plus, again the Times' estimate, about 15,000 horses died each year on the streets – not a bad estimate assuming that each of the 150,000 horses lived an average of 10 years.

All this – the manure, the urine and the horse carcasses – combined to pose a huge disease threat, potentially big enough to destroy cities as they then existed.

Let's now apply current healthcare reform thinking to the horse refuse problem. The market based approach to healthcare reform, a.k.a. the Medicare Modernization Act, would have proposed deregulating horse management, refuse collection and refuse dispersal. Market based thinkers like to deregulate. They probably also would have proposed tax breaks for companies that researched, implemented and demonstrated

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<sup>233</sup> Lee, When Horses Posed a Public Health Hazard, NY Times, June 9, 2008

new and 'better' horse refuse control technologies and practices. Market based thinkers like tax breaks. They would have wanted to create an environment in which entrepreneurs and business builders would flourish, figuring that the market would solve the horse refuse problem more efficiently than any other approach.

By contrast, the government solution team, a.k.a. the Affordable Care Act thinkers, would have proposed a new government authority to oversee and manage horses. They likely would have wanted more regulations to control every aspect of horse management from feeding to housing to exercising and to refuse collection and dispersal. They would have wanted to license horse owners and users to ensure that the newest thinking and technologies applied to horse rearing. In short, the government solution team would have wanted to pass lots of rules to regulate as much about horses as possible.

I hope this brief historical example shows how both approaches – the market based and government solution – would have failed miserably to solve New York City's horse problem...just as they have failed to solve our healthcare system problems.

We know what ultimately solved the horse problem in New York – someone invented a car. The horse problem disappeared shortly thereafter. A new technology, unrelated to horse refuse, completely changed the paradigm and eliminated the manure problem.

Our question has changed. It's no longer 'what form of healthcare reform can we best solve our healthcare system problems?' Instead it has become 'what is the healthcare equivalent of cars?'. I have 4 ideas.

First, the combination of plant based proteins and new medications to address obesity. Things like Impossible Meats, Beyond Meat burgers and the like. Burger King introduced the Impossible Whopper in 2019 to positive reviews. Indeed, as part of my research for this chapter, I visited my local Burger King and ate one; it was delicious. As good as premium burgers and, arguable, healthier. We regularly eat these at home though, truth be told, I prefer the Beyond Burger taste – an individual preference.

Plant based meats act and taste like premium beef and, with their increased scale and 2022 inflation, have become less expensive. This portends a positive trend.

Combine this movement from animal to plant based protein new obesity drugs like semaglutide, trade name Wegovy, manufactured by Nova Nordisk. A high quality study found that obese patients lost an average of 15% of their body weight over 68 weeks, making it twice as effective as older drugs. A similar new anti-obesity drug is Saxenda, also manufactured by Nova Nordisk.

This combination of plant based proteins and new anti-obesity medications could – emphasize 'could' – have a significant impact on our obesity rates. Stay tuned.

A second potential healthcare equivalent of cars is gene editing using CRISPR technologies. Full disclosure: as a non-scientist, I do not understand how DNA editing

works. But as an occasional medical news article reader, I have seen reports about sickle cell and leukemia patients being cured by DNA editing.<sup>234</sup> 'Cured' means there is no evidence that the disease exists in the patient, different from 'remission'. That's tremendously exciting. DNA editing research and trials are continuing in many directions. Again, stay tuned.

A third potential healthcare equivalent of cars is mRNA technology, or messenger RNA. Again as a non-scientist, I don't know how this works. But mRNA technologies are the basis of the Pfizer and Moderna anti-Covid vaccinations that apparently worked quite well. Messenger RNA instructs the body to make specific new proteins. Still early days but a promising and exciting technology.

And a fourth potential healthcare equivalent of cars is the movement to home based healthcare and away from hospital care. Wall Street is betting that this movement will success. Consider these purchase prices from home based healthcare companies in 2021:

- Kindred at Home purchased by Humana, 2021 with **\$8.1 billion** market value
- LHC Group Inc, market cap **\$5.5 billion** Sept 2021
- Encompass Health, market cap **\$7.9 billion**, Sept 2021
- LHC Group, purchased by UHC, 3/22 for **\$5.4 billion**

Compare those prices to publicly traded hospital company market values, also in 2021: Tenet Health, 65 hospitals, \$8 billion market value; Universal Health, 211 hospitals, \$12 billion.

Which, if any, of these potential healthcare equivalent of cars will succeed? I don't know. Maybe all, maybe none.

*Footnotes for this chapter appear at the end of this text.*

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<sup>234</sup> Sickle Cell success – BBC report Feb 20, 2022 'Sickle Cell: 'The Revolutionary Gene Editing....' <https://www.bbc.com/news/health-60348497>, Leukemia cure, Boston Globe, 2/3/22 'Doctors: Cancer Patients Cured a Decade After Gene Therapy', Laura Ungar

## Public Health Insurance

Medicare became law on July 30, 1965, when President Lyndon B. Johnson signed the Social Security Amendments of 1965 into law. The legislation created both the Medicare and Medicaid programs as amendments to the Social Security Act.<sup>235</sup>

Medicare was established to provide health insurance coverage for Americans aged 65 and older, as well as certain younger individuals with disabilities. It was designed to address the growing healthcare needs of older adults and provide them with access to affordable healthcare services. Prior to the establishment of Medicare, many older Americans struggled to afford medical care, leading to significant financial burdens and barriers to accessing necessary healthcare services.

The creation of Medicare was a significant milestone in U.S. healthcare history, marking the federal government's commitment to ensuring access to healthcare for older adults and individuals with disabilities. Since its inception, Medicare has undergone several expansions and reforms to improve coverage and access to care for its beneficiaries, making it one of the most important and widely used healthcare programs in the United States.

Medicare consists of 4 main parts:

### 7. **Part A (Hospital Insurance):**

- Covers inpatient hospital stays, skilled nursing facility care, hospice care, and some home health care services.
- Most people do not pay a premium for Part A if they or their spouse paid Medicare taxes while working.

### 8. **Part B (Medical Insurance):**

- Covers outpatient care, doctor visits, preventive services, and some medical equipment and supplies.
- Requires a monthly premium, which can vary depending on income.

### 9. **Part C (Medicare Advantage):**

- Private insurance plans approved by Medicare that provide all Part A and Part B benefits.
- Often includes additional benefits such as vision, dental, and prescription drug coverage.
- Plans may have different costs and coverage rules.

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<sup>235</sup> Much of this section comes from ChatGPT, written in April 2024.



#### **10. Part D (Prescription Drug Coverage):**

- Helps cover the cost of prescription drugs.
- Offered by private insurance companies approved by Medicare.
- Monthly premiums, deductibles, and copayments or coinsurance apply.

#### **11. Medigap (Medicare Supplement Insurance):**

- Sold by private insurance companies to fill "gaps" in Original Medicare coverage, such as copayments, coinsurance, and deductibles.
- Helps pay for expenses not covered by Original Medicare.

#### **12. Other Coverage Options:**

- Some people may qualify for other Medicare programs, such as Medicare Savings Programs or programs for people with specific health conditions.

Overall, Medicare provides essential healthcare coverage for millions of Americans, though it's crucial for individuals to understand the different parts and options available to choose the coverage that best suits their needs.

### **The Four Components Medicare**

**Medicare Part A**, often referred to as Hospital Insurance, covers a range of inpatient hospital services and certain types of post-hospital care. Here's a more detailed breakdown of what Medicare Part A covers:

#### **6. Inpatient Hospital Care:**

- Part A covers semi-private rooms, meals, general nursing, and other hospital services and supplies when you're formally admitted as an inpatient by a doctor.
- It includes care received in acute care hospitals, critical access hospitals, inpatient rehabilitation facilities, and long-term care hospitals.

#### **7. Skilled Nursing Facility (SNF) Care:**

- Part A covers a stay in a skilled nursing facility (SNF) if it's medically necessary following a hospital stay of at least three days.
- SNF care includes services such as skilled nursing care, rehabilitation services, and other related health services.

#### **8. Hospice Care:**

- Part A covers hospice care for individuals with a terminal illness whose life expectancy is six months or less.

- Hospice care includes services like pain relief, symptom management, and emotional and spiritual support for both the individual and their family.

#### **9. Home Health Care:**

- Part A covers certain home health services if you're homebound and require skilled nursing care, physical therapy, speech-language pathology services, or continued occupational therapy.

#### **10. Blood:**

- Part A covers the cost of the first three pints of blood you receive in a calendar year, or the blood you get as a hospital inpatient during a stay, after you've paid a deductible.

It's important to note that while Medicare Part A covers a significant portion of inpatient hospital services and related care, it doesn't cover everything. For example, it typically doesn't cover private-duty nursing, a private room (unless medically necessary), or personal care items like toothpaste or razors.

Most people don't have to pay a premium for Medicare Part A if they or their spouse paid Medicare taxes while working. However, there are deductibles, coinsurance, and copayments associated with Part A services. It's essential to understand these costs and coverage limitations to make informed decisions about your healthcare needs.

Inpatient hospital care covered by Medicare Part A includes a range of services and supplies necessary for treating acute medical conditions and providing necessary care during a hospital stay. Here are some services that are typically included:

#### **9. Room and Board:**

- Coverage for semi-private rooms (unless medically necessary for a private room), meals, and general nursing care.

#### **10. Nursing Care:**

- Skilled nursing services provided by registered nurses (RNs) or licensed practical nurses (LPNs) for the management and monitoring of medical conditions.

#### **11. Medical Services and Supplies:**

- Physician services, including consultations, exams, and medical procedures performed during the hospital stay.
- Necessary medical supplies and equipment used during the hospitalization, such as IVs, oxygen, and other medical devices.

#### **12. Diagnostic Tests and Procedures:**

- Coverage for diagnostic tests, laboratory work, and medical imaging procedures necessary for diagnosing and treating the patient's medical condition.

### **13. Surgical Services:**

- Coverage for medically necessary surgeries performed during the hospital stay, including pre-operative and post-operative care.

### **14. Hospital Services:**

- Coverage for hospital services such as operating rooms, recovery rooms, and emergency room services used during the hospital stay.

### **15. Medications:**

- Coverage for medications administered during the hospitalization, including those administered intravenously or through other means.

### **16. Therapies:**

- Coverage for therapies provided during the hospital stay, such as physical therapy, occupational therapy, and speech-language pathology services.

Services typically excluded from Medicare Part A coverage for inpatient hospital care include:

### **5. Personal Comfort Items:**

- Personal comfort items such as telephone or television services, unless provided as part of the hospital's standard care.

### **6. Private Duty Nursing:**

- Nursing services provided by individuals not employed or contracted by the hospital, unless specifically authorized by Medicare under certain circumstances.

### **7. Private Room Charges:**

- Charges associated with a private room unless medically necessary as determined by the attending physician.

### **8. Certain Medical Procedures and Treatments:**

- Some elective procedures or treatments not deemed medically necessary by Medicare may not be covered.

Skilled Nursing vs. Long Term Care

Medicare Part A covers skilled nursing facility (SNF) care under certain circumstances. A Medicare beneficiary can stay in a skilled nursing facility as long as they meet specific criteria and as long as the care remains medically necessary. Here are the key points regarding Medicare coverage for skilled nursing facility stays:

**6. Qualifying Hospital Stay:**

- The beneficiary must have a qualifying hospital stay of at least three consecutive days as an inpatient. Observation days do not count toward this requirement.

**7. Medically Necessary Care:**

- The skilled nursing care must be medically necessary and related to the condition for which the beneficiary was hospitalized.

**8. Skilled Care Requirement:**

- The care provided in the skilled nursing facility must require skilled nursing or rehabilitation services on a daily basis. This includes services such as physical therapy, occupational therapy, or skilled nursing care.

**9. Coverage Period:**

- Medicare Part A covers up to 100 days of skilled nursing facility care per benefit period.
- The first 20 days are covered in full by Medicare.
- For days 21 through 100, the beneficiary is responsible for a daily coinsurance amount.

**10. Benefit Period:**

- A benefit period begins the day the beneficiary is admitted to a hospital or skilled nursing facility as an inpatient and ends when they haven't received any inpatient hospital care or skilled nursing care in a skilled nursing facility for 60 consecutive days.
- If the beneficiary needs skilled nursing care again after the benefit period ends, a new benefit period begins, and they may qualify for another 100 days of coverage.

While Medicare covers skilled nursing facility care for a limited period, it does not cover long-term care services or custodial care (assistance with activities of daily living like bathing, dressing, and eating) in a skilled nursing facility. After Medicare coverage ends, beneficiaries may need to explore other options for long-term care, such as Medicaid or private long-term care insurance, if they require ongoing assistance.

Medicare makes a distinction between skilled nursing care and long-term care based on the level of care required and the specific services provided. Understanding this difference is crucial for Medicare beneficiaries to determine their coverage eligibility. Here's how Medicare distinguishes between skilled nursing care and long-term care:

**5. Skilled Nursing Care:**

- Skilled nursing care refers to services provided by licensed healthcare professionals, such as registered nurses (RNs) or licensed practical nurses (LPNs), that are necessary for the treatment and management of a medical condition.
- Skilled nursing care involves services that require the expertise of trained medical professionals and cannot be safely performed by individuals without medical training.
- Examples of skilled nursing care include wound care, intravenous medication administration, physical therapy, and rehabilitation services following surgery or illness.

**6. Rehabilitation Services:**

- Medicare covers skilled nursing facility care when it is primarily for skilled nursing or rehabilitation services on a daily basis. This includes services such as physical therapy, occupational therapy, or speech-language pathology services that are needed to improve the beneficiary's condition or help them regain function.

**7. Time-Limited Care:**

- Skilled nursing care provided under Medicare is typically time-limited and intended to help the beneficiary recover from an acute illness, injury, or surgical procedure.
- Medicare Part A covers up to 100 days of skilled nursing facility care per benefit period, with the understanding that the care is expected to result in improvement or stabilization of the beneficiary's condition.

**8. Long-Term Care:**

- Long-term care refers to assistance with activities of daily living (ADLs) and other support services that are needed on an ongoing basis due to chronic illness, disability, or advanced age.
- Long-term care includes services such as assistance with bathing, dressing, eating, toileting, and mobility, as well as supervision and assistance with medications.

- Medicare does not generally cover long-term care services, as they are considered custodial care and not primarily skilled nursing or rehabilitative services.

**Medicare Part B**, also known as Medical Insurance, covers a wide range of outpatient services, preventive care, and medically necessary services that are not covered by Medicare Part A. Here's an overview of what Medicare Part B covers:

#### **11. Doctor Visits and Services:**

- Coverage for visits to doctors, including primary care physicians, specialists, and other healthcare providers.
- Services provided during doctor visits, such as physical exams, consultations, and evaluations.

#### **12. Outpatient Care:**

- Coverage for outpatient medical services and procedures received outside of a hospital setting.
- This includes services such as lab tests, X-rays, diagnostic imaging, and outpatient surgeries.

#### **13. Preventive Care:**

- Coverage for preventive services to help prevent illness or detect health problems early when they are most treatable.
- Examples include flu shots, vaccines, screenings for various conditions (e.g., cancer screenings, mammograms, colonoscopies), and counseling services.

#### **14. Durable Medical Equipment (DME):**

- Coverage for durable medical equipment prescribed by a doctor for use at home.
- Examples include wheelchairs, walkers, oxygen equipment, and hospital beds.

#### **15. Ambulance Services:**

- Coverage for emergency and non-emergency ambulance transportation to a hospital or other medical facility when medically necessary.

#### **16. Outpatient Mental Health Services:**

- Coverage for outpatient mental health services, including individual and group therapy sessions, counseling, and psychiatric evaluations.

**17. Outpatient Rehabilitation Services:**

- Coverage for outpatient therapy services, including physical therapy, occupational therapy, and speech-language pathology services.

**18. Some Prescription Drugs:**

- Limited coverage for certain outpatient prescription drugs that cannot be self-administered and are typically administered by a healthcare provider.

**19. Some Preventive Medications:**

- Coverage for certain preventive medications, such as certain vaccines (e.g., flu shots) and injectable osteoporosis drugs.

**20. Clinical Research Studies:**

- Coverage for certain costs associated with participating in approved clinical research studies.

While Medicare Part B covers many services, beneficiaries are generally responsible for paying a monthly premium, an annual deductible, and coinsurance or copayments for covered services. Additionally, not all services are covered at 100%, so beneficiaries may have out-of-pocket costs associated with their care.

What are some physician or outpatient services that typically are not covered by Medicare?

While Medicare Part B covers a wide range of physician and outpatient services, there are certain services and expenses that are typically not covered by Medicare. These may include:

- 11. Routine Dental Care:** Medicare does not cover most routine dental care, including cleanings, fillings, extractions, dentures, and dental plates.
- 12. Routine Vision Care:** Medicare does not cover routine eye exams for eyeglasses or contact lenses. However, it does cover some vision-related services if they are deemed medically necessary, such as exams for diabetic retinopathy or glaucoma.
- 13. Routine Hearing Care:** Medicare does not cover routine hearing exams or hearing aids. However, it may cover diagnostic hearing and balance exams if they are ordered by a doctor for the evaluation of a suspected medical condition.
- 14. Cosmetic Procedures:** Medicare does not cover cosmetic procedures or surgeries performed solely for cosmetic purposes. This includes procedures such as cosmetic surgery, Botox injections for wrinkles, and hair transplants.

15. **Acupuncture:** While acupuncture may be considered an alternative therapy for certain medical conditions, Medicare typically does not cover acupuncture treatments.
16. **Long-Term Care:** Medicare does not cover custodial or long-term care services, such as assistance with activities of daily living (e.g., bathing, dressing, eating) provided in a nursing home or at home.
17. **Over-the-Counter Medications:** Medicare does not cover most over-the-counter medications, vitamins, or supplements, even if they are recommended by a doctor.
18. **Alternative Medicine:** Medicare generally does not cover alternative or complementary medicine services, such as chiropractic care, massage therapy, or herbal supplements.
19. **Medical Services Outside the United States:** Except in certain limited circumstances, Medicare does not cover medical services received outside of the United States.
20. **Experimental or Investigational Procedures:** Medicare typically does not cover services or treatments that are considered experimental or investigational and not proven to be effective.

How can a Medicare beneficiary get access to these services? Specifically, how can a beneficiary get financial coverage for these?

Medicare beneficiaries seeking coverage for services that are not covered by traditional Medicare Part A and Part B have a few options to explore alternative coverage or financial assistance:

#### 6. **Medicare Advantage (Part C) Plans:**

- Medicare Advantage plans are offered by private insurance companies approved by Medicare. These plans provide all of the benefits covered by Medicare Part A and Part B and often include additional benefits beyond what Original Medicare covers.
- Many Medicare Advantage plans offer coverage for services such as routine dental care, vision care, and hearing care that are not covered by Original Medicare.
- Some Medicare Advantage plans also offer coverage for services like acupuncture, chiropractic care, and fitness programs that are not covered by traditional Medicare.
- Beneficiaries should review the specific benefits and costs associated with each Medicare Advantage plan to determine if it meets their needs.



## **7. Medicare Supplement Insurance (Medigap):**

- Medigap plans are supplemental insurance policies sold by private insurance companies to help fill the "gaps" in Original Medicare coverage, such as copayments, coinsurance, and deductibles.
- While Medigap plans do not typically cover services that are not covered by Medicare, they can help beneficiaries pay for out-of-pocket costs associated with covered services.
- Some Medigap plans may offer additional benefits beyond what Original Medicare covers, such as coverage for foreign travel emergencies.

## **8. Other Insurance Coverage:**

- Some beneficiaries may have access to other insurance coverage through employer-sponsored plans, retiree health plans, or union plans that offer coverage for services not covered by Medicare.
- Veterans may be eligible for coverage through the Department of Veterans Affairs (VA) for certain healthcare services not covered by Medicare.

## **9. State and Local Assistance Programs:**

- Some states offer assistance programs that provide coverage or financial assistance for services not covered by Medicare, such as prescription drugs, dental care, and vision care.
- Beneficiaries can contact their State Health Insurance Assistance Program (SHIP) or State Medicaid office to inquire about available assistance programs in their area.

## **10. Out-of-Pocket Payment:**

- In some cases, beneficiaries may need to pay out-of-pocket for services that are not covered by Medicare or other insurance plans.
- Beneficiaries can explore payment options with healthcare providers, such as setting up payment plans or negotiating discounted rates for services.

**Medicare Part C**, also known as Medicare Advantage, is an alternative way for Medicare beneficiaries to receive their Medicare benefits through private insurance plans approved by Medicare. Unlike traditional Medicare (Parts A and B), which is administered by the federal government, Medicare Advantage plans are offered by private insurance companies that contract with Medicare to provide all of the beneficiary's Part A and Part B benefits.

Here are some key features of Medicare Part C or Medicare Advantage:

## **7. All-in-One Coverage:**

- Medicare Advantage plans provide all of the benefits covered by Medicare Part A (Hospital Insurance) and Part B (Medical Insurance), and often include additional benefits beyond what Original Medicare covers.
- These additional benefits may include coverage for prescription drugs (Part D), routine dental care, vision care, hearing aids, and wellness programs.

#### **8. Variety of Plan Options:**

- Medicare Advantage plans come in various types, including Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), Private Fee-for-Service (PFFS) plans, Special Needs Plans (SNPs), and Medicare Medical Savings Account (MSA) plans.
- Each plan type has different rules and restrictions regarding network providers, out-of-pocket costs, and coverage limitations.

#### **9. Managed Care Approach:**

- Many Medicare Advantage plans use a managed care approach to healthcare delivery, which may involve network restrictions and requirements for referrals to see specialists.
- HMOs typically require beneficiaries to use network providers and obtain referrals from a primary care physician to see specialists.
- PPOs offer more flexibility in provider choice but may have higher out-of-pocket costs for services received out of network.

#### **10. Annual Enrollment Period:**

- Beneficiaries can enroll in or switch Medicare Advantage plans during the annual Medicare Open Enrollment Period, which runs from October 15 to December 7 each year.
- Some beneficiaries may also be eligible for special enrollment periods based on certain qualifying events, such as moving to a new area or losing other coverage.

#### **11. Premiums and Cost-Sharing:**

- Medicare Advantage plans may have premiums in addition to the standard Medicare Part B premium, although some plans offer \$0 premium options.
- Beneficiaries are still responsible for paying their Medicare Part B premium, as well as any copayments, coinsurance, and deductibles associated with their Medicare Advantage plan.

#### **12. Coverage Limitations:**

- While Medicare Advantage plans must provide at least the same level of coverage as Original Medicare, they may have different rules, restrictions, and coverage limitations.
- Beneficiaries should carefully review the benefits and costs of each Medicare Advantage plan to ensure it meets their healthcare needs and budget.

Medicare Part C has become increasingly popular among Medicare beneficiaries for several reasons:

#### **8. All-in-One Coverage:**

- Medicare Advantage plans often provide comprehensive coverage that includes all the benefits of Original Medicare (Parts A and B), along with additional benefits such as prescription drug coverage (Part D), dental, vision, and hearing benefits, wellness programs, and sometimes even gym memberships.
- This all-in-one coverage simplifies healthcare management for beneficiaries by consolidating their coverage into a single plan.

#### **9. Cost Savings:**

- Medicare Advantage plans may offer lower out-of-pocket costs compared to Original Medicare, including lower deductibles, copayments, and coinsurance.
- Many Medicare Advantage plans have annual out-of-pocket maximums, providing financial protection for beneficiaries in case of significant medical expenses.
- Some Medicare Advantage plans offer \$0 monthly premiums, providing an affordable option for beneficiaries on a fixed income.

#### **10. Additional Benefits:**

- Medicare Advantage plans often offer additional benefits beyond what Original Medicare covers, such as vision, dental, and hearing benefits, which can be particularly appealing to beneficiaries who need these services.
- Many plans also offer wellness programs, preventive care services, and access to telehealth services, which can help beneficiaries stay healthy and manage chronic conditions more effectively.

#### **11. Provider Networks:**

- While some Medicare Advantage plans have restrictive provider networks, others offer broader networks or even out-of-network coverage in certain circumstances, providing beneficiaries with flexibility in choosing their healthcare providers.
- Beneficiaries who prefer having a primary care physician to coordinate their care may find the managed care approach of Medicare Advantage appealing.

#### **12. Value-Added Services:**

- Some Medicare Advantage plans offer value-added services such as care coordination, disease management programs, transportation assistance, and home health services, which can improve the overall quality of care for beneficiaries.

#### **13. Annual Enrollment Period:**

- The annual Medicare Open Enrollment Period provides beneficiaries with an opportunity to review and change their Medicare coverage each year, including switching to a Medicare Advantage plan if it better meets their needs.

#### **14. Market Competition:**

- Medicare Advantage plans are offered by private insurance companies competing for beneficiaries' business, leading to innovation, improved benefits, and enhanced customer service.
- The availability of a wide range of plan options allows beneficiaries to choose a plan that best suits their individual healthcare needs and preferences.

Still, some 35% of Medicare beneficiaries remain in traditional Medicare for several reasons.

#### **9. Freedom of Provider Choice:**

- Original Medicare allows beneficiaries to see any healthcare provider who accepts Medicare, without the need for referrals or obtaining permission from a primary care physician.
- Some beneficiaries prefer the flexibility of choosing their healthcare providers, including specialists and hospitals, without restrictions imposed by network limitations.

#### **10. Predictable Coverage:**

- Original Medicare provides standardized coverage, making it easier for beneficiaries to understand their benefits and costs.

- While copayments, coinsurance, and deductibles still apply, beneficiaries may appreciate the transparency and predictability of costs associated with Original Medicare.

#### **11. Consistency of Coverage:**

- Original Medicare coverage remains consistent regardless of where beneficiaries live or travel within the United States.
- Beneficiaries who frequently travel or live in multiple states may find Original Medicare more convenient than Medicare Advantage plans, which may have limited provider networks or coverage areas.

#### **12. Access to Specialists:**

- Some beneficiaries with complex medical conditions or specialized healthcare needs may prefer Original Medicare because it allows them to see specialists without requiring referrals or network restrictions.
- Original Medicare generally offers more flexibility in accessing specialized care, which can be important for individuals with chronic or serious health conditions.

#### **13. Supplemental Coverage Options:**

- Beneficiaries who choose Original Medicare can supplement their coverage with a Medicare Supplement Insurance (Medigap) policy to help cover out-of-pocket costs, such as deductibles, copayments, and coinsurance.
- Medigap plans offer standardized benefits across different insurance companies, providing beneficiaries with additional financial protection and peace of mind.

#### **14. Preference for Fee-for-Service Model:**

- Some beneficiaries prefer the fee-for-service model of Original Medicare, where healthcare providers are paid for each service rendered, rather than the managed care approach of Medicare Advantage plans.
- Fee-for-service Medicare allows beneficiaries to have more control over their healthcare decisions and treatment options.

#### **15. Concerns About Plan Stability:**

- Medicare Advantage plans may change their benefits, provider networks, premiums, and formularies annually, which can be a concern for beneficiaries who prefer the stability and consistency of Original Medicare.

#### **16. Lack of Availability:**

- In some areas, particularly rural or underserved areas, there may be limited availability of Medicare Advantage plans, making Original Medicare the only viable option for beneficiaries.

Some beneficiaries may prefer the flexibility, consistency, and freedom of choice provided by Original Medicare. The decision to remain in traditional Medicare versus enrolling in Medicare Advantage is highly individual and depends on each beneficiary's healthcare needs, preferences, and priorities.

**Medicare Part D** is the prescription drug coverage component of Medicare. It was introduced as part of the Medicare Modernization Act of 2003 and became effective in 2006. Part D is designed to help Medicare beneficiaries afford the costs of prescription drugs, whether they are taken at home or administered in a clinical setting. Here are the key features of Medicare Part D:

#### **7. Coverage through Private Insurance Plans:**

- Medicare Part D is provided through private insurance plans approved by Medicare. These plans are offered by insurance companies and other private companies that contract with Medicare.
- Beneficiaries can choose from a variety of Part D plans available in their area, each offering a different list of covered drugs (formulary), premiums, deductibles, and copayments or coinsurance.

#### **8. Prescription Drug Formulary:**

- Each Medicare Part D plan maintains a formulary, which is a list of covered prescription drugs. Formularies vary between plans and can change from year to year.
- Part D plans are required to cover at least two drugs in each therapeutic category and class, ensuring beneficiaries have access to a range of treatment options.

#### **9. Annual Enrollment Period:**

- Beneficiaries can enroll in or make changes to their Medicare Part D coverage during the annual Medicare Open Enrollment Period, which runs from October 15 to December 7 each year.
- Outside of this period, beneficiaries may be eligible for a Special Enrollment Period if they experience certain qualifying events, such as losing other prescription drug coverage.

#### **10. Premiums and Cost-Sharing:**

- Beneficiaries typically pay a monthly premium for Medicare Part D coverage, in addition to any premiums they pay for Medicare Part A (if applicable) and Part B.
- Part D plans also have an annual deductible, which beneficiaries must pay out-of-pocket before their plan begins to cover prescription drug costs.
- After meeting the deductible, beneficiaries typically pay a copayment or coinsurance for each prescription filled, and the plan covers the remaining cost.

#### **11. Coverage Gap (Donut Hole):**

- Until recently, Medicare Part D included a coverage gap, often referred to as the "donut hole," where beneficiaries had to pay a larger share of their prescription drug costs.
- However, due to changes in the Affordable Care Act, the coverage gap has been gradually closing. As of 2021, beneficiaries only pay 25% of the cost of their brand-name drugs and 25% of the cost of generic drugs while in the coverage gap.
- The coverage gap will be fully phased out by 2024, at which point beneficiaries will pay no more than 25% of the cost of their drugs, both generic and brand-name, until they reach catastrophic coverage.

#### **12. Catastrophic Coverage:**

- Once a beneficiary's out-of-pocket spending on prescription drugs reaches a certain threshold, they qualify for catastrophic coverage. At this point, they pay a reduced copayment or coinsurance for covered drugs for the remainder of the year.

Medicare Part D provides essential prescription drug coverage for millions of Medicare beneficiaries, helping them afford the medications they need to manage chronic conditions, prevent illness, and improve their overall health and well-being.

The George W. Bush administration proposed and championed Medicare Part C (Medicare Advantage) and Part D (Prescription Drug Coverage) as part of the Medicare Modernization Act of 2003. There were several reasons behind the decision to propose these additions to Medicare:

#### **5. Addressing Rising Prescription Drug Costs:**

- One of the primary motivations for introducing Medicare Part D was to address the rising costs of prescription drugs for Medicare beneficiaries.
- Prescription drug coverage was seen as a critical component of comprehensive healthcare coverage, particularly as prescription drug

costs were becoming increasingly burdensome for seniors and individuals with disabilities.

#### **6. Expanding Medicare Coverage Options:**

- Medicare Part C (Medicare Advantage) was introduced to provide beneficiaries with more choices and flexibility in how they receive their Medicare benefits.
- Medicare Advantage plans, offered by private insurance companies, were intended to offer additional benefits and services beyond what Original Medicare covers, such as prescription drug coverage, dental, vision, and wellness programs.

#### **7. Promoting Competition and Market-Based Solutions:**

- The Bush administration favored market-based solutions and competition to improve efficiency and drive down costs in healthcare.
- By introducing Medicare Advantage and Part D, the administration aimed to encourage competition among private insurance plans, leading to innovation, improved benefits, and better value for beneficiaries.

#### **8. Political and Legislative Priorities:**

- The proposal for Medicare Part D and Medicare Advantage was part of the broader legislative agenda of the Bush administration, which sought to enact significant reforms in healthcare and social policy.
- Medicare Part D and Medicare Advantage were ultimately included in the Medicare Modernization Act of 2003, which was passed by Congress and signed into law by President Bush in December 2003.

Overall, the introduction of Medicare Part C (Medicare Advantage) and Part D (Prescription Drug Coverage) was driven by a combination of factors, including the need to address rising prescription drug costs, expand coverage options for beneficiaries, promote market competition, and advance the administration's legislative priorities in healthcare reform.

Medicare is generally quite popular among its beneficiaries. Surveys and polls consistently show high levels of satisfaction with Medicare among older adults and individuals with disabilities who are enrolled in the program. According to data from the Centers for Medicare & Medicaid Services (CMS), the vast majority of Medicare beneficiaries express satisfaction with their coverage and access to care.

Here are some key factors contributing to the popularity of Medicare among beneficiaries:

#### **5. Comprehensive Coverage:**



- Medicare provides comprehensive healthcare coverage, including hospital insurance (Part A), medical insurance (Part B), and prescription drug coverage (Part D), as well as options for supplemental coverage through Medicare Advantage (Part C) and Medigap plans.
- The breadth of coverage offered by Medicare helps ensure that beneficiaries have access to essential healthcare services without facing significant financial barriers.

#### **6. Provider Choice:**

- Medicare beneficiaries have the freedom to choose their healthcare providers, including doctors, specialists, hospitals, and other healthcare facilities.
- The ability to see the providers of their choice without needing referrals or obtaining permission from a primary care physician is highly valued by many beneficiaries.

#### **7. Affordability:**

- While beneficiaries may still have out-of-pocket costs such as premiums, deductibles, and coinsurance, Medicare generally offers more affordable coverage options compared to private insurance plans, particularly for older adults and individuals with pre-existing health conditions.

#### **8. Stability and Reliability:**

- Medicare is a longstanding and well-established program with a strong track record of providing healthcare coverage to millions of Americans.
- The stability and reliability of Medicare contribute to its popularity and trustworthiness among beneficiaries.

Comparatively, private insurance plans vary widely in popularity among subscribers, depending on factors such as plan features, network coverage, cost, and individual preferences. While some individuals may prefer the flexibility and additional benefits offered by private insurance plans, others may find that Medicare provides more comprehensive coverage and greater peace of mind, particularly as they age and their healthcare needs become more complex.

### **How Medicare is Funded**

Medicare is funded through a combination of general revenue contributions, payroll taxes, beneficiary premiums, and other sources. Here's an overview of how Medicare is funded:

#### **6. Payroll Taxes:**

- The largest source of funding for Medicare comes from payroll taxes paid by employees and employers under the Federal Insurance Contributions Act (FICA).
- The Medicare payroll tax is composed of two parts: the Hospital Insurance (HI) tax and the Supplementary Medical Insurance (SMI) tax.
- The HI tax funds Medicare Part A (Hospital Insurance), while the SMI tax funds Medicare Part B (Medical Insurance) and Medicare Part D (Prescription Drug Coverage).

#### **7. General Revenue Contributions:**

- Medicare Part A (Hospital Insurance) is primarily funded through payroll taxes, but it also receives contributions from general revenues to cover any shortfalls in funding.
- General revenue contributions help ensure that Medicare Part A remains adequately funded to cover the costs of hospital and inpatient care for beneficiaries.

#### **8. Beneficiary Premiums:**

- Medicare beneficiaries also contribute to the funding of Medicare through premiums for certain parts of the program.
- Most beneficiaries do not pay premiums for Medicare Part A if they or their spouse paid Medicare taxes while working. However, beneficiaries may be required to pay premiums for Medicare Part B (Medical Insurance) and Medicare Part D (Prescription Drug Coverage).
- Premiums for Medicare Part B and Part D are set annually and may vary depending on factors such as income level and enrollment status.

#### **9. Medicare Advantage Payments:**

- Medicare Advantage plans receive payments from the federal government to provide Medicare-covered benefits to beneficiaries enrolled in their plans.
- These payments are based on a complex formula known as the Medicare Advantage capitated payment system, which takes into account factors such as beneficiary demographics, health status, and regional costs.

#### **10. Other Sources:**

- In addition to payroll taxes, general revenue contributions, and beneficiary premiums, Medicare may receive funding from other sources, such as interest earned on the Medicare trust funds, state contributions to the

Medicaid program (which helps cover some Medicare costs for dually eligible beneficiaries), and certain taxes on high-income individuals.

Medicare cost about \$929 billion in 2021, or about \$13,000 per beneficiary. The cost per beneficiary has been increasing at a slower rate than overall inflation and private insurance costs over the past 5-8 years. Here are some key points:

- According to data from the Centers for Medicare & Medicaid Services (CMS), Medicare costs per beneficiary grew by about 2-3% annually from 2015 to 2022. This is well below the overall inflation rate during this period.
- Specifically, Medicare spending per beneficiary increased 2.3% in 2021 and 2.9% in 2022, while overall inflation was around 7-9% those years.
- In comparison, private health insurance premiums for employer-sponsored family coverage increased around 4-6% annually from 2015-2022 according to the Kaiser Family Foundation.
- The slower growth in Medicare costs is attributed to payment reforms, increased use of cheaper generic drugs, and delivery system reforms encouraging more cost-effective care.
- However, Medicare costs are expected to rise more rapidly in the coming years due to an aging population and rising healthcare costs overall.

Medicare's funding situation has been a longstanding issue of concern. The program currently gets funding from three main sources:

- Payroll taxes
- Premiums paid by beneficiaries
- General revenues from the federal government

There are two separate trust funds - one for Hospital Insurance (Part A, covering inpatient hospital care) and one for Supplementary Medical Insurance (Parts B and D, covering outpatient care and prescription drugs).

The often-cited projection that the Medicare Hospital Insurance Trust Fund will be depleted or "run out of money" in around 7 years (specifically 2028 according to the latest Medicare Trustees report) does not mean Medicare itself is going bankrupt or will cease operating altogether.

What it means is that the Hospital Insurance Trust Fund's reserves will be depleted by 2028 based on current income and expenditure projections. After 2028, income to the fund from payroll taxes and other revenue would cover only 90% of projected Part A costs.

The Supplementary Medical Insurance Trust Fund is expected to remain adequately financed into the indefinite future because its funding can be adjusted through changes in premiums and general revenue contributions.

However, shoring up the financial condition of the Hospital Insurance Trust Fund will likely require significant legislative reforms by Congress, such as increasing payroll taxes allocated to Medicare, reducing expenditures through further cost-saving measures, or supplementing the fund with general revenues.

Here are some key points to consider:

**4. Trust Fund Depletion:**

- The Medicare Trustees issue annual reports that project the financial status of the HI Trust Fund based on revenue and expenditure projections. These reports include estimates of when the trust fund will be depleted if current trends continue.
- The projected depletion date has fluctuated over time due to various factors such as changes in healthcare costs, enrollment trends, economic conditions, and legislative changes.

**5. Impact on Benefits:**

- If the HI Trust Fund were to be depleted, it would not mean that Medicare benefits would disappear entirely. Instead, it would mean that the trust fund would no longer have sufficient funds to cover all of its obligations fully.
- In the event of trust fund depletion, Medicare Part A would still be able to pay a portion of its costs through ongoing revenue from payroll taxes and other sources, but benefits might need to be reduced, or additional funding sources might need to be allocated to cover the shortfall.

**6. Need for Policy Changes:**

- The projected depletion of the HI Trust Fund underscores the need for policy changes to address the long-term financial sustainability of the Medicare program.
- Potential policy solutions to address trust fund depletion include increasing revenue through payroll taxes or other sources, reducing expenditures through benefit reforms or cost-saving measures, improving the efficiency of healthcare delivery, and implementing measures to address the underlying drivers of healthcare costs.

**Measuring Medicare's Outcomes**

The easiest way to measure a healthcare system's outcomes or quality is by measuring life expectancy. I like this admittedly imperfect metric for a couple of reasons:

- The data are relatively easy to access.

- Life expectancy generally improves in lock-step with a healthcare system. A well functioning system generally will generate longer life expectancies than a poorly functioning one.
- Life expectancy data also include variables that a narrowly defined medical care system might miss. Access to healthy foods, for example, probably play a life expectancy role. This suggests that a well functioning healthcare system should address the population's nutritional needs, not just their acute care needs.

Let's compare American life expectancies at age 65 to other countries.<sup>236</sup>

- For American men who survived to age 65 in 2021, their remaining life expectancy was around 18.1 years.
- For American women at age 65, remaining life expectancy was around 20.6 years in 2021.
- This places the U.S. below the average among OECD countries for life expectancy at age 65. For example, a 65-year-old man in Switzerland could expect to live around 19.8 more years on average.

Some key comparisons on life expectancy at birth and age 65 from 2021 OECD data:

- Switzerland: 81.1 years at birth, 21.1 remaining at age 65
- Norway: 82.7 years at birth, 20.3 remaining at 65
- Australia: 83.3 years at birth, 21.1 remaining at 65
- Canada: 82.2 years at birth, 21.3 remaining at 65
- United States: 77.0 years at birth, 18.5 remaining at 65

The correlation between life expectancy and overall healthcare system quality is complex, as life expectancy can be influenced by many socioeconomic and environmental factors beyond just the healthcare system itself. However, most research suggests there is a meaningful but moderate correlation.

- Access to high-quality healthcare is undoubtedly a key determinant of life expectancy, especially through prevention and effective management of chronic diseases that affect mortality.
- Countries that rank highly on measures of healthcare access, affordability, and clinical outcomes tend to have higher life expectancies on average.

However, factors like poverty, education levels, diet, rates of smoking/obesity, air pollution, and income inequality also significantly impact life expectancy independently of healthcare.

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<sup>236</sup> This section comes from Claude.ai, April 2024

Statistical analysis estimates that differences in healthcare system performance may account for around 25-40% of the life expectancy gap between the U.S. and other wealthy nations.

The remaining gap is attributed to the socioeconomic, environmental, and behavioral factors prevalent in the U.S. population.

Within countries, individuals with higher incomes and better healthy behaviors tend to experience longer life expectancies, even with similar healthcare access.

That's why I suggest that life expectancy is a good but definitely imperfect measure of Medicare's quality.

### Summary

Medicare has been one of the most significant and impactful social programs in American history since its establishment in 1965.

What Medicare Accomplished:

- Provided access to health insurance for millions of elderly Americans age 65+ who previously could not afford or qualify for private coverage.
- Helped dramatically reduce elderly poverty and financial insecurity by covering major hospital and medical expenses.
- Improved access to preventive services and treatment for the elderly population.
- Along with Medicaid, helped desegregate some hospitals that previously refused Black patients.
- Established a national health insurance model and system that other programs like Medicaid and CHIP were built upon.

How Medicare Changed the World:

- Served as a model for other nations to establish universal healthcare programs for their citizens.
- Shifted the physician reimbursement system and expanded the role of private health insurance companies as contractors.
- Created a massive new sector of the economy around the administration of government-funded health insurance.
- Facilitated the integration of new medical technologies and drugs by covering them nationwide.
- Demonstrated how a large social insurance program could be successfully implemented and administered.

Overall Quality and Impact:

- While not perfect, Medicare has been incredibly successful in providing essential health coverage to the elderly.

- It remains one of the most popular and solidly supported government programs in American public opinion.
- Medicare has greatly improved quality of life and financial security for tens of millions of American seniors.
- However, its long-term financial sustainability remains an ongoing challenge that may require reforms.

Overall, Medicare drastically improved access to healthcare for America's senior citizens, served as a model for other countries, fundamentally changed the healthcare system's economics, and continues to provide vital health security today despite future financing concerns.

### **A word about Medicaid**

Medicaid fills critical gaps in health coverage for tens of millions of America's most vulnerable low-income populations.<sup>237</sup> It is a joint federal and state program that provides health coverage to low-income Americans. Here's an overview of this major government health insurance program:

#### **Purpose & Eligibility:**

- Medicaid's main purpose is to provide health coverage for low-income adults, children, pregnant women, elderly adults, and people with disabilities.
- Eligibility is based on income level, which must be below a certain federal poverty line threshold. This threshold varies by state.
- As of 2022, over 83 million Americans were enrolled in Medicaid and the related Children's Health Insurance Program (CHIP).

#### **Benefits Covered:**

- Mandatory benefits covered by all state programs include inpatient/outpatient hospital services, physician services, laboratory/x-ray services, and early and periodic screening for children.
- States can choose to provide additional optional benefits like prescription drug coverage, physical therapy, dental, vision, and others.

#### **Funding:**

- Medicaid is funded jointly by the states and the federal government.
- The federal government pays states a matching rate (averaged 64% in 2020) based on the state's per capita income.
- Total Medicaid spending was over \$670 billion in 2020.

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<sup>237</sup> Much of this section comes from Claude ai.

#### Program Administration:

- Medicaid is a federal-state partnership program. The states administer their own Medicaid programs while following federal guidelines.
- This allows for state flexibility in program rules, benefits, eligibility, and provider payments.

#### Impact:

- Medicaid covers a large share of low-income children, pregnant women, seniors in nursing homes, and people with disabilities.
- It helps provide services that promote care in home/community settings rather than institutions.
- Critics argue for more uniformity across state programs and better cost control measures.

Medicaid generally provides more comprehensive benefits particularly for long-term care services. Here's a brief summary of benefits in both programs:

#### Medicare Benefits:

- Hospital Insurance (Part A) - Inpatient hospital care, skilled nursing facility care, hospice, home health services
- Medical Insurance (Part B) - Physician services, outpatient care, preventive services, durable medical equipment
- Prescription Drug Coverage (Part D) - Outpatient prescription drugs
- Medicare Advantage (Part C) - Managed care plans that provide Parts A, B and usually D

#### Medicaid Benefits:

- Inpatient/outpatient hospital services
- Physician/certified nurse practitioner services
- Lab/x-ray services
- Nursing facility/home health care services for over 21
- Early periodic screening, diagnosis and treatment for under 21
- Family planning services
- Rural health clinic/FQHC services
- Transportation to medical care



Additionally, states can choose to provide optional Medicaid benefits like:

- Prescription drugs
- Rehabilitation services
- Personal care services
- Dental, vision, physical therapy and other therapies

Key Differences:

- Medicaid provides more comprehensive long-term care coverage
- Medicaid covers a broader range of benefits like dental, vision, therapies that Medicare does not
- But Medicaid varies significantly by state, while Medicare benefits are nationally uniform
- Lower-income Medicare beneficiaries can have Medicaid as a supplement

Medicaid generally provides more comprehensive benefits particularly for long-term care services and non-medical benefits that promote overall health for low-income populations.

Medicaid's financial strength and sustainability are an ongoing issue of concern, though its funding outlook is somewhat better than Medicare's in the near-term.

Funding Sources:

- Medicaid is jointly funded by the federal government and states.
- The federal share is around 64% on average, though this federal matching rate varies by state based on per capita income.
- Total Medicaid spending was over \$670 billion in fiscal year 2020.

Cost Growth:

- Medicaid costs have been growing faster than the overall economy, driven by enrollment growth, rising healthcare costs, and expansion of benefits.
- Total Medicaid spending increased by around 6% annually from 2017-2020.
- This growth rate is projected to continue in the range of 5-6% per year over the next decade.

Future Outlook:

- Medicaid's funding is not facing the same insolvency projections as Medicare's Hospital Insurance Trust Fund in the short-term.

- As an entitlement, federal/state funding is obligated to match enrollment and costs.
- However, the program's growing expense poses significant budgetary pressures long-term.
- Cost-controls and potential delivery system reforms may be needed to rein in spending growth.

#### Challenges:

- Economic downturns increase Medicaid enrollment as more people qualify due to low incomes.
- An aging population will increase Medicaid long-term care costs substantially in coming decades.
- State budgets can be strained during recessions, making their matching funding requirements difficult.

Medicaid accounts for a significant portion of state budgets across the country.

According to data from the Kaiser Family Foundation:

- In fiscal year 2021, Medicaid made up 16.8% of total state spending on average across all 50 states and D.C.
- However, there is considerable variation between states in terms of how much of their budget goes to Medicaid:

#### High Percentages:

- New York (34.8%)
- Missouri (33.4%)
- Pennsylvania (31.3%)
- New Mexico (30.9%)
- West Virginia (30.8%)

#### Low Percentages:

- Wyoming (7.9%)
- Nevada (8.9%)
- Utah (9.9%)
- Idaho (10.6%)
- Hawaii (11.1%)

- The 10 states with the highest percentage of spending on Medicaid averaged 28.9% in 2021.
- The 10 states with the lowest percentage averaged 13.3%.

This high degree of variation is due to factors like:

- A state's Medicaid enrollment and eligible population
- The state's Federal Medical Assistance Percentage (FMAP) match rate
- Decisions to expand Medicaid eligibility under the ACA
- Cost of living and healthcare costs in each state

So while Medicaid does not face the same short-term funding crisis as Medicare, its long-term cost trajectory and pressure on state/federal budgets remain major fiscal policy concerns that could necessitate cost-saving reforms or measures to raise more program revenue over time.

### **An Eye on the Future Medicare for All**

"Medicare for All" is a healthcare policy proposal that advocates for a single-payer, government-funded healthcare system in which all residents of a country are covered for medical services.<sup>238</sup> While opinions on this approach may vary, proponents highlight several potential advantages:

#### **10. Universal Coverage:**

- One of the primary advantages is the achievement of universal healthcare coverage. Under Medicare for All, everyone would have access to necessary medical services, regardless of income or employment status.

#### **11. Simplified Administration:**

- A single-payer system could reduce administrative complexity by streamlining billing and paperwork. This simplification might lead to cost savings and more efficient healthcare delivery.

#### **12. Cost Control:**

- Proponents argue that a single-payer system could potentially control healthcare costs more effectively through negotiation with providers, bulk purchasing of medications, and overall cost management.

#### **13. Preventive Care Emphasis:**

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<sup>238</sup> Much of this section comes from ChatGPT

- With a focus on preventive care, Medicare for All could encourage early intervention and wellness programs, potentially reducing the overall burden of disease and the associated costs.

#### **14. Elimination of Health Disparities:**

- Advocates claim that a single-payer system could help address health disparities by ensuring that everyone, regardless of socioeconomic status, has equal access to healthcare services.

#### **15. Financial Security:**

- With universal coverage, individuals would not face financial ruin due to medical expenses. This could provide greater financial security and reduce the fear of bankruptcy related to healthcare costs.

#### **16. Improved Health Outcomes:**

- By providing access to healthcare services for everyone, proponents argue that Medicare for All could lead to improved health outcomes on a population level.

#### **17. Simplified Choice of Providers:**

- A single-payer system could simplify the choice of healthcare providers for individuals, as everyone would be covered under the same system.

#### **18. Reduced Administrative Costs:**

- Streamlining administrative processes and reducing the complexity of dealing with multiple insurers could lead to significant cost savings.

It's important to note that while these advantages are highlighted by proponents, there are also concerns and criticisms related to the potential costs, the impact on the healthcare industry, and the role of government in healthcare. The debate over healthcare policy is complex, and different stakeholders may have varied perspectives on the best approach.

### **How Medicare for All Achieves Universal Coverage**

Medicare for All aims to achieve universal coverage by implementing a single-payer healthcare system, where the government serves as the sole payer for healthcare services. This means that all residents of a country would be covered under a single, comprehensive healthcare plan. Here are key features of how Medicare for All achieves universal coverage:

#### **10. Single-Payer System:**

- In a single-payer system, the government is the primary entity responsible for paying healthcare providers for medical services. This eliminates the need for multiple private insurance plans.

#### **11. Comprehensive Benefits:**

- Medicare for All typically proposes comprehensive coverage, including hospital services, preventive care, mental health services, prescription drugs, and other necessary medical treatments. This ensures that all essential healthcare needs are covered.

#### **12. No Exclusions for Pre-Existing Conditions:**

- Unlike some private insurance plans that may deny coverage or charge higher premiums based on pre-existing conditions, Medicare for All is designed to provide coverage without such exclusions or discriminatory practices.

#### **13. Automatic Enrollment:**

- The system may involve automatic enrollment for all residents, ensuring that everyone is covered by default. This eliminates the need for individuals to navigate complex insurance markets or worry about being uninsured.

#### **14. No Out-of-Pocket Costs for Essential Services:**

- Medicare for All proposals often aim to eliminate or significantly reduce out-of-pocket costs for essential healthcare services, making healthcare more affordable and accessible.

#### **15. Standardized Benefits:**

- The system typically establishes standardized benefits, ensuring that everyone receives the same level of coverage for basic healthcare needs. This promotes equity in access to medical services.

#### **16. Public Funding:**

- Medicare for All relies on public funding, usually through taxation. This ensures that the financial burden is distributed across the population, and everyone contributes to the healthcare system based on their ability to pay.

#### **17. Negotiation with Healthcare Providers:**

- The government, as the single payer, can negotiate directly with healthcare providers, pharmaceutical companies, and other stakeholders

to control costs and ensure fair pricing for medical services and medications.

#### **18. Preventive and Primary Care Focus:**

- By emphasizing preventive and primary care, Medicare for All aims to address health issues at an early stage, reducing the overall burden of disease and potentially lowering long-term healthcare costs.

It's important to note that the specific details of Medicare for All proposals can vary, and the implementation process may involve significant legislative and administrative changes. The concept of achieving universal coverage through a single-payer system is a central tenet of these proposals. The success of such a system depends on effective planning, funding mechanisms, and public support.

### **How Medicare for All Simplifies Healthcare Administration**

Medicare for All simplifies healthcare administration in several ways:

#### **10. Elimination of Multiple Payers:**

- Medicare for All envisions a single-payer system, where the government becomes the sole payer for healthcare services. This eliminates the need for multiple private insurance companies, each with its own set of policies, forms, and administrative processes.

#### **11. Streamlined Billing and Claims Processing:**

- With a single-payer system, healthcare providers would submit claims to the government payer. This simplifies billing and claims processing, reducing the complexity and paperwork associated with dealing with numerous private insurers.

#### **12. Standardized Benefits and Reimbursement:**

- Medicare for All proposals often include standardized benefits and reimbursement rates for healthcare services. This standardization simplifies the process for both healthcare providers and payers, reducing the need for negotiations and complex contracts.

#### **13. Automatic Enrollment:**

- The system may involve automatic enrollment for all residents, eliminating the need for individuals to navigate private insurance markets or apply for coverage. This reduces administrative overhead associated with enrollment processes.

#### **14. Reduced Administrative Costs:**

- By consolidating the administration under a single-payer, Medicare for All aims to reduce administrative costs related to marketing, underwriting, and managing multiple insurance plans. This can lead to overall cost savings within the healthcare system.

#### **15. Simplified Provider Networks:**

- Healthcare providers would deal with a single payer, simplifying their interactions with payers and reducing the need to navigate and contract with multiple insurance networks.

#### **16. Unified Electronic Health Records (EHR):**

- A single-payer system could facilitate the development of a unified electronic health records (EHR) system, making it easier to share patient information among healthcare providers and reduce the need for disparate systems.

#### **17. Consistent Coverage Rules:**

- With standardized benefits and coverage rules, Medicare for All seeks to create consistency in healthcare coverage. This reduces confusion for both patients and healthcare providers regarding what is covered under the plan.

#### **18. Efficient Negotiation and Drug Pricing:**

- The government, as the single payer, would have more bargaining power to negotiate with pharmaceutical companies for drug prices. This could lead to more efficient negotiations and potentially lower drug costs.

While the simplification of healthcare administration is a significant goal, it's important to acknowledge that the transition to a single-payer system involves complex challenges and considerations. Critics argue that the potential benefits should be carefully weighed against the potential disruptions and changes to the existing healthcare infrastructure.

### **How Medicare for All Controls Healthcare Spending**

Proponent of Medicare for All argue that it helps control healthcare spending through various mechanisms. While there are different proposals and variations, here are common ways in which Medicare for All aims to control healthcare spending:

#### **10. Negotiating Power:**

- A single-payer system consolidates the negotiating power of the government, allowing it to negotiate directly with healthcare providers, pharmaceutical companies, and other stakeholders. This can lead to lower prices for medical services, drugs, and other healthcare-related expenses.

### **11. Bulk Purchasing of Medications:**

- With a single-payer system, the government can engage in bulk purchasing of medications, negotiating lower prices for prescription drugs. This can result in significant cost savings and contribute to controlling overall healthcare spending.

### **12. Administrative Efficiency:**

- By eliminating the administrative complexity associated with multiple private insurance plans, Medicare for All aims to increase administrative efficiency. Streamlining billing, claims processing, and administrative tasks can reduce overhead costs within the healthcare system.

### **13. Preventive Care Emphasis:**

- Medicare for All often emphasizes preventive care and early intervention. By addressing health issues at an early stage, the system aims to reduce the overall burden of disease, potentially lowering long-term healthcare costs.

### **14. Standardized Benefits and Reimbursement:**

- Standardizing benefits and reimbursement rates across the healthcare system can contribute to cost control. Healthcare providers and payers operate under consistent rules, reducing the need for complex negotiations and individual contracts.

### **15. Global Budgeting:**

- Some Medicare for All proposals consider implementing global budgeting for healthcare spending. This involves setting a predetermined budget for healthcare expenditures, which can encourage efficiency and resource allocation within the system.

### **16. Reduced Administrative Costs:**

- The consolidation of administrative functions under a single-payer system is expected to reduce administrative costs associated with marketing, underwriting, and managing multiple private insurance plans.

### **17. Preventing Price Gouging:**

- Advocates argue that a single-payer system can prevent price gouging by setting reasonable reimbursement rates for healthcare services. This can prevent excessive charges from healthcare providers.

### **18. Addressing Overutilization:**



- Some Medicare for All proposals include measures to address overutilization of healthcare services. By promoting evidence-based practices and discouraging unnecessary procedures, the system aims to control costs associated with unnecessary medical interventions.

It's important to note that the effectiveness of these cost-control measures depends on the specific details of the Medicare for All proposal and its implementation. Critics argue that potential savings may be offset by increased demand for healthcare services, and the overall impact on healthcare spending is a subject of ongoing debate.

### **How Medicare for All Emphasizes Preventive Care**

Medicare for All emphasizes preventive care as a key component of its healthcare approach. The goal is to shift the focus from treating illnesses and conditions after they occur to preventing them in the first place. Here are ways in which Medicare for All aims to prioritize and promote preventive care:

#### **10. Comprehensive Coverage:**

- Medicare for All proposals typically include comprehensive coverage for preventive services. This can include routine check-ups, vaccinations, screenings, and other preventive measures without cost-sharing for patients.

#### **11. Early Detection and Screening:**

- The emphasis is placed on early detection and screening for common diseases and conditions. Regular screenings, such as mammograms, colonoscopies, and vaccinations, are included in the covered services to detect potential health issues early when they may be more treatable.

#### **12. Immunizations:**

- Medicare for All supports and promotes access to immunizations for preventable diseases. By ensuring that vaccinations are readily available and covered, the goal is to protect individuals and communities from vaccine-preventable illnesses.

#### **13. Health Education and Promotion:**

- The system may include health education and promotion efforts to inform individuals about healthy lifestyles, nutrition, exercise, and other factors that contribute to overall well-being. Educating the public about healthy choices can help prevent various health issues.

#### **14. Chronic Disease Management:**

- Medicare for All aims to address chronic diseases through preventive measures and management strategies. By providing ongoing care and

support for individuals with chronic conditions, the system seeks to prevent complications and improve overall health outcomes.

**15. Access to Primary Care:**

- Ensuring access to primary care is a fundamental aspect of preventive care. Medicare for All aims to provide individuals with consistent access to primary care physicians, promoting regular check-ups and health maintenance.

**16. Community-Based Health Initiatives:**

- Some proposals may allocate resources for community-based health initiatives. These initiatives can include programs that promote healthy living, provide education on preventive measures, and engage communities in activities that support overall well-being.

**17. Incentives for Providers:**

- Medicare for All proposals may include incentives for healthcare providers to prioritize preventive care. This can involve reimbursement models that reward healthcare professionals for delivering preventive services and promoting patient health.

**18. Integration of Behavioral Health Services:**

- Addressing mental health is often part of preventive care. By integrating behavioral health services into the healthcare system, Medicare for All aims to identify and address mental health concerns early on, preventing more serious issues.

By incorporating these elements into the healthcare system, Medicare for All seeks to create a proactive and preventive approach that not only improves health outcomes for individuals but also contributes to the overall health of the population.

**How Medicare for All Eliminates Health Disparities**

Medicare for All aims to address and reduce health disparities through various mechanisms designed to ensure equitable access to healthcare services. Here are ways in which Medicare for All seeks to eliminate health disparities:

**11. Universal Coverage:**

- By providing universal coverage, Medicare for All ensures that everyone, regardless of socioeconomic status, has access to necessary healthcare services. Universal coverage is a fundamental step toward reducing disparities in healthcare access.

**12. Equal Access to Services:**

- Medicare for All seeks to provide equal access to a comprehensive set of healthcare services for all individuals. This includes preventive care, primary care, specialty services, mental health services, and other essential healthcare components.

### **13. Elimination of Cost Barriers:**

- By eliminating or significantly reducing out-of-pocket costs for essential services, Medicare for All aims to remove financial barriers that can disproportionately affect individuals with lower incomes. This can help ensure that cost is not a barrier to receiving necessary medical care.

### **14. Standardized Benefits:**

- Standardizing benefits across the healthcare system helps ensure that all individuals receive the same level of coverage for basic healthcare needs. This consistency can contribute to reducing disparities in access to specific services.

### **15. Culturally Competent Care:**

- Medicare for All proposals often emphasize the importance of culturally competent care. This involves recognizing and addressing the unique cultural, linguistic, and social factors that can impact healthcare outcomes, particularly for marginalized communities.

### **16. Community-Based Health Initiatives:**

- Some proposals may allocate resources for community-based health initiatives. These initiatives can address social determinants of health and focus on improving health outcomes in specific communities facing disparities.

### **17. Focus on Preventive Care:**

- Preventive care is a key aspect of Medicare for All, and promoting early detection and intervention can help address health issues before they become more severe. This approach is crucial for reducing disparities in health outcomes.

### **18. Health Education and Outreach:**

- Medicare for All may include initiatives to provide health education and outreach to underserved communities. Informing individuals about preventive measures, healthy lifestyles, and available healthcare resources can empower communities to make informed decisions about their health.

### **19. Investment in Underserved Areas:**

- Some proposals may prioritize investments in healthcare infrastructure in underserved areas. This can involve increasing the number of healthcare facilities, ensuring an adequate healthcare workforce, and addressing geographic disparities in healthcare access.

## **20. Data Collection and Monitoring:**

- Implementing robust data collection and monitoring systems can help identify and address disparities in healthcare outcomes. By understanding the specific challenges faced by different populations, policymakers can tailor interventions to reduce disparities.

It's important to note that while Medicare for All aims to address health disparities, the effectiveness of these measures depends on the specific details of the proposal, its implementation, and ongoing efforts to monitor and adapt strategies to evolving needs. Reducing health disparities requires a comprehensive and sustained approach across multiple dimensions of healthcare delivery and social determinants of health.

## **How Medicare for All Improves the Financial Security of All Americans**

Medicare for All proponents argue that implementing a single-payer healthcare system could improve the financial security of all Americans through several mechanisms. Here are ways in which Medicare for All aims to enhance financial security:

### **11. Elimination of Out-of-Pocket Costs:**

- Medicare for All typically envisions reducing or eliminating out-of-pocket costs for essential healthcare services. By doing so, individuals would be less likely to face financial hardship due to medical expenses.

### **12. Universal Coverage:**

- The provision of universal healthcare coverage ensures that all Americans have access to necessary medical services. With everyone covered, individuals are less likely to face financial ruin due to medical emergencies or untreated health conditions.

### **13. No Medical Bankruptcy:**

- By removing the financial burden associated with high healthcare costs, Medicare for All aims to reduce the incidence of medical bankruptcies. Individuals and families would not face the prospect of financial devastation due to overwhelming medical bills.

### **14. Preventive Care Emphasis:**

- Medicare for All emphasizes preventive care, which can help identify and address health issues before they become more severe and costly.

Preventive measures can contribute to long-term financial savings by avoiding expensive treatments for advanced illnesses.

**15. Stable Premiums and Deductibles:**

- A single-payer system could lead to more stable premiums and deductibles. With a government-administered healthcare plan, the pricing structure may be more predictable, providing individuals with a clearer understanding of their healthcare expenses.

**16. Income-Linked Financing:**

- Financing Medicare for All through progressive taxation ensures that individuals contribute based on their ability to pay. This approach aims to distribute the financial burden more equitably, reducing the strain on lower-income individuals and families.

**17. Negotiation for Lower Drug Prices:**

- The government, as the single payer, would have more negotiating power over drug prices. This could lead to lower prescription drug costs, contributing to financial relief for individuals who rely on medications.

**18. Financial Predictability:**

- Knowing that essential healthcare services are covered without significant out-of-pocket costs provides individuals with greater financial predictability. This stability allows for better financial planning and reduces the anxiety associated with unexpected medical expenses.

**19. Freed-up Disposable Income:**

- With reduced or eliminated healthcare costs, individuals and families may have more disposable income. This can be used for other essential needs, contributing to overall economic well-being.

**20. Job Flexibility:**

- Individuals may experience increased job flexibility as they are not tied to employer-sponsored health insurance. This can facilitate career changes, entrepreneurship, and other professional pursuits without the concern of losing healthcare coverage.

While proponents argue that Medicare for All could enhance financial security, critics raise concerns about potential tax implications, the overall cost of implementing such a system, and potential trade-offs. The debate over the financial implications of Medicare for All is complex and involves considerations of both costs and benefits.

**How Does Medicare for All Improve Health Outcomes**

Proponents of Medicare for All argue that implementing a single-payer healthcare system could lead to improved health outcomes for the population. Here are ways in which Medicare for All aims to enhance health outcomes:

**11. Universal Access to Healthcare:**

- Medicare for All provides universal access to healthcare services, ensuring that all residents have coverage for essential medical treatments, preventive care, and health services. This universal access is intended to reduce disparities in healthcare utilization and outcomes.

**12. Early Detection and Prevention:**

- The emphasis on preventive care and regular check-ups in Medicare for All aims to detect health issues at an early stage. Early detection allows for timely intervention and preventive measures, reducing the severity of illnesses and improving overall health outcomes.

**13. Comprehensive Coverage:**

- Medicare for All typically offers comprehensive coverage, including preventive services, primary care, specialty care, mental health services, and prescription drugs. Comprehensive coverage addresses a wide range of health needs and contributes to holistic healthcare.

**14. Elimination of Financial Barriers:**

- By reducing or eliminating out-of-pocket costs for essential healthcare services, Medicare for All aims to remove financial barriers that may prevent individuals from seeking necessary medical care. Financial accessibility is crucial for timely and appropriate healthcare utilization.

**15. Focus on Social Determinants of Health:**

- Medicare for All may incorporate initiatives addressing social determinants of health, such as housing, education, and nutrition. Addressing these broader factors can positively impact health outcomes and contribute to overall well-being.

**16. Health Education and Promotion:**

- Initiatives promoting health education and prevention can be integrated into the healthcare system. Educating the public about healthy lifestyles, nutrition, and disease prevention contributes to better health awareness and outcomes.

**17. Reduced Delayed Care:**

- With universal coverage, individuals are less likely to delay seeking medical care due to concerns about affordability. Timely access to healthcare services can prevent the progression of illnesses and improve outcomes.

#### **18. Coordination of Care:**

- A single-payer system can facilitate better coordination of care among healthcare providers. Improved communication and collaboration can enhance the management of chronic conditions and complex medical cases, leading to better health outcomes.

#### **19. Mental Health Integration:**

- Integrating mental health services into the overall healthcare system addresses the importance of mental health in overall well-being. Comprehensive mental health support can positively impact mental health outcomes.

#### **20. Evidence-Based Medicine:**

- Medicare for All may emphasize evidence-based medicine, encouraging healthcare providers to follow established guidelines and practices supported by scientific evidence. This approach can lead to more effective and standardized care.

It's important to note that the effectiveness of Medicare for All in improving health outcomes depends on various factors, including the specific design of the program, implementation strategies, and ongoing efforts to address challenges in the healthcare system. The debate around the impact of Medicare for All on health outcomes is multifaceted and involves considerations of access, quality of care, and overall public health.

### **Simplified Choice of Providers**

Medicare for All simplifies the choice of healthcare providers by streamlining the healthcare system and offering a single, comprehensive coverage plan. Here are ways in which it aims to simplify the choice of providers:

#### **11. Universal Coverage:**

- Medicare for All provides universal coverage, ensuring that everyone has access to the same set of healthcare providers. This eliminates the need to navigate complex networks associated with multiple private insurance plans.

#### **12. No Network Restrictions:**

- Unlike many private insurance plans that may have specific networks of providers, Medicare for All aims to eliminate network restrictions. Individuals can choose healthcare providers based on their preferences, without concerns about in-network or out-of-network distinctions.

### **13. Freedom to Choose Any Doctor or Hospital:**

- With Medicare for All, individuals have the freedom to choose any doctor, specialist, or hospital that accepts the coverage. This flexibility simplifies the process of selecting healthcare providers and allows individuals to maintain existing relationships with their preferred providers.

### **14. Consistent Benefits Across Providers:**

- Standardized benefits across the healthcare system mean that individuals receive the same level of coverage regardless of the healthcare provider they choose. This consistency simplifies the decision-making process for individuals seeking medical care.

### **15. No Referral Requirements:**

- Some insurance plans require referrals from primary care physicians to see specialists. Medicare for All typically eliminates the need for referrals, allowing individuals to directly access the healthcare providers they need without additional administrative steps.

### **16. Simplified Billing and Administration:**

- Medicare for All streamlines billing and administrative processes. Healthcare providers deal with a single payer, reducing the administrative burden associated with managing multiple insurance plans with varying reimbursement rules.

### **17. Access to Primary Care:**

- The system emphasizes access to primary care, ensuring that individuals can easily find and choose a primary care physician. Access to primary care is crucial for preventive services and managing overall health.

### **18. Continuity of Care:**

- Medicare for All supports continuity of care, allowing individuals to maintain relationships with their healthcare providers over time. This can contribute to better-coordinated and personalized care.

### **19. Elimination of Employer-Based Networks:**

- With Medicare for All, individuals are not bound by employer-based networks. This flexibility is particularly beneficial for those who change



jobs or pursue self-employment, as their choice of providers is not tied to employer-sponsored plans.

## **20. Reduced Administrative Complexity for Providers:**

- Healthcare providers experience reduced administrative complexity by dealing with a single payer. This simplification can contribute to more efficient and streamlined interactions between providers and the healthcare system.

While the aim is to simplify the choice of providers, it's important to consider that the actual implementation and the specifics of the Medicare for All plan can vary. Additionally, ongoing efforts are needed to monitor and address any challenges that may arise in the transition to a single-payer system.

## **How Does Medicare for All Reduce Healthcare Administration Costs**

Medicare for All is designed to reduce healthcare administration costs through the implementation of a single-payer system. Here are ways in which it aims to achieve this:

### **11. Simplified Billing and Claims Processing:**

- With Medicare for All, healthcare providers would submit claims to a single payer (the government), streamlining billing and claims processing. This simplification reduces the administrative burden associated with dealing with multiple private insurers, each with its own billing processes and requirements.

### **12. Reduced Administrative Overhead for Providers:**

- Healthcare providers would experience reduced administrative overhead as they interact with a single, standardized system. This includes fewer resources dedicated to managing billing, claims, and administrative tasks associated with multiple insurers.

### **13. Elimination of Private Insurance Administrative Costs:**

- Medicare for All aims to eliminate the administrative costs associated with managing private insurance plans. This includes marketing, underwriting, and administrative overhead specific to each private insurer, leading to overall cost savings.

### **14. Standardized Benefits and Reimbursement:**

- Standardizing benefits and reimbursement rates across the healthcare system simplifies the negotiation process for healthcare providers. This reduces the need for complex negotiations and individual contracts, contributing to administrative efficiency.

#### **15. Reduced Marketing and Advertising Expenses:**

- Private insurers currently spend significant resources on marketing and advertising to attract and retain customers. With a single-payer system, the need for such marketing efforts diminishes, leading to cost savings.

#### **16. Efficient Allocation of Resources:**

- Medicare for All eliminates the need for insurance companies to allocate resources for tasks such as profit margins, shareholder returns, and executive compensation. This allows for a more efficient allocation of resources directly to healthcare services.

#### **17. Consolidated Administrative Functions:**

- Administrative functions related to insurance coverage, claims processing, and other tasks are consolidated under a single-payer system. This consolidation reduces redundancy, simplifies processes, and minimizes administrative complexity.

#### **18. Savings on Fraud Prevention:**

- A single-payer system can result in more effective fraud prevention measures. With a unified system, it becomes easier to implement standardized fraud detection and prevention practices, reducing the resources required for individual insurers to combat fraud.

#### **19. Streamlined Enrollment Processes:**

- Medicare for All typically involves simplified enrollment processes. With universal coverage and potentially automatic enrollment, the need for complex enrollment procedures and paperwork is reduced, leading to administrative efficiency.

#### **20. Lower Administrative Costs per Beneficiary:**

- The administrative costs per beneficiary can be lower in a single-payer system due to economies of scale. The efficiency gained from serving a larger population under a unified system can contribute to lower administrative costs per individual covered.

It's important to note that while proponents argue that Medicare for All can lead to significant administrative cost savings, critics raise concerns about potential challenges in implementing and managing such a system. The actual impact on administrative costs may depend on the specific design and implementation of the single-payer system.

### **Why Medicare for All is a Bad Idea**

Critics of Medicare for All typically raise several concerns and potential drawbacks, including:

**11. Cost:**

- Critics argue that implementing Medicare for All could result in substantial increases in government spending. Financing such a program might require higher taxes, which could impact the economy and individual incomes.

**12. Impact on Quality of Care:**

- Some opponents express concerns about potential reductions in the quality of healthcare. They argue that a single-payer system may lead to longer wait times for medical services and less innovation in the healthcare sector.

**13. Disruption to Existing Systems:**

- Transitioning to a single-payer system could involve significant disruptions to existing healthcare systems, including the private insurance industry. Critics worry about the potential negative impact on jobs and the overall economy during the transition.

**14. Loss of Choice:**

- Critics argue that a single-payer system may limit individuals' choices by eliminating private insurance options. Some people value the ability to choose their healthcare plans and providers, and they fear that a government-controlled system could restrict those choices.

**15. Bureaucracy and Administrative Challenges:**

- Concerns are raised about potential bureaucratic challenges and administrative inefficiencies in a government-run healthcare system. Critics worry that a single-payer system might lead to increased red tape, delays in care, and administrative complexities.

**16. Incentives for Innovation:**

- Opponents argue that a competitive healthcare market fosters innovation and technological advancements. They express concerns that a government-dominated system might reduce the incentives for medical research and innovation.

**17. Potential Tax Burden:**

- Implementing Medicare for All could require substantial tax increases to fund the program. Critics are concerned about the potential burden on taxpayers and the economic consequences of higher taxes.

#### **18. Resistance to Change:**

- Some individuals may resist the idea of a major overhaul of the healthcare system, especially if they are satisfied with their current insurance arrangements. Opposition may come from those who fear uncertainty or perceive a loss of control over their healthcare choices.

#### **19. Variability in Healthcare Needs:**

- Critics argue that a one-size-fits-all approach may not adequately address the diverse healthcare needs of different populations and demographics. Tailoring healthcare plans to individual preferences and needs may be more challenging in a single-payer system.

#### **20. Political and Ideological Divisions:**

- The debate over Medicare for All is often influenced by political and ideological divisions. Opposition may stem from differing views on the role of government in healthcare and the balance between individual freedom and collective responsibility.

It's important to note that these concerns are raised by critics, and supporters of Medicare for All contend that the proposed system would address current shortcomings in the healthcare system, provide universal access to care, and reduce overall healthcare costs. The ongoing debate revolves around finding a balance that addresses the needs of the population while considering the potential drawbacks and challenges associated with a significant healthcare system overhaul.

### **How Will Medicare for All Raise Healthcare Costs**

Some potential ways Medicare for All might increase healthcare spending:

#### **10. Increased Demand for Services:**

- Critics suggest that the elimination of out-of-pocket costs and the provision of universal coverage could lead to an increase in the demand for healthcare services. A surge in demand, especially for elective or non-urgent procedures, could strain the healthcare system and potentially lead to higher costs.

#### **11. Reduced Incentives for Cost Containment:**

- Some critics argue that a government-run, single-payer system may reduce incentives for cost containment and efficiency. In a competitive market, providers and insurers have an incentive to control costs to

remain competitive. In a single-payer system, critics express concerns that such market forces may be diminished.

**12. Potential for Overutilization:**

- Critics worry that the absence of cost-sharing measures could lead to overutilization of healthcare services. Without financial barriers, individuals might be more inclined to seek unnecessary or excessive medical care, contributing to increased healthcare costs.

**13. Challenges in Controlling Drug Prices:**

- While proponents argue that a single-payer system could negotiate lower drug prices, critics express concerns about the potential challenges in effectively controlling pharmaceutical costs. Negotiating with drug manufacturers may not guarantee significant reductions in drug prices.

**14. Transition Costs:**

- Critics point out that the transition to a Medicare for All system may involve significant upfront costs. The process of implementing the new system, including changes to administrative structures, workforce training, and infrastructure development, could lead to temporary increases in overall healthcare spending.

**15. Potential for Bureaucratic Inefficiencies:**

- Concerns are raised about the potential for bureaucratic inefficiencies in a government-administered system. Critics argue that a single-payer system might introduce administrative complexities, red tape, and delays in decision-making, which could impact overall healthcare costs.

**16. Impact on Provider Reimbursement:**

- Critics express concerns that a government-run system might result in lower reimbursement rates for healthcare providers. If reimbursement rates are set too low, there could be challenges in maintaining an adequate supply of healthcare professionals and facilities, potentially affecting the quality of care.

**17. Resistance from Healthcare Industry:**

- Some critics argue that the healthcare industry, including pharmaceutical companies, insurers, and certain healthcare providers, may resist cost containment efforts associated with a single-payer system. This resistance could pose challenges in achieving cost savings.

**18. Economic Impact of Tax Increases:**

- Financing Medicare for All could require substantial tax increases to fund the program. Critics argue that higher taxes could have broader economic consequences, potentially impacting economic growth, individual incomes, and job creation.

It's important to recognize that the potential impact on healthcare costs is a complex and debated aspect of Medicare for All. Proponents argue that the system could lead to overall cost savings through administrative efficiencies, negotiation of lower prices, and a focus on preventive care. The ongoing discussion revolves around finding a balance that addresses cost concerns while ensuring access to quality healthcare for all.

### **How Medicare for All Will Reduce Medicare Care Quality**

Medicare for All critics raise concerns about potential challenges that could affect the quality of care. Here are some arguments made by critics:

#### **9. Provider Reimbursement Rates:**

- Critics express concerns that Medicare for All might lead to lower reimbursement rates for healthcare providers. If reimbursement rates are set too low, there could be challenges in attracting and retaining skilled healthcare professionals. This, in turn, could potentially impact the quality of care provided.

#### **10. Reduced Incentives for Innovation:**

- Some opponents argue that a single-payer system might reduce incentives for innovation in healthcare. In a competitive market, providers and pharmaceutical companies have incentives to invest in research and development to stay ahead. Critics worry that a government-dominated system may result in fewer innovations in medical treatments and technologies.

#### **11. Impact on Access to Specialized Care:**

- Critics express concerns about the potential impact on access to specialized and advanced medical treatments. If reimbursement rates are not sufficient, healthcare providers may limit certain services or technologies, potentially affecting the availability of specialized care options.

#### **12. Bureaucratic Inefficiencies:**

- Concerns are raised about the potential for bureaucratic inefficiencies in a government-run healthcare system. Critics argue that increased bureaucracy, red tape, and administrative complexities could slow down decision-making processes, potentially affecting the efficiency and quality of care.

### **13. Difficulty in Addressing Regional Variances:**

- Critics worry that a single-payer system might face challenges in addressing regional variances in healthcare needs and costs. Healthcare requirements can vary significantly across different regions, and critics argue that a one-size-fits-all approach may not adequately address these variations.

### **14. Possible Impact on Provider Networks:**

- The restructuring associated with Medicare for All could potentially impact existing provider networks. If healthcare providers face challenges in adapting to the new system, it may lead to disruptions in established patient-provider relationships, potentially affecting the continuity and quality of care.

### **15. Potential for Longer Wait Times:**

- Critics express concerns that increased demand for healthcare services, especially in the absence of cost-sharing measures, could lead to longer wait times for medical treatments. Longer wait times may impact patient outcomes and satisfaction.

### **16. Resistance to Change:**

- Some individuals and healthcare professionals may resist the significant changes associated with transitioning to a single-payer system. Resistance to change could pose challenges in adapting to new care delivery models and may affect the overall quality of healthcare services.

It's important to note that these concerns are raised by critics, and proponents of Medicare for All argue that the system could lead to improved quality through better coordination of care, emphasis on preventive services, and standardized benefits. The debate over the impact on healthcare quality involves considerations of access, efficiency, and the overall healthcare delivery model. The effectiveness of Medicare for All in maintaining or enhancing healthcare quality would depend on the specific design and implementation of the program.

### **How Medicare for All Will Negatively Disrupt the Existing Healthcare System**

The transition to Medicare for All could potentially lead to disruptions in the existing healthcare system, and critics often raise concerns about various aspects of this transformation. While proponents argue that a single-payer system could bring about positive changes, opponents highlight potential negative impacts. Here are some concerns raised by critics:

### **11. Job Displacement:**

- Critics worry that the shift to Medicare for All could result in job displacement, particularly in the private health insurance sector. Employees working in administrative roles related to private insurance may face challenges during the transition.

#### **12. Impact on Private Insurance Industry:**

- The implementation of Medicare for All could have a significant impact on the private health insurance industry. Critics argue that the elimination or reduction of private insurance options could disrupt the existing market and lead to economic challenges for companies in this sector.

#### **13. Transition Costs:**

- The transition to a single-payer system may involve significant upfront costs. Critics express concerns about the financial implications of the transition, including the costs associated with restructuring administrative systems, implementing new technology, and retraining healthcare professionals.

#### **14. Potential for Provider Disruptions:**

- Healthcare providers may experience disruptions during the transition, especially if there are changes in reimbursement rates or adjustments to administrative processes. Critics worry that these disruptions could impact the stability of healthcare delivery.

#### **15. Resistance from Stakeholders:**

- Various stakeholders in the healthcare system, including healthcare providers, pharmaceutical companies, and insurers, may resist the changes associated with Medicare for All. Resistance from these stakeholders could pose challenges in the implementation of the new system.

#### **16. Uncertainty for Healthcare Professionals:**

- Healthcare professionals may face uncertainties about the impact of Medicare for All on their practices, reimbursement rates, and overall job stability. This uncertainty could potentially affect the morale and job satisfaction of healthcare professionals.

#### **17. Potential for Reduced Innovation:**

- Critics argue that a government-run system might reduce incentives for innovation in healthcare. In a competitive market, providers and pharmaceutical companies have incentives to invest in research and



development. The shift to a single-payer system may impact these incentives.

#### **18. Challenges in Managing Increased Demand:**

- The elimination of out-of-pocket costs and the provision of universal coverage could potentially lead to increased demand for healthcare services. Critics express concerns about the healthcare system's ability to effectively manage and respond to this surge in demand.

#### **19. Regional Variations in Healthcare Needs:**

- Healthcare needs can vary significantly across different regions. Critics worry that a one-size-fits-all approach may not adequately address regional variations in healthcare requirements, potentially leading to disparities in access and quality of care.

#### **20. Political and Public Resistance:**

- The implementation of Medicare for All may face political and public resistance. Some individuals may be resistant to major changes in the healthcare system, and opposition could pose challenges in achieving widespread acceptance and support.

It's important to note that these concerns are raised by critics, and proponents of Medicare for All argue that the system could address current shortcomings in the healthcare system, provide universal access to care, and reduce overall healthcare costs. The ongoing debate involves finding a balance that considers the potential disruptions while aiming to achieve the goals of improved access and affordability.

### **How Medicare for All Will Reduce Patient Choices and Options**

Medicare for All could potentially impact patient choices and options in the healthcare system. While proponents argue that a single-payer system may enhance access to care for all individuals, critics express concerns about potential limitations on patient choices. Here are some arguments made by critics regarding how Medicare for All might reduce patient choices:

#### **11. Limitation of Private Insurance Options:**

- Medicare for All proposals often involve the elimination or significant reduction of private health insurance options. Critics argue that this could limit individuals' ability to choose from a variety of plans with different coverage options and provider networks.

#### **12. Restrictions on Provider Choices:**

- In a single-payer system, the government may negotiate reimbursement rates with healthcare providers, potentially leading to limitations on the

number of providers willing to accept those rates. Critics express concerns that this could restrict patients' choices of healthcare providers.

**13. Standardized Benefits:**

- Medicare for All typically involves standardizing benefits across the healthcare system. While this simplifies the process, critics argue that it may limit the ability of individuals to choose plans tailored to their specific healthcare needs and preferences.

**14. Impact on Specialty Care Access:**

- Critics worry that the emphasis on cost containment in a single-payer system might lead to limitations in access to specialized or elective medical services. Patients may have fewer options for seeking specialized care or choosing specific healthcare facilities.

**15. Reduced Flexibility in Plan Selection:**

- The elimination of private insurance options could result in reduced flexibility for individuals to choose plans that align with their preferences, including factors such as deductibles, co-pays, and coverage for specific medical services.

**16. Potential for Longer Wait Times:**

- Increased demand for healthcare services, coupled with potential cost-containment measures, could lead to longer wait times for medical treatments. Critics argue that this may limit patients' ability to promptly access the care they need.

**17. Impact on Provider Networks:**

- The restructuring associated with Medicare for All might impact existing provider networks. Critics express concerns that changes in reimbursement rates or administrative processes may lead to disruptions in established patient-provider relationships.

**18. Limited Control Over Healthcare Decisions:**

- Critics argue that a government-administered system may limit individuals' control over their healthcare decisions. The standardization of benefits and potential restrictions on certain medical services could reduce patient autonomy in choosing the care that best suits their needs.

**19. Potential for Reduced Innovation in Care Models:**

- In a single-payer system, critics express concerns about potential reductions in innovation in healthcare delivery models. A more centralized

system may be less conducive to experimentation with new care models and approaches.

## **20. Resistance to Change:**

- Patients and healthcare professionals may resist major changes in the healthcare system. The transition to Medicare for All could face opposition from those who value their current insurance arrangements and fear a loss of control over their healthcare choices.

It's important to note that these concerns are raised by critics, and the actual impact on patient choices and options would depend on the specific design and implementation of Medicare for All. Proponents argue that the system could increase overall access to care and simplify the healthcare process, while opponents highlight potential trade-offs in terms of choice and flexibility.

## **Medicare for All Raises Bureaucratic and Administrative Challenges**

Here are some of the bureaucratic and administrative challenges that some critics have been raised:

### **13. System Overhaul and Implementation:**

- The shift to a single-payer system involves a comprehensive overhaul of the existing healthcare infrastructure. Implementing new administrative structures, technology systems, and processes on a national scale can be a complex and resource-intensive task.

### **14. Transition Costs:**

- The transition to Medicare for All may come with significant upfront costs. Adapting to new administrative requirements, retraining healthcare professionals, and updating technology systems could require substantial financial investments.

### **15. Workforce Training:**

- Healthcare professionals and administrative staff may require training to adapt to the new system. Training a large workforce to navigate changes in billing, claims processing, and administrative procedures is a logistical challenge.

### **16. Data Integration and Standardization:**

- Achieving seamless data integration and standardization across the healthcare system is crucial for the efficient operation of a single-payer system. This involves addressing interoperability issues and ensuring that diverse healthcare entities can effectively share information.

**17. Provider Reimbursement:**

- Establishing fair and effective provider reimbursement rates is a complex task. Determining rates that are acceptable to healthcare providers while maintaining cost control requires careful negotiation and administrative coordination.

**18. Coordination with State Programs:**

- Coordination with existing state-level healthcare programs and Medicaid systems may present challenges. Ensuring a smooth transition and integration with state-specific programs requires effective collaboration and administrative planning.

**19. Claims Processing and Billing:**

- Streamlining claims processing and billing is a key aspect of administrative efficiency. The implementation of a single-payer system requires the development of standardized processes to handle claims and billing on a national scale.

**20. Technology Infrastructure:**

- Upgrading and modernizing the technology infrastructure to support a national healthcare system is a significant undertaking. Ensuring the security, interoperability, and efficiency of healthcare information systems is a complex administrative task.

**21. Resistance from Stakeholders:**

- Stakeholders, including healthcare providers, insurers, and pharmaceutical companies, may resist administrative changes associated with Medicare for All. Overcoming potential resistance and ensuring buy-in from diverse stakeholders is a challenge.

**22. Public Education and Communication:**

- Effectively communicating changes to the public and educating individuals about the new system is crucial. Public awareness campaigns and communication strategies are necessary to inform individuals about their rights, benefits, and changes in healthcare procedures.

**23. Addressing Regional Variations:**

- The administrative challenges include addressing regional variations in healthcare needs, costs, and delivery. Tailoring administrative processes to accommodate these variations while maintaining national standards requires careful consideration.

## **24. Ensuring Adequate Healthcare Workforce:**

- The transition to a single-payer system may require adjustments in the healthcare workforce to meet increased demand. Ensuring an adequate number of healthcare professionals and support staff is an administrative challenge.

It's important to note that while critics highlight these administrative challenges, proponents argue that the long-term benefits of Medicare for All, such as improved access, simplified billing, and overall cost savings, could outweigh these initial complexities. The effectiveness of addressing administrative challenges would depend on the planning, implementation, and ongoing management of the transition to a single-payer system.

### **How Medicare for All Might Reduce Healthcare Innovation**

Critics of Medicare for All express concerns that a transition to a single-payer healthcare system could potentially reduce incentives for healthcare innovation. While proponents argue that a single-payer system could lead to cost savings and increased access to care, opponents highlight potential challenges related to innovation. Here are some arguments made by critics regarding how Medicare for All might impact healthcare innovation:

#### **11. Reduced Financial Incentives for Research and Development:**

- Critics argue that a single-payer system might reduce financial incentives for pharmaceutical companies and healthcare providers to invest in research and development. In a competitive market, the potential for high profits can drive innovation. A more centralized system may alter these financial dynamics.

#### **12. Risk Aversion in a Government-Run System:**

- Some critics express concerns that a government-administered healthcare system may be more risk-averse when it comes to adopting new and innovative medical technologies. Bureaucratic processes and decision-making may prioritize cost containment over embracing novel, yet potentially more expensive, treatments.

#### **13. Impact on Biotechnology and Life Sciences:**

- The biotechnology and life sciences sectors heavily rely on private investments for innovation. Critics argue that a reduction in private investment resulting from changes in the market dynamics under a single-payer system could impede progress in these fields.

#### **14. Potential for Limited Choice of Treatments:**

- A single-payer system may negotiate prices and coverage for medical treatments on a national level. Critics worry that centralized decision-making could limit the variety of available treatments and reduce options for patients seeking innovative therapies.

#### **15. Slower Adoption of New Technologies:**

- Critics express concerns that a more centralized healthcare system may lead to slower adoption of new medical technologies. The bureaucracy associated with decision-making and budgetary constraints may result in delays in incorporating innovative treatments into standard medical practice.

#### **16. Impact on Academic Medical Centers:**

- Academic medical centers often play a crucial role in medical research and innovation. Critics argue that changes in funding mechanisms and reimbursement rates under a single-payer system may affect the ability of academic institutions to invest in groundbreaking research.

#### **17. Potential Brain Drain in Healthcare Professions:**

- Some critics suggest that the potential for lower earning potential and reduced financial rewards for innovation could lead to a "brain drain" in healthcare professions. Skilled professionals may be drawn to sectors or countries that offer more favorable incentives for innovation.

#### **18. Incentives for Cost Control Over Innovation:**

- In a system that prioritizes cost control, critics argue that healthcare providers may face pressure to focus on cost-effective treatments rather than invest in cutting-edge, albeit more expensive, medical innovations.

#### **19. Impact on Startups and Small Biotech Companies:**

- Critics express concerns about the potential challenges faced by startups and small biotech companies in securing funding under a single-payer system. Reduced profitability and increased regulatory hurdles could impact the ability of these entities to contribute to innovation.

#### **20. Potential Disincentives for Entrepreneurship:**

- A shift to a single-payer system may alter the incentives for entrepreneurship in the healthcare sector. Critics worry that reduced profit margins and increased regulation may discourage entrepreneurs from entering the healthcare industry.

It's important to note that these concerns are raised by critics, and the impact on healthcare innovation would depend on various factors, including the specific design of

the single-payer system, ongoing policy adjustments, and efforts to balance cost containment with support for innovation. Proponents argue that a single-payer system could foster a more efficient and equitable healthcare system, but the potential trade-offs with innovation remain a part of the broader debate.

### **How Might Medicare for All Affect Individual and Corporate Taxes**

While specific policy details can vary, here are general considerations regarding how Medicare for All might affect taxes:

#### **Individual Taxes:**

##### **5. Potential for Increased Taxes:**

- Financing a comprehensive healthcare system like Medicare for All would likely require additional government revenue. Proponents often discuss funding sources such as progressive income taxes, payroll taxes, and other measures. Consequently, some individuals, particularly those with higher incomes, could see an increase in their tax burden.

##### **6. Offset by Elimination of Premiums and Out-of-Pocket Costs:**

- Supporters argue that while taxes may increase, individuals and families would no longer be required to pay premiums, deductibles, or copayments associated with private health insurance. This could offset the impact of higher taxes, especially for those who currently face significant healthcare-related costs.

##### **7. Progressive Taxation Approach:**

- Proponents often advocate for a progressive taxation approach, where higher-income individuals contribute a larger percentage of their income toward funding Medicare for All. This is seen as a way to distribute the financial burden more equitably.

##### **8. Potential for Savings:**

- Supporters argue that the overall cost of healthcare for individuals and families would decrease under Medicare for All. While taxes may go up, the elimination of private insurance premiums and reduced out-of-pocket expenses could result in net savings for many households.

#### **Corporate Taxes:**

##### **7. Impact on Employers:**

- Under Medicare for All, employers may see changes in their financial responsibilities related to employee healthcare. While some proponents argue that businesses could experience cost savings by no longer

providing private health insurance plans, critics suggest that increased corporate taxes may offset these potential savings.

#### **8. Potential for Employer Payroll Taxes:**

- One proposed funding mechanism for Medicare for All involves implementing payroll taxes on employers. This could be a way to shift the financial responsibility for healthcare from businesses to the broader tax base.

#### **9. Reduced Administrative Costs for Employers:**

- Supporters argue that employers could benefit from reduced administrative costs associated with managing private health insurance plans for their employees. A single-payer system may simplify administrative processes for businesses.

#### **10. Economic Impact:**

- Critics express concerns that increased corporate taxes could have broader economic consequences, potentially affecting job creation, business investment, and economic growth. Proponents argue that the overall reduction in healthcare costs could positively impact the economy.

#### **11. Potential for Redistribution of Costs:**

- The shift to Medicare for All could redistribute the costs of healthcare from employers to the government. This could lead to changes in corporate financial strategies and impact industries differently based on their current healthcare spending.

#### **12. Sector-Specific Considerations:**

- Different industries may be affected in varying ways. Some sectors that currently provide generous health benefits may face higher taxes, while others with lower healthcare costs may benefit from a more level playing field.

It's important to note that the specific impact on taxes would depend on the details of the Medicare for All proposal, including the chosen funding mechanisms and how the transition is structured. The debate over the financial aspects of Medicare for All involves considerations of both the costs and potential savings for individuals, employers, and the government.

### **Can Medicare for All Address the Healthcare Needs of Americans?**

While proponents argue that a single-payer system can provide more equitable access to care, critics raise concerns about potential challenges in addressing the diverse



healthcare needs of the population. Here are considerations on both sides of the debate:

### **Proponents' Arguments:**

#### **6. Universal Access to Basic Healthcare:**

- Proponents contend that Medicare for All aims to ensure universal access to basic healthcare services for all Americans. By providing a baseline level of coverage, the system seeks to address fundamental healthcare needs across the population.

#### **7. Standardized Benefits:**

- Medicare for All proposals often include standardized benefits, eliminating variations in coverage between different insurance plans. This standardization is intended to ensure that individuals receive consistent and comprehensive healthcare services regardless of their specific circumstances.

#### **8. Preventive Care Emphasis:**

- Supporters argue that a single-payer system can emphasize preventive care, addressing health needs at an earlier stage and potentially reducing the overall burden on the healthcare system. By focusing on preventive measures, the system aims to improve population health.

#### **9. Elimination of Disparities in Access:**

- Proponents suggest that Medicare for All can help eliminate disparities in access to healthcare. By providing coverage to all individuals, regardless of factors such as income or employment status, the system seeks to reduce variations in healthcare access.

#### **10. Efficient Resource Allocation:**

- A single-payer system could streamline administrative processes and resource allocation, ensuring that healthcare resources are distributed more efficiently. This efficiency may contribute to a more equitable distribution of healthcare services.

### **Critics' Concerns:**

#### **7. One-Size-Fits-All Approach:**

- Critics argue that a single-payer system may adopt a one-size-fits-all approach that does not adequately address the diverse healthcare needs of individuals and communities. Different populations may have unique health requirements that may not be fully accommodated.

## **8. Regional Variations:**

- Healthcare needs can vary significantly across regions due to factors such as demographics, prevalence of certain health conditions, and local healthcare infrastructure. Critics express concerns that a nationalized system may struggle to address these regional variations effectively.

## **9. Limited Choice of Providers:**

- Critics worry that a single-payer system might limit individuals' choices of healthcare providers. While proponents argue for cost containment, critics express concerns that reduced provider options could impact the ability of individuals to access specialized or preferred care.

## **10. Inadequate Addressing of Specific Conditions:**

- Some critics suggest that certain specialized or rare health conditions may not receive sufficient attention or resources in a more centralized healthcare system. Tailoring care to specific conditions or demographic groups could be challenging.

## **11. Resistance to Innovations in Care Models:**

- Critics argue that a government-dominated system may be less conducive to experimenting with innovative care models and approaches. The potential for bureaucratic hurdles and resistance to change could impede the adoption of new and effective healthcare solutions.

## **12. Potential for Longer Wait Times:**

- Increased demand for healthcare services, combined with potential resource constraints, could lead to longer wait times for medical treatments. Critics express concerns that longer wait times may negatively impact patient outcomes.

The debate over whether Medicare for All can effectively address variations in healthcare needs revolves around finding a balance between providing universal access and accommodating the diverse health requirements of the population. The effectiveness of the system would depend on the specific design, implementation, and ongoing adjustments made to address these considerations.

### **How Will Our Divisive Political Environment Affect Medicare for All?**

The divisive political environment in the United States has a significant impact on discussions and potential implementations of policies, including Medicare for All. The perspectives and stances of political actors, policymakers, and the general public contribute to the challenges and opportunities for advancing such proposals. Here are

key considerations regarding how the divisive political environment may affect Medicare for All:

### **Challenges:**

#### **6. Partisan Divisions:**

- Healthcare policy, including proposals like Medicare for All, has become deeply polarized along party lines. Divisions between Democrats and Republicans can hinder bipartisan support for comprehensive healthcare reform, making it challenging to pass legislation.

#### **7. Ideological Differences:**

- Ideological differences regarding the role of government in healthcare and the balance between individual choice and collective responsibility contribute to the political divide. Finding common ground on the fundamental principles of healthcare policy is a significant hurdle.

#### **8. Interest Group Opposition:**

- Powerful interest groups, including those representing insurance companies, pharmaceuticals, and healthcare providers, may actively oppose or lobby against significant changes to the healthcare system. The influence of these groups can create obstacles for transformative healthcare proposals.

#### **9. Public Opinion Variability:**

- Public opinion on healthcare reform, including Medicare for All, varies across political affiliations. Bridging the gap in public support and addressing concerns from different ideological perspectives is a complex task.

#### **10. Fiscal Concerns:**

- Discussions around how to fund Medicare for All often involve debates on tax increases and government spending. Fiscal conservatives may express concerns about the potential economic impact and sustainability of such a large-scale healthcare program.

### **Opportunities:**

#### **7. Public Demand for Change:**

- Despite political divisions, there is public demand for improvements in the healthcare system. The impact of the COVID-19 pandemic has further highlighted the importance of accessible and affordable healthcare. Public

pressure may create opportunities for policymakers to revisit healthcare reform proposals.

#### **8. Evolving Policy Discourse:**

- The political landscape is dynamic, and policy priorities can evolve over time. Shifting public attitudes, changes in leadership, and external factors may contribute to a reevaluation of healthcare policies, potentially creating openings for new proposals.

#### **9. State-Level Initiatives:**

- Some states have explored or implemented their own healthcare reforms. State-level initiatives, even if limited in scope, could serve as test cases for certain aspects of healthcare reform and inform national discussions.

#### **10. Incremental Changes:**

- Given the challenges of passing comprehensive reform, there may be opportunities for incremental changes to the healthcare system. Policymakers may explore targeted measures that address specific issues, gradually building towards broader reforms.

#### **11. Coalitions and Compromise:**

- Building coalitions and finding areas of compromise can be crucial for advancing healthcare policy. While comprehensive reform may face hurdles, targeted measures that garner bipartisan support could lay the groundwork for broader changes.

#### **12. External Events Shaping Priorities:**

- Unforeseen events, such as public health crises or economic challenges, can reshape political priorities. External factors may create windows of opportunity for reexamining and reforming healthcare policy.

The future of Medicare for All is intricately tied to the dynamics of the political environment. Achieving consensus and overcoming political divisions will require strategic policymaking, effective communication, and a willingness to find common ground on the complex issues surrounding healthcare reform. The interplay of political, economic, and societal factors will continue to shape the trajectory of healthcare policy discussions in the United States.

### **Rationing and treatment rejection in Medicare**

Medicare typically does not cover certain services, treatments, or items that are considered elective, cosmetic, or not medically necessary. Here are some examples:

10. **Cosmetic Surgery:** Procedures performed solely for cosmetic purposes, such as facelifts, breast augmentation, and liposuction, are generally not covered.
11. **Acupuncture:** While some private Medicare Advantage plans may offer coverage for acupuncture, traditional Medicare typically does not cover this service.
12. **Long-Term Care:** Medicare does not cover most long-term care services, including assisted living facilities, custodial care, and nursing home care.
13. **Dental Care:** Routine dental care, such as cleanings, fillings, and extractions, is generally not covered by Medicare. Some Medicare Advantage plans may offer limited dental coverage.
14. **Vision Care:** Routine eye exams, eyeglasses, and contact lenses are typically not covered by Medicare, though there are exceptions for certain eye diseases and conditions.
15. **Hearing Aids:** Medicare does not cover hearing aids or routine hearing exams, though some Medicare Advantage plans may offer coverage for these services.
16. **Foot Care:** Routine foot care, including podiatry services, is generally not covered unless it's related to a medical condition such as diabetes.
17. **Acupressure, Massage Therapy, and Chiropractic Services:** These services are typically not covered by traditional Medicare, though coverage may be available through certain Medicare Advantage plans.
18. **Experimental or Investigational Treatments:** Medicare does not cover treatments that are considered experimental or not proven to be effective.

#### **How does Medicare decide which services to fund and which to reject?**

Medicare determines which services to cover based on several factors, including:

8. **Medical Necessity:** Medicare covers services and treatments that are deemed medically necessary to diagnose or treat a medical condition. This means the service must be considered reasonable and necessary for the diagnosis or treatment of an illness or injury.
9. **Evidence-Based Medicine:** Medicare evaluates medical treatments and services based on scientific evidence of their effectiveness. Services that have been proven through clinical studies to improve health outcomes or quality of life are more likely to be covered.
10. **National Coverage Determinations (NCDs):** The Centers for Medicare & Medicaid Services (CMS) establishes National Coverage Determinations (NCDs) to specify whether Medicare will cover a particular item or service. These

determinations are based on factors such as clinical evidence, expert opinions, and public comments.

11. **Local Coverage Determinations (LCDs):** Medicare Administrative Contractors (MACs) develop Local Coverage Determinations (LCDs) that provide additional guidance on coverage for specific services within their geographic jurisdictions. LCDs may vary by region and can provide more detailed criteria for coverage.
12. **Cost-Effectiveness:** Medicare considers the cost-effectiveness of services when making coverage decisions. While Medicare aims to provide access to necessary healthcare services, it also seeks to manage costs and ensure the sustainability of the program.
13. **Statutory Exclusions:** Some services are explicitly excluded from Medicare coverage by law. For example, Medicare cannot cover most dental care, eyeglasses, and hearing aids under the original Medicare program.
14. **Public Input and Stakeholder Feedback:** Medicare may consider input from healthcare providers, beneficiary advocacy groups, medical societies, and other stakeholders when making coverage decisions. Public comments and feedback are often solicited during the decision-making process for NCDs and LCDs.

Overall, Medicare aims to strike a balance between providing access to essential healthcare services while managing costs and ensuring the quality and effectiveness of care. Coverage decisions are based on a combination of medical evidence, clinical judgment, statutory requirements, and input from stakeholders.

Medicare's coverage policies evolve over time, and they may update their coverage decisions periodically to reflect advancements in medical technology and changes in clinical evidence. However, there are certain technology-based treatments or services that Medicare historically has been cautious about covering due to various factors such as limited evidence of effectiveness, high costs, or ongoing research. Here are some examples:

7. **Virtual Reality Therapy:** While virtual reality (VR) therapy shows promise in various healthcare applications, including pain management and mental health treatment, Medicare's coverage for VR therapy may be limited due to a lack of extensive clinical evidence supporting its effectiveness in specific medical conditions.
8. **Telehealth Services:** While Medicare has expanded coverage for telehealth services in response to the COVID-19 pandemic, coverage for certain telehealth modalities and services may still be limited. For example, coverage for remote patient monitoring devices or certain telehealth platforms may vary based on specific criteria.

9. **Genetic Testing and Personalized Medicine:** Medicare may cover certain genetic tests for specific medical conditions or hereditary diseases. However, coverage for more comprehensive genetic testing panels or personalized medicine approaches may be limited due to concerns about cost-effectiveness and the need for additional evidence of clinical utility.
10. **Robotic Surgery:** While robotic-assisted surgical procedures have become more common in recent years, Medicare's coverage for robotic surgery may be limited to specific indications and procedures. Coverage decisions may depend on factors such as the availability of clinical evidence demonstrating improved outcomes compared to traditional surgical approaches.
11. **Stem Cell Therapy:** Medicare's coverage for stem cell therapy may be limited due to concerns about the safety, efficacy, and regulation of stem cell treatments. Coverage decisions may vary depending on whether the stem cell therapy is considered standard of care for a specific medical condition or is part of an approved clinical trial.
12. **Artificial Intelligence (AI) Applications:** Medicare's coverage for AI-based diagnostic tools or decision support systems may be limited to specific applications with robust clinical evidence supporting their accuracy and clinical utility. Coverage decisions may also depend on regulatory approval and compliance with Medicare billing requirements.

It's essential to note that Medicare's coverage decisions are subject to change, and coverage for specific technology-based treatments or services may evolve over time as new evidence emerges and healthcare practices evolve. Individuals should consult with healthcare providers and Medicare representatives to understand the current coverage policies and options available to them.

Medicare aims to provide coverage for medically necessary treatments that are proven to be effective and appropriate for the patient's condition. However, there may be instances where Medicare does not cover certain treatments that could be considered potentially life-saving. Here are some reasons why this might occur:

6. **Lack of Sufficient Evidence:** Medicare typically requires strong evidence of a treatment's effectiveness before providing coverage. If there is insufficient clinical evidence to support the effectiveness of a particular treatment for a specific condition, Medicare may not cover it, even if it has the potential to be life-saving.
7. **Experimental or Investigational Treatments:** Medicare generally does not cover treatments that are considered experimental or investigational, meaning they have not yet been proven through rigorous clinical trials to be safe and effective for the intended use.

8. **Off-Label Use of Drugs:** Medicare may not cover the off-label use of drugs, meaning the use of a medication for a condition or indication not approved by the Food and Drug Administration (FDA). While off-label use is common in medical practice, Medicare may only cover medications for FDA-approved indications.
9. **Cost Considerations:** In some cases, the cost of a treatment may be prohibitively high, and Medicare may determine that the cost outweighs the potential benefit, especially if there are other, more cost-effective treatments available.
10. **Statutory Exclusions:** Certain treatments or services may be explicitly excluded from Medicare coverage by law. For example, Medicare cannot cover most dental care, hearing aids, or cosmetic surgery under the original Medicare program.

It's important to note that Medicare's coverage policies may vary depending on factors such as the specific medical condition, the individual's health status, and the availability of alternative treatments. In some cases, individuals may have the option to appeal Medicare's coverage decision or seek coverage through other avenues, such as clinical trials, private insurance, or financial assistance programs.

Medicare typically covers a wide range of cancer treatments that are considered medically necessary and proven to be effective. However, there may be certain cancer treatments or related services that Medicare does not cover or has limitations on coverage. Here are some examples:

6. **Off-Label Use of Drugs:** Medicare may not cover the off-label use of drugs for cancer treatment, meaning the use of a medication for a purpose other than its FDA-approved indication. Coverage for off-label use is evaluated on a case-by-case basis and may depend on the availability of strong clinical evidence supporting the treatment's effectiveness.
7. **Experimental or Investigational Treatments:** Medicare generally does not cover treatments that are considered experimental or investigational for cancer, meaning they have not yet been proven through rigorous clinical trials to be safe and effective. Coverage for experimental treatments may be available through clinical trials or other research studies but is not typically covered by Medicare outside of these contexts.
8. **Alternative or Complementary Therapies:** Medicare typically does not cover alternative or complementary therapies for cancer treatment that have not been proven to be effective through scientific research. This may include treatments such as acupuncture, herbal remedies, and dietary supplements.
9. **High-Cost Drugs or Therapies:** Medicare may have limitations on coverage for certain high-cost cancer drugs or therapies, particularly if the cost exceeds



Medicare's established payment limits or if the treatment is considered to be of limited clinical benefit.

10. **Non-Medically Necessary Services:** Medicare generally does not cover cancer treatments that are not considered medically necessary or appropriate for the patient's condition. This may include treatments that are considered to be primarily palliative or supportive in nature and do not directly target the underlying cancer.

It's important for individuals with cancer and their caregivers to work closely with healthcare providers and Medicare representatives to understand the coverage options available and any potential limitations or restrictions on coverage for specific treatments. In some cases, individuals may have the option to appeal Medicare's coverage decision or explore alternative sources of coverage or financial assistance for cancer treatment costs.

### **Some coronary treatments that Medicare rejects as an example**

Medicare generally provides coverage for a wide range of treatments for coronary artery disease and related conditions, particularly those that are considered medically necessary and proven to be effective. However, there may be certain coronary treatments or related services that Medicare does not cover or has limitations on coverage. Here are some examples:

6. **Elective Angioplasty or Stenting:** Medicare may not cover elective coronary angioplasty or stenting procedures if they are not deemed medically necessary. Coverage is typically provided for these procedures when they are performed to alleviate symptoms of coronary artery disease or to treat acute coronary syndromes.
7. **High-Risk or Investigational Procedures:** Medicare may not cover certain high-risk or investigational coronary procedures that have not been proven through rigorous clinical trials to be safe and effective. This may include emerging techniques or devices for treating coronary artery disease that are still undergoing evaluation.
8. **Preventive Screening Tests:** Medicare generally does not cover routine screening tests for coronary artery disease in asymptomatic individuals who do not have risk factors. Coverage for screening tests such as coronary calcium scoring or coronary CT angiography may be limited to certain high-risk populations or individuals with specific indications.
9. **Alternative or Complementary Therapies:** Medicare typically does not cover alternative or complementary therapies for coronary artery disease that have not been proven to be effective through scientific research. This may include treatments such as chelation therapy, acupuncture, or herbal remedies.

- 10. Non-Medically Necessary Services:** Medicare generally does not cover coronary treatments or procedures that are not considered medically necessary or appropriate for the patient's condition. This may include treatments that are considered to be primarily preventive in nature or that do not directly address the underlying coronary artery disease.

It's important for individuals with coronary artery disease and their healthcare providers to carefully review Medicare's coverage policies and guidelines to understand the options available and any potential limitations or restrictions on coverage for specific treatments. In some cases, individuals may have the option to appeal Medicare's coverage decision or explore alternative sources of coverage or financial assistance for coronary treatment costs.

### **How Medicare's treatment approval / rejection protocols compare to NICE's protocols in the UK's National Health Service**

Medicare in the United States and the National Health Service (NHS) in the United Kingdom operate under different healthcare systems and have different protocols for determining coverage and treatment approval. While both systems aim to provide access to high-quality healthcare services, there are some key differences in their approaches to treatment approval and rejection:

#### **3. Medicare in the United States:**

- Medicare is a federal health insurance program primarily for people aged 65 and older, as well as some younger individuals with disabilities.
- Coverage decisions are made by the Centers for Medicare & Medicaid Services (CMS), which sets coverage policies based on factors such as medical necessity, clinical evidence, cost-effectiveness, and statutory requirements.
- Medicare coverage decisions may vary by region and may be influenced by input from stakeholders, including healthcare providers, beneficiary advocacy groups, and medical societies.
- Medicare generally provides coverage for treatments that are deemed medically necessary and proven to be effective, although coverage for certain treatments may be limited or subject to specific criteria.

#### **4. National Institute for Health and Care Excellence (NICE) in the United Kingdom:**

- NICE is an independent organization responsible for providing national guidance and recommendations on health technologies and clinical practices in England and Wales.

- NICE evaluates the clinical and cost-effectiveness of treatments and interventions through its technology appraisal and clinical guideline programs.
- NICE assesses the evidence base for treatments and issues guidance on whether they should be recommended for use within the NHS based on considerations such as clinical effectiveness, cost-effectiveness, and impact on patient outcomes.
- NICE's recommendations are influential in determining access to treatments within the NHS, and healthcare providers are generally expected to follow NICE guidance in their clinical practice.

In terms of stringency, it's challenging to make a direct comparison between Medicare's coverage protocols and NICE's protocols, as they operate within different healthcare systems with unique priorities and constraints. Both systems strive to ensure that patients have access to effective and appropriate treatments while managing costs and promoting high-quality care. However, the specific criteria and processes for treatment approval and rejection may differ between the two systems based on their respective healthcare delivery models and organizational structures.

### **A brief description of NICE's rationing protocol**

The National Institute for Health and Care Excellence (NICE) in the United Kingdom does not operate under a formal "rationing" protocol per se, but it does employ a rigorous system to assess the clinical and cost-effectiveness of healthcare interventions. Here's an overview of NICE's approach:

7. **Health Technology Assessment (HTA):** NICE conducts health technology assessments to evaluate the clinical and cost-effectiveness of healthcare interventions, including drugs, medical devices, procedures, and public health programs. These assessments are based on systematic reviews of available evidence, economic analyses, and consultation with clinical experts.
8. **Evidence Review and Appraisal:** NICE reviews the available evidence on the effectiveness and safety of the intervention in question, considering data from clinical trials, observational studies, and other sources. The quality and reliability of the evidence are carefully assessed to ensure robustness.
9. **Cost-Effectiveness Analysis:** NICE evaluates the cost-effectiveness of the intervention by comparing its clinical benefits with its costs. Economic analyses are conducted to assess factors such as the cost per quality-adjusted life year (QALY) gained. NICE uses a cost-effectiveness threshold to determine whether an intervention represents value for money within the context of the NHS budget.
10. **Guidance Development:** Based on its assessment, NICE develops guidance recommending whether the intervention should be adopted within the NHS. This

guidance is published in the form of technology appraisals, clinical guidelines, diagnostics guidance, and public health guidance. Recommendations may include advice on which patient groups are most likely to benefit from the intervention, dosage and administration details, and any conditions or criteria for use.

11. **Consultation and Stakeholder Involvement:** NICE involves various stakeholders, including patient representatives, healthcare professionals, industry stakeholders, and the public, throughout the guidance development process. Stakeholder input is sought during scoping, evidence review, and consultation phases to ensure that multiple perspectives are considered.
12. **Implementation:** NICE guidance is intended to inform clinical practice and decision-making within the NHS. While NICE recommendations are not legally binding, healthcare providers and commissioners are generally expected to adhere to NICE guidance in their decision-making processes, subject to local variation and individual patient circumstances.

Overall, NICE's approach aims to ensure that NHS resources are allocated efficiently and that patients have access to effective, evidence-based healthcare interventions that represent value for money. While difficult decisions may arise regarding the funding and provision of certain interventions, NICE's transparent and evidence-based approach seeks to balance clinical need, patient benefit, and affordability within the context of finite healthcare resources.

### **NICE uses QALYs to determine treatment cost effectiveness**

The National Institute for Health and Care Excellence (NICE) in the United Kingdom uses Quality-Adjusted Life Years (QALYs) as a measure of health outcomes to assess the cost-effectiveness of healthcare interventions. QALYs combine both the quantity and quality of life gained from a healthcare intervention into a single measure. Here's how NICE uses QALYs to determine treatment cost-effectiveness:

13. **Definition of QALY:** A QALY is a measure of health outcome that combines both the length of life (quantity) and the quality of life (utility or health-related quality of life) experienced during that time. One QALY is equivalent to one year of life lived in perfect health. Health states considered less desirable than perfect health have QALY values less than 1.
14. **Utility Values:** Utility values represent the quality of life associated with different health states. These values are typically obtained through preference-based measures such as the EuroQol 5-Dimension (EQ-5D) questionnaire, which assesses health-related quality of life across five dimensions (mobility, self-care, usual activities, pain/discomfort, and anxiety/depression). Utility values range from 0 (representing death) to 1 (representing perfect health), with negative values indicating health states worse than death.

15. **Assessment of Health Benefits:** When evaluating a healthcare intervention, NICE considers the impact of the intervention on patients' health-related quality of life over time. This is done by estimating the number of QALYs gained or lost as a result of the intervention compared to the relevant comparator or standard of care.
16. **Cost per QALY:** NICE assesses the cost-effectiveness of a healthcare intervention by calculating the incremental cost per QALY gained compared to the next best alternative or comparator. This involves comparing the additional costs of the intervention (e.g., drug costs, administration costs, monitoring costs) with the additional health benefits in terms of QALYs gained. Interventions with lower incremental cost per QALY gained are generally considered more cost-effective.
17. **Cost-Effectiveness Threshold:** NICE uses a cost-effectiveness threshold to determine whether an intervention represents value for money within the context of the National Health Service (NHS) budget. This threshold represents the maximum amount that the NHS is willing to pay for each additional QALY gained. While the exact threshold may vary over time, it is typically set at around £20,000 to £30,000 per QALY gained.
18. **Decision Making:** Based on its assessment of cost-effectiveness, NICE provides recommendations on whether the intervention should be funded and adopted within the NHS. Interventions with incremental cost-effectiveness ratios below the cost-effectiveness threshold are generally recommended for adoption, while those above the threshold may face greater scrutiny or may not be recommended for routine use.

Overall, QALYs provide a standardized and quantitative measure of health outcomes that allows NICE to compare the costs and benefits of different healthcare interventions in a consistent and transparent manner. By considering both the costs and health benefits of interventions in terms of QALYs, NICE aims to ensure that NHS resources are allocated efficiently and that patients have access to cost-effective treatments that provide meaningful improvements in health-related quality of life.

What is the EuroQol 5-Dimension (EQ-5D) questionnaire?

The EuroQol 5-Dimension (EQ-5D) questionnaire is a widely used instrument for measuring health-related quality of life (HRQoL) across five dimensions. It is a standardized, generic measure designed to provide a simple, generic measure of health for clinical and economic appraisal. The EQ-5D is used in a variety of healthcare settings, including clinical trials, health technology assessments, and population health surveys. Here's an overview of the EQ-5D questionnaire:

6. **Dimensions:** The EQ-5D assesses health-related quality of life across five dimensions:

- Mobility: Assessing the respondent's ability to move around.
  - Self-care: Assessing the respondent's ability to perform self-care activities (e.g., bathing, dressing).
  - Usual activities: Assessing the respondent's ability to perform usual activities (e.g., work, study, housework, family or leisure activities).
  - Pain/discomfort: Assessing the respondent's level of pain or discomfort.
  - Anxiety/depression: Assessing the respondent's level of anxiety or depression.
7. **Levels:** Within each dimension, respondents indicate their current health state by selecting one of three levels:
- No problems
  - Some problems
  - Extreme problems
8. **Scoring:** The EQ-5D descriptive system can be converted into a health utility index by applying country-specific value sets. These value sets are based on preferences elicited from general population surveys using methods such as time trade-off (TTO) or visual analogue scale (VAS). Health utility index scores typically range from 0 (representing death or a health state equivalent to death) to 1 (representing full health or perfect health). Negative scores are possible, indicating health states considered worse than death.
9. **EQ VAS:** In addition to the EQ-5D descriptive system, the EQ-5D questionnaire includes a visual analogue scale (EQ VAS) where respondents rate their current health status on a vertical scale ranging from 0 (worst imaginable health state) to 100 (best imaginable health state).
10. **Versions:** The EQ-5D questionnaire is available in several versions, including the EQ-5D-3L (3-level version) and the EQ-5D-5L (5-level version), which offers greater sensitivity by providing five response levels for each dimension.

The EQ-5D questionnaire is used to assess and quantify health-related quality of life from the patient's perspective, allowing for comparisons of health outcomes across different populations, interventions, and healthcare settings. Its simplicity and ease of administration make it a valuable tool for health outcome measurement in both research and clinical practice.

### **QALY value in US dollars, 2024**

The value of a Quality-Adjusted Life Year (QALY) in US dollars in 2024 is not a fixed or standard figure. The concept of a QALY is used primarily in health economics and

healthcare decision-making to assess the cost-effectiveness of medical interventions. The value of a QALY can vary depending on several factors, including the perspective of the analysis, the healthcare system context, the specific intervention being evaluated, and the willingness-to-pay threshold used by decision-makers.

In the United States, there isn't a universally accepted value for a QALY as there is in some other countries with government-funded healthcare systems. Instead, decision-makers such as insurers, healthcare providers, and policymakers may use different methods or criteria to determine the value of a QALY within their specific contexts.

Some economic evaluations in the US healthcare system may use a willingness-to-pay threshold, which represents the maximum amount that society is willing to pay for a QALY gained. This threshold can vary but is often cited to be in the range of \$50,000 to \$150,000 per QALY gained. However, it's important to note that these values are not fixed and can vary depending on the context and the preferences of decision-makers.

In summary, the value of a QALY in US dollars in 2024 is not a set figure and would depend on the specific analysis, context, and willingness-to-pay threshold used in the evaluation.

### **How the dollar value of 1 QALY is determined**

The dollar value of 1 Quality-Adjusted Life Year (QALY) is not determined based on an individual's income or earnings. Instead, it is typically assessed in health economics studies and healthcare decision-making processes using a willingness-to-pay (WTP) threshold or cost-effectiveness threshold.

The willingness-to-pay threshold represents the maximum amount that society is willing to pay for one additional QALY gained from a healthcare intervention. This threshold is often determined based on various factors, including societal preferences, budget constraints, opportunity costs, and the value of health improvements relative to other goods and services.

Decision-makers such as government agencies, insurers, and healthcare providers may use different methods to establish a willingness-to-pay threshold within their specific contexts. Some countries with government-funded healthcare systems have established explicit thresholds for cost-effectiveness analysis. For example, in the United Kingdom, the National Institute for Health and Care Excellence (NICE) has historically used a threshold range of £20,000 to £30,000 per QALY gained as a reference point for assessing the cost-effectiveness of healthcare interventions within the National Health Service (NHS).

In the United States, willingness-to-pay thresholds may vary depending on the payer, the specific healthcare intervention being evaluated, and other contextual factors. While there is no universally accepted threshold, some studies have suggested thresholds in

the range of \$50,000 to \$150,000 per QALY gained based on empirical analyses and surveys of societal preferences.

It's important to note that the dollar value of a QALY is not directly tied to an individual's income or earnings. Instead, it reflects societal preferences and the value placed on health improvements relative to other goods and services. Therefore, 1 QALY gained from a healthcare intervention would generally be considered equally valuable regardless of the individual's income level.

The difference in estimated values of a Quality-Adjusted Life Year (QALY) between Harvard Professor David Cutler's estimation in 2003, in his book *Your Money or Your Life*, and current estimations can be attributed to several factors:

6. **Methodological Differences:** Different researchers may use different methods and assumptions to estimate the value of a QALY, leading to variation in results. David Cutler's estimation in 2003 may have relied on different data sources, economic models, or approaches compared to more recent estimations.
7. **Changes in Healthcare Costs:** Healthcare costs and the cost-effectiveness of medical interventions can change over time due to factors such as advances in medical technology, changes in treatment patterns, and shifts in healthcare delivery models. These changes can affect the perceived value of health improvements and may contribute to differences in estimated values of a QALY over time.
8. **Changes in Societal Preferences:** Societal preferences regarding the value of health improvements and the allocation of healthcare resources may evolve over time. Attitudes towards healthcare spending, willingness to pay for health benefits, and ethical considerations can influence the perceived value of a QALY and may vary across different time periods and contexts.
9. **Inflation Adjustments:** While inflation is a factor to consider when comparing economic values over time, it's important to note that the value of a QALY is not solely determined by inflation. Changes in healthcare costs, healthcare utilization patterns, and societal preferences can also influence the estimated value of a QALY, independent of inflation.
10. **Data Availability and Quality:** The availability and quality of data used to estimate the value of a QALY may have improved over time, leading to more accurate and reliable estimates in recent years. Advances in data collection methods, health outcomes research, and economic modeling techniques can contribute to more robust estimations of the value of health outcomes.

Overall, the discrepancy in estimated values of a QALY between David Cutler's estimation in 2003 and current estimations may reflect differences in methodology, changes in healthcare costs and societal preferences, and improvements in data



availability and quality over time. It's essential to interpret estimates of the value of a QALY within the specific context of the analysis and to consider the underlying assumptions and limitations of the methods used to generate these estimates.

Quality-Adjusted Life Years (QALYs) have been widely used in health economics and healthcare decision-making for several decades, and the theory and methodology behind QALYs are generally accepted within the healthcare research and administration community. Here are some reasons why QALYs are widely accepted:

6. **Standardized Measure:** QALYs provide a standardized and quantitative measure of health outcomes that allows for comparisons across different health interventions, populations, and healthcare settings. This makes QALYs a valuable tool for assessing the effectiveness and value of healthcare interventions in a consistent and transparent manner.
7. **Incorporation of Patient Preferences:** QALYs incorporate patient preferences for health states, as measured through preference-based instruments such as the EuroQol 5-Dimension (EQ-5D) questionnaire or the Health Utilities Index (HUI). By capturing individuals' subjective valuations of health-related quality of life, QALYs provide a patient-centered perspective on health outcomes.
8. **Cost-Effectiveness Analysis:** QALYs are commonly used in cost-effectiveness analysis to assess the value for money of healthcare interventions. By comparing the costs of interventions with the health benefits in terms of QALYs gained, decision-makers can prioritize resource allocation and identify interventions that offer the greatest health improvements for a given budget.
9. **Regulatory and Reimbursement Decisions:** QALYs are used by government agencies, insurers, and healthcare providers to inform regulatory decisions, reimbursement policies, and coverage determinations. For example, agencies such as the National Institute for Health and Care Excellence (NICE) in the United Kingdom use QALYs to assess the cost-effectiveness of healthcare interventions and provide guidance on their adoption within the healthcare system.
10. **Transparency and Accountability:** QALYs promote transparency and accountability in healthcare decision-making by providing a clear and quantifiable measure of health outcomes. By explicitly considering both the costs and benefits of healthcare interventions in terms of QALYs, decision-makers can justify resource allocation decisions and prioritize interventions that offer the greatest health gains per dollar spent.

While QALYs are widely accepted and commonly used in healthcare research and administration, it's important to acknowledge that they are not without limitations. Criticisms of QALYs include concerns about equity, cultural differences in valuing health states, and challenges in measuring complex health outcomes comprehensively.

Despite these limitations, QALYs remain a valuable tool for evaluating health outcomes and informing resource allocation decisions in healthcare.

### **QALYs and Medicare for All**

The inclusion of Quality-Adjusted Life Years (QALYs) in a Medicare for All system would depend on various factors, including the specific design of the healthcare system, policy priorities, and political considerations. Here are some points to consider:

6. **Cost-Effectiveness Analysis:** Medicare for All would likely aim to provide comprehensive healthcare coverage to all residents of the United States. While cost containment measures would be necessary to ensure the sustainability of the healthcare system, the extent to which cost-effectiveness analysis, including the use of QALYs, would be incorporated into decision-making could vary.
7. **Political Considerations:** The use of QALYs in healthcare decision-making is a topic of debate, and opinions on their appropriateness and ethical implications vary. Some stakeholders argue that QALYs can help ensure efficient resource allocation and promote value-based healthcare delivery, while others raise concerns about equity, fairness, and the potential for discriminatory practices.
8. **Patient-Centered Care:** Medicare for All would likely prioritize patient-centered care and equitable access to healthcare services. While QALYs provide a standardized measure of health outcomes, they may not fully capture individual preferences, values, and priorities. As such, there may be a need to balance the use of QALYs with other considerations, such as patient-reported outcomes and shared decision-making.
9. **Regulatory and Reimbursement Policies:** If QALYs were to be incorporated into a Medicare for All system, they could potentially inform regulatory decisions, reimbursement policies, and coverage determinations. Government agencies responsible for healthcare oversight and administration, such as the Centers for Medicare & Medicaid Services (CMS), could use QALYs to assess the cost-effectiveness of healthcare interventions and guide resource allocation decisions.
10. **Public Perception and Acceptance:** The inclusion of QALYs in a Medicare for All system would likely be subject to public scrutiny and debate. Stakeholder engagement, transparency, and accountability would be important considerations in shaping healthcare policy and ensuring that decision-making processes are perceived as fair and equitable.

Ultimately, the inclusion of QALYs in a Medicare for All system would require careful consideration of the benefits, challenges, and implications for healthcare delivery, patient outcomes, and healthcare spending. Policymakers would need to weigh the potential advantages of using QALYs to inform resource allocation decisions against concerns about equity, access, and patient-centered care.

In Canada, the healthcare system is publicly funded and administered at the provincial and territorial level, with each province and territory responsible for delivering healthcare services to its residents. While Canada's healthcare system, often referred to as Medicare, provides universal coverage for medically necessary healthcare services, the use of Quality-Adjusted Life Years (QALYs) to determine treatment approval or rejection varies across jurisdictions.

Generally, Canadian healthcare decision-making processes prioritize evidence-based medicine, clinical effectiveness, and cost-effectiveness in treatment decisions. Health technology assessment (HTA) agencies, such as the Canadian Agency for Drugs and Technologies in Health (CADTH) and the Institut national d'excellence en santé et en services sociaux (INESSS) in Quebec, play a significant role in evaluating the clinical and economic evidence for healthcare interventions.

While QALYs are commonly used in health economics and healthcare decision-making worldwide, including in countries with government-funded healthcare systems such as the United Kingdom, their use in Canada may vary. Some HTA agencies in Canada may incorporate QALYs or similar measures of health-related quality of life into their assessments of healthcare interventions to assess their cost-effectiveness and value for money.

However, the extent to which QALYs are used to inform treatment approval or rejection decisions in Canada can depend on several factors, including jurisdictional differences, institutional practices, stakeholder preferences, and public policy priorities. Other considerations, such as patient preferences, equity, and feasibility, may also influence healthcare decision-making in Canada.

In summary, while QALYs may be used as part of health technology assessment processes in Canada, their use and influence on treatment approval or rejection decisions may vary across provinces and territories. Decision-makers in Canada typically consider a range of factors, including clinical effectiveness, cost-effectiveness, patient preferences, and equity, when making decisions about the allocation of healthcare resources and coverage of healthcare interventions.

In France, healthcare decision-making is guided by the principles of solidarity, universality, and equity, with a strong emphasis on ensuring access to high-quality healthcare for all citizens. The French healthcare system, known as "l'Assurance Maladie" or "la Sécurité Sociale," is based on a mix of public and private financing and delivery of healthcare services.

While Quality-Adjusted Life Years (QALYs) are commonly used in health economics and healthcare decision-making in some countries, such as the United Kingdom, their use in France may be less prevalent. Instead, the French healthcare system relies on a combination of clinical effectiveness, evidence-based medicine, and economic evaluation to inform treatment approval or rejection decisions.

The French National Authority for Health (Haute Autorité de Santé, HAS) plays a key role in evaluating the clinical and economic evidence for healthcare interventions and providing recommendations to inform healthcare policy and practice. HAS conducts health technology assessments (HTAs) to assess the clinical benefits, safety, and cost-effectiveness of new drugs, medical devices, procedures, and healthcare technologies.

While HAS may consider measures of health-related quality of life, such as QALYs, as part of its HTA processes, the specific methods and criteria used to evaluate healthcare interventions in France may vary. HAS takes into account a range of factors, including clinical effectiveness, patient safety, public health impact, and economic considerations, when making recommendations about the adoption and reimbursement of healthcare interventions.

Decision-making in France typically emphasizes evidence-based medicine, clinical effectiveness, and patient-centered care to ensure the delivery of high-quality healthcare services to the population.

While the British National Health Service (NHS) incorporates Quality-Adjusted Life Years (QALYs) into its health technology assessment processes to assess the cost-effectiveness of healthcare interventions, and to provide guidance on treatment decisions, it's not accurate to characterize the French system as allowing for more subjective decisions made solely by individual doctors.

Both the NHS in the UK and the French healthcare system (l'Assurance Maladie) rely on evidence-based medicine, clinical guidelines, and health technology assessment to inform treatment decisions. Here's a nuanced view:

### **3. British National Health Service (NHS):**

- The NHS uses QALYs and other measures of health outcomes as part of its health technology assessment processes conducted by organizations like the National Institute for Health and Care Excellence (NICE). These assessments inform recommendations about which healthcare interventions should be funded and provided within the NHS.
- While NICE provides guidance on the cost-effectiveness of healthcare interventions, individual treatment decisions are typically made by healthcare professionals in consultation with patients, taking into account clinical considerations, patient preferences, and other factors.

### **4. French Healthcare System (l'Assurance Maladie):**

- In France, the Haute Autorité de Santé (HAS) conducts health technology assessments to evaluate the clinical and economic evidence for healthcare interventions. HAS provides recommendations to inform healthcare policy and practice, including reimbursement decisions.

- Like in the UK, individual treatment decisions in France involve healthcare professionals (including doctors) working with patients to make decisions based on clinical evidence, patient preferences, and other relevant factors.

In both systems, treatment decisions are guided by a combination of clinical evidence, patient preferences, and healthcare professionals' expertise. While QALYs and health technology assessment may play a more prominent role in decision-making within the NHS, and individual doctors in France may have more autonomy, both systems aim to ensure access to high-quality, evidence-based healthcare for their populations.

Ultimately, treatment decisions are made collaboratively between healthcare professionals and patients, taking into account the best available evidence and the individual needs and preferences of the patient.

## **Systemic Evolution Part 1: Fee for Service**

Perceptive writers have waxed poetic about the failings of healthcare financing for centuries. Moliere, an articulate French playwright wrote about his own healthcare system faults eloquently in the 1600s. Arguably his most famous play, *The Imaginary Invalid*, describes how a hypochondriacal gentleman plots to marry his daughter to a physician for the resulting free medical care. Fee-for-service medical costs, it appears, were too expensive even for the wealthy in the 1600s. Perceptive writers like Moliere entertained audiences with gallows humor about their shared tribulations some 400 years ago.

More recently George Bernard Shaw wrote about British society in the 1900s. His analysis of the then-healthcare system mirrored Moliere's from 3 centuries earlier. Some things never change.

Shaw wrote *The Doctor's Dilemma* in 1909 to skewer the private, fee-based healthcare financing system. The Preface, reproduced in large part below, 'is an extensive tirade against the ... medical profession, as being excessively given to protestations of the public good and the actual pursuit of private interest' according to the Wikipedia summary.

In other words, Shaw saw physicians as professionals who claimed to do well for themselves by doing good for others, but in the end, always did well for themselves regardless their patient outcomes.

Since Shaw is far more articulate than I, I decided to include much of his Preface to the *Doctor's Dilemma* verbatim here.

As you read this, consider how Shaw's complaints about his healthcare system in 1909 mirror many of our own today. Ask yourself how much has changed over the past 116 years. (If you really want to depress yourself, read Moliere's *Imaginary Invalid* and ask yourself the same questions.)

### **The Doctor's Dilemma by George Bernard Shaw**

#### **Preface**

#### **On Doctors, 1909**

It is not the fault of our doctors that the medical service of the community, as at present provided for, is a murderous absurdity.

That any sane nation, having observed that you could provide for the supply of bread by giving bakers a pecuniary interest in baking for you, should go on to give a surgeon a pecuniary interest in cutting off your leg, is enough to make one despair of political humanity.

But that is precisely what we have done. And the more appalling the mutilation, the more the mutilator is paid. He who corrects the ingrowing toe-nail receives a few

shillings: he who cuts your inside out receives hundreds of guineas, except when he does it to a poor person for practice.

Scandalized voices murmur that these operations are necessary. They may be. It may also be necessary to hang a man or pull down a house. But we take good care not to make the hangman and the housebreaker the judges of that. If we did, no man's neck would be safe and no man's house stable. But we do make the doctor the judge, and fine him anything from sixpence to several hundred guineas if he decides in our favor.

I cannot knock my shins severely without forcing on some surgeon the difficult question, "Could I not make a better use of a pocketful of guineas than this man is making of his leg? Could he not write as well—or even better—on one leg than on two? And the guineas would make all the difference in the world to me just now. My wife—my pretty ones—the leg may mortify—it is always safer to operate—he will be well in a fortnight—artificial legs are now so well made that they are really better than natural ones—evolution is towards motors and leglessness, etc., etc., etc."

Now there is no calculation that an engineer can make as to the behavior of a girder under a strain, or an astronomer as to the recurrence of a comet, more certain than the calculation that under such circumstances we shall be dismembered unnecessarily in all directions by surgeons who believe the operations to be necessary solely because they want to perform them. The process metaphorically called bleeding the rich man is performed not only metaphorically but literally every day by surgeons who are quite as honest as most of us. After all, what harm is there in it? The surgeon need not take off the rich man's (or woman's) leg or arm: he can remove the appendix or the uvula, and leave the patient none the worse after a fortnight or so in bed, whilst the nurse, the general practitioner, the apothecary, and the surgeon will be the better.

### **DOUBTFUL CHARACTER BORNE BY THE MEDICAL PROFESSION**

Again I hear the voices indignantly muttering old phrases about the high character of a noble profession and the honor and conscience of its members. I must reply that the medical profession has not a high character: it has an infamous character. I do not know a single thoughtful and well-informed person who does not feel that the tragedy of illness at present is that it delivers you helplessly into the hands of a profession which you deeply mistrust, because it not only advocates and practices the most revolting cruelties in the pursuit of knowledge, and justifies them on grounds which would equally justify practicing the same cruelties on yourself or your children, or burning down London to test a patent fire extinguisher, but, when it has shocked the public, tries to reassure it with lies of breath-bereaving brazenness. That is the character the medical profession has got just now. It may be deserved or it may not: there it is at all events, and the doctors who have not realized this are living in a fool's paradise.

As to the humor and conscience of doctors, they have as much as any other class of men, no more and no less.

And what other men dare pretend to be impartial where they have a strong pecuniary interest on one side? Nobody supposes that doctors are less virtuous than judges; but a judge whose salary and reputation depended on whether the verdict was for plaintiff or defendant, prosecutor or prisoner, would be as little trusted as a general in the pay of the enemy.

To offer me a doctor as my judge, and then weight his decision with a bribe of a large sum of money and a virtual guarantee that if he makes a mistake it can never be proved against him, is to go wildly beyond the ascertained strain which human nature will bear.

It is simply unscientific to allege or believe that doctors do not under existing circumstances perform unnecessary operations and manufacture and prolong lucrative illnesses.

The only ones who can claim to be above suspicion are those who are so much sought after that their cured patients are immediately replaced by fresh ones. And there is this curious psychological fact to be remembered: a serious illness or a death advertizes the doctor exactly as a hanging advertizes the barrister who defended the person hanged.

Suppose, for example, a royal personage gets something wrong with his throat, or has a pain in his inside. If a doctor effects some trumpery cure with a wet compress or a peppermint lozenge nobody takes the least notice of him. But if he operates on the throat and kills the patient, or extirpates an internal organ and keeps the whole nation palpitating for days whilst the patient hovers in pain and fever between life and death, his fortune is made: every rich man who omits to call him in when the same symptoms appear in his household is held not to have done his utmost duty to the patient. The wonder is that there is a king or queen left alive in Europe.

## **DOCTOR'S CONSCIENCES**

There is another difficulty in trusting to the honor and conscience of a doctor. Doctors are just like other Englishmen: most of them have no honor and no conscience: what they commonly mistake for these is sentimentality and an intense dread of doing anything that everybody else does not do, or omitting to do anything that everybody else does. This of course does amount to a sort of working or rule-of-thumb conscience; but it means that you will do anything, good or bad, provided you get enough people to keep you in countenance by doing it also. It is the sort of conscience that makes it possible to keep order on a pirate ship, or in a troop of brigands. It may be said that in the last analysis there is no other sort of honor or conscience in existence—that the assent of the majority is the only sanction known to ethics. No doubt this holds good in political practice. If mankind knew the facts, and agreed with the doctors, then the doctors would be in the right; and any person who thought otherwise would be a lunatic. But mankind does not agree, and does not know the facts. All that can be said for medical popularity is that until there is a practicable alternative to blind trust in the doctor, the truth about the doctor is so terrible that we dare not face it. Moliere saw



through the doctors; but he had to call them in just the same. Napoleon had no illusions about them; but he had to die under their treatment just as much as the most credulous ignoramus that ever paid sixpence for a bottle of strong medicine. In this predicament most people, to save themselves from unbearable mistrust and misery, or from being driven by their conscience into actual conflict with the law, fall back on the old rule that if you cannot have what you believe in you must believe in what you have. When your child is ill or your wife dying, and you happen to be very fond of them, or even when, if you are not fond of them, you are human enough to forget every personal grudge before the spectacle of a fellow creature in pain or peril, what you want is comfort, reassurance, something to clutch at, were it but a straw. This the doctor brings you. You have a wildly urgent feeling that something must be done; and the doctor does something. Sometimes what he does kills the patient; but you do not know that; and the doctor assures you that all that human skill could do has been done. And nobody has the brutality to say to the newly bereft father, mother, husband, wife, brother, or sister, "You have killed your lost darling by your credulity."

## **THE PECULIAR PEOPLE**

Besides, the calling in of the doctor is now compulsory except in cases where the patient is an adult—and not too ill to decide the steps to be taken. We are subject to prosecution for manslaughter or for criminal neglect if the patient dies without the consolations of the medical profession. This menace is kept before the public by the Peculiar People. The Peculiars, as they are called, have gained their name by believing that the Bible is infallible, and taking their belief quite seriously. The Bible is very clear as to the treatment of illness. The Epistle of James; chapter v., contains the following explicit directions:

14. Is any sick among you? let him call for the elders of the Church; and let them pray over him, anointing him with oil in the name of the Lord:

15. And the prayer of faith shall save the sick, and the Lord shall raise him up; and if he have committed sins, they shall be forgiven him.

The Peculiars obey these instructions and dispense with doctors. They are therefore prosecuted for manslaughter when their children die.

When I was a young man, the Peculiars were usually acquitted. The prosecution broke down when the doctor in the witness box was asked whether, if the child had had medical attendance, it would have lived. It was, of course, impossible for any man of sense and honor to assume divine omniscience by answering this in the affirmative, or indeed pretending to be able to answer it at all. And on this the judge had to instruct the jury that they must acquit the prisoner. Thus a judge with a keen sense of law (a very rare phenomenon on the Bench, by the way) was spared the possibility of leaving to sentence one prisoner (under the Blasphemy laws) for questioning the authority of Scripture, and another for ignorantly and superstitiously accepting it as a guide to

conduct. To-day all this is changed. The doctor never hesitates to claim divine omniscience, nor to clamor for laws to punish any scepticism on the part of laymen. A modern doctor thinks nothing of signing the death certificate of one of his own diphtheria patients, and then going into the witness box and swearing a peculiar into prison for six months by assuring the jury, on oath, that if the prisoner's child, dead of diphtheria, had been placed under his treatment instead of that of St. James, it would not have lived. And he does so not only with impunity, but with public applause, though the logical course would be to prosecute him either for the murder of his own patient or for perjury in the case of St. James. Yet no barrister, apparently, dreams of asking for the statistics of the relative case-mortality in diphtheria among the Peculiars and among the believers in doctors, on which alone any valid opinion could be founded. The barrister is as superstitious as the doctor is infatuated; and the Peculiar goes unpitied to his cell, though nothing whatever has been proved except that his child does without the interference of a doctor as effectually as any of the hundreds of children who die every day of the same diseases in the doctor's care.

## **RECOIL OF THE DOGMA OF MEDICAL INFALLIBILITY ON THE DOCTOR**

On the other hand, when the doctor is in the dock, or is the defendant in an action for malpractice, he has to struggle against the inevitable result of his former pretences to infinite knowledge and unerring skill. He has taught the jury and the judge, and even his own counsel, to believe that every doctor can, with a glance at the tongue, a touch on the pulse, and a reading of the clinical thermometer, diagnose with absolute certainty a patient's complaint, also that on dissecting a dead body he can infallibly put his finger on the cause of death, and, in cases where poisoning is suspected, the nature of the poison used. Now all this supposed exactness and infallibility is imaginary; and to treat a doctor as if his mistakes were necessarily malicious or corrupt malpractices (an inevitable deduction from the postulate that the doctor, being omniscient, cannot make mistakes) is as unjust as to blame the nearest apothecary for not being prepared to supply you with sixpenny-worth of the elixir of life, or the nearest motor garage for not having perpetual motion on sale in gallon tins. But if apothecaries and motor car makers habitually advertized elixir of life and perpetual motion, and succeeded in creating a strong general belief that they could supply it, they would find themselves in an awkward position if they were indicted for allowing a customer to die, or for burning a chauffeur by putting petrol into his car. That is the predicament the doctor finds himself in when he has to defend himself against a charge of malpractice by a plea of ignorance and fallibility. His plea is received with flat credulity; and he gets little sympathy, even from laymen who know, because he has brought the incredulity on himself. If he escapes, he can only do so by opening the eyes of the jury to the facts that medical science is as yet very imperfectly differentiated from common curemongering witchcraft; that diagnosis, though it means in many instances (including even the identification of pathogenic bacilli under the microscope) only a choice among terms so loose that they would not be accepted as definitions in any really exact science, is, even at that, an

uncertain and difficult matter on which doctors often differ; and that the very best medical opinion and treatment varies widely from doctor to doctor, one practitioner prescribing six or seven scheduled poisons for so familiar a disease as enteric fever where another will not tolerate drugs at all; one starving a patient whom another would stuff; one urging an operation which another would regard as unnecessary and dangerous; one giving alcohol and meat which another would sternly forbid, etc., etc., etc.: all these discrepancies arising not between the opinion of good doctors and bad ones (the medical contention is, of course, that a bad doctor is an impossibility), but between practitioners of equal eminence and authority. Usually it is impossible to persuade the jury that these facts are facts. Juries seldom notice facts; and they have been taught to regard any doubts of the omniscience and omnipotence of doctors as blasphemy. Even the fact that doctors themselves die of the very diseases they profess to cure passes unnoticed. We do not shoot out our lips and shake our heads, saying, "They save others: themselves they cannot save": their reputation stands, like an African king's palace, on a foundation of dead bodies; and the result is that the verdict goes against the defendant when the defendant is a doctor accused of malpractice.

Fortunately for the doctors, they very seldom find themselves in this position, because it is so difficult to prove anything against them. The only evidence that can decide a case of malpractice is expert evidence: that is, the evidence of other doctors; and every doctor will allow a colleague to decimate a whole countryside sooner than violate the bond of professional etiquette by giving him away. It is the nurse who gives the doctor away in private, because every nurse has some particular doctor whom she likes; and she usually assures her patients that all the others are disastrous noodles, and soothes the tedium of the sick-bed by gossip about their blunders. She will even give a doctor away for the sake of making the patient believe that she knows more than the doctor. But she dare not, for her livelihood, give the doctor away in public. And the doctors stand by one another at all costs. Now and then some doctor in an unassailable position, like the late Sir William Gull, will go into the witness box and say what he really thinks about the way a patient has been treated; but such behavior is considered little short of infamous by his colleagues.

## **WHY DOCTORS DO NOT DIFFER**

The truth is, there would never be any public agreement among doctors if they did not agree to agree on the main point of the doctor being always in the right. Yet the two guinea man never thinks that the five shilling man is right: if he did, he would be understood as confessing to an overcharge of one pound seventeen shillings; and on the same ground the five shilling man cannot encourage the notion that the owner of the sixpenny surgery round the corner is quite up to his mark. Thus even the layman has to be taught that infallibility is not quite infallible, because there are two qualities of it to be had at two prices.

Treatment variation! Below

But there is no agreement even in the same rank at the same price. During the first great epidemic of influenza towards the end of the nineteenth century a London evening paper sent round a journalist-patient to all the great consultants of that day, and published their advice and prescriptions; a proceeding passionately denounced by the medical papers as a breach of confidence of these eminent physicians. The case was the same; but the prescriptions were different, and so was the advice. Now a doctor cannot think his own treatment right and at the same time think his colleague right in prescribing a different treatment when the patient is the same. Anyone who has ever known doctors well enough to hear medical shop talked without reserve knows that they are full of stories about each other's blunders and errors, and that the theory of their omniscience and omnipotence no more holds good among themselves than it did with Moliere and Napoleon. But for this very reason no doctor dare accuse another of malpractice. He is not sure enough of his own opinion to ruin another man by it. He knows that if such conduct were tolerated in his profession no doctor's livelihood or reputation would be worth a year's purchase. I do not blame him: I would do the same myself. But the effect of this state of things is to make the medical profession a conspiracy to hide its own shortcomings. No doubt the same may be said of all professions. They are all conspiracies against the laity; and I do not suggest that the medical conspiracy is either better or worse than the military conspiracy, the legal conspiracy, the sacerdotal conspiracy, the pedagogic conspiracy, the royal and aristocratic conspiracy, the literary and artistic conspiracy, and the innumerable industrial, commercial, and financial conspiracies, from the trade unions to the great exchanges, which make up the huge conflict which we call society. But it is less suspected. The Radicals who used to advocate, as an indispensable preliminary to social reform, the strangling of the last king with the entrails of the last priest, substituted compulsory vaccination for compulsory baptism without a murmur.

## THE CRAZE FOR OPERATIONS

Thus everything is on the side of the doctor. When men die of disease they are said to die from natural causes. When they recover (and they mostly do) the doctor gets the credit of curing them. In surgery all operations are recorded as successful if the patient can be got out of the hospital or nursing home alive, though the subsequent history of the case may be such as would make an honest surgeon vow never to recommend or perform the operation again.

The large range of operations which consist of amputating limbs and extirpating organs admits of no direct verification of their necessity. There is a fashion in operations as there is in sleeves and skirts: the triumph of some surgeon who has at last found out how to make a once desperate operation fairly safe is usually followed by a rage for that operation not only among the doctors, but actually among their patients. **Show current**

**data, TURP etc.** There are men and women whom the operating table seems to fascinate; half-alive people who through vanity, or hypochondria, or a craving to be the constant objects of anxious attention or what not, lose such feeble sense as they ever had of the value of their own organs and limbs. They seem to care as little for mutilation as lobsters or lizards, which at least have the excuse that they grow new claws and new tails if they lose the old ones. Whilst this book was being prepared for the press a case was tried in the Courts, of a man who sued a railway company for damages because a train had run over him and amputated both his legs. He lost his case because it was proved that he had deliberately contrived the occurrence himself for the sake of getting an idler's pension at the expense of the railway company, being too dull to realize how much more he had to lose than to gain by the bargain even if he had won his case and received damages above his utmost hopes.

Thus amazing case makes it possible to say, with some prospect of being believed, that there is in the classes who can afford to pay for fashionable operations a sprinkling of persons so incapable of appreciating the relative importance of preserving their bodily integrity, (including the capacity for parentage) and the pleasure of talking about themselves and hearing themselves talked about as the heroes and heroines of sensational operations, that they tempt surgeons to operate on them not only with large fees, but with personal solicitation. Now it cannot be too often repeated that when an operation is once performed, nobody can ever prove that it was unnecessary. If I refuse to allow my leg to be amputated, its mortification and my death may prove that I was wrong; but if I let the leg go, nobody can ever prove that it would not have mortified had I been obstinate. Operation is therefore the safe side for the surgeon as well as the lucrative side. The result is that we hear of "conservative surgeons" as a distinct class of practitioners who make it a rule not to operate if they can possibly help it, and who are sought after by the people who have vitality enough to regard an operation as a last resort. But no surgeon is bound to take the conservative view. If he believes that an organ is at best a useless survival, and that if he extirpates it the patient will be well and none the worse in a fortnight, whereas to await the natural cure would mean a month's illness, then he is clearly justified in recommending the operation even if the cure without operation is as certain as anything of the kind ever can be. Thus the conservative surgeon and the radical or extirpatory surgeon may both be right as far as the ultimate cure is concerned; so that their consciences do not help them out of their differences.

## **CREDULITY AND CHLOROFORM**

There is no harder scientific fact in the world than the fact that belief can be produced in practically unlimited quantity and intensity, without observation or reasoning, and even in defiance of both, by the simple desire to believe founded on a strong interest in believing. Everybody recognizes this in the case of the amatory infatuations of the adolescents who see angels and heroes in obviously (to others) commonplace and even objectionable maidens and youths. But it holds good over the entire field of human

activity. The hardest-headed materialist will become a consulter of table-rappers and slate-writers if he loses a child or a wife so beloved that the desire to revive and communicate with them becomes irresistible. The cobbler believes that there is nothing like leather. The Imperialist who regards the conquest of England by a foreign power as the worst of political misfortunes believes that the conquest of a foreign power by England would be a boon to the conquered. Doctors are no more proof against such illusions than other men. Can anyone then doubt that under existing conditions a great deal of unnecessary and mischievous operating is bound to go on, and that patients are encouraged to imagine that modern surgery and anesthesia have made operations much less serious matters than they really are? When doctors write or speak to the public about operations, they imply, and often say in so many words, that chloroform has made surgery painless. People who have been operated on know better. The patient does not feel the knife, and the operation is therefore enormously facilitated for the surgeon; but the patient pays for the anesthesia with hours of wretched sickness; and when that is over there is the pain of the wound made by the surgeon, which has to heal like any other wound. This is why operating surgeons, who are usually out of the house with their fee in their pockets before the patient has recovered consciousness, and who therefore see nothing of the suffering witnessed by the general practitioner and the nurse, occasionally talk of operations very much as the hangman in Barnaby Rudge talked of executions, as if being operated on were a luxury in sensation as well as in price.

## **MEDICAL POVERTY**

To make matters worse, doctors are hideously poor. The Irish gentleman doctor of my boyhood, who took nothing less than a guinea, though he might pay you four visits for it, seems to have no equivalent nowadays in English society. Better be a railway porter than an ordinary English general practitioner. A railway porter has from eighteen to twenty-three shillings a week from the Company merely as a retainer; and his additional fees from the public, if we leave the third-class twopenny tip out of account (and I am by no means sure that even this reservation need be made), are equivalent to doctor's fees in the case of second-class passengers, and double doctor's fees in the case of first. Any class of educated men thus treated tends to become a brigand class, and doctors are no exception to the rule. They are offered disgraceful prices for advice and medicine. Their patients are for the most part so poor and so ignorant that good advice would be resented as impracticable and wounding. When you are so poor that you cannot afford to refuse eighteenpence from a man who is too poor to pay you any more, it is useless to tell him that what he or his sick child needs is not medicine, but more leisure, better clothes, better food, and a better drained and ventilated house.

It is kinder to give him a bottle of something almost as cheap as water, and tell him to come again with another eighteenpence if it does not cure him. When you have done that over and over again every day for a week, how much scientific conscience have you left? If you are weak-minded enough to cling desperately to your eighteenpence as

denoting a certain social superiority to the sixpenny doctor, you will be miserably poor all your life; whilst the sixpenny doctor, with his low prices and quick turnover of patients, visibly makes much more than you do and kills no more people.

A doctor's character can no more stand out against such conditions than the lungs of his patients can stand out against bad ventilation. The only way in which he can preserve his self-respect is by forgetting all he ever learnt of science, and clinging to such help as he can give without cost merely by being less ignorant and more accustomed to sick-beds than his patients. Finally, he acquires a certain skill at nursing cases under poverty-stricken domestic conditions, just as women who have been trained as domestic servants in some huge institution with lifts, vacuum cleaners, electric lighting, steam heating, and machinery that turns the kitchen into a laboratory and engine house combined, manage, when they are sent out into the world to drudge as general servants, to pick up their business in a new way, learning the slatternly habits and wretched makeshifts of homes where even bundles of kindling wood are luxuries to be anxiously economized.

### **THE SUCCESSFUL DOCTOR**

The doctor whose success blinds public opinion to medical poverty is almost as completely demoralized. His promotion means that his practice becomes more and more confined to the idle rich. The proper advice for most of their ailments is typified in Abernethy's "Live on sixpence a day and earn it." But here, as at the other end of the scale, the right advice is neither agreeable nor practicable. And every hypochondriacal rich lady or gentleman who can be persuaded that he or she is a lifelong invalid means anything from fifty to five hundred pounds a year for the doctor. Operations enable a surgeon to earn similar sums in a couple of hours; and if the surgeon also keeps a nursing home, he may make considerable profits at the same time by running what is the most expensive kind of hotel. These gains are so great that they undo much of the moral advantage which the absence of grinding pecuniary anxiety gives the rich doctor over the poor one. It is true that the temptation to prescribe a sham treatment because the real treatment is too dear for either patient or doctor does not exist for the rich doctor. He always has plenty of genuine cases which can afford genuine treatment; and these provide him with enough sincere scientific professional work to save him from the ignorance, obsolescence, and atrophy of scientific conscience into which his poorer colleagues sink. But on the other hand his expenses are enormous. Even as a bachelor, he must, at London west end rates, make over a thousand a year before he can afford even to insure his life. His house, his servants, and his equipage (or autpage) must be on the scale to which his patients are accustomed, though a couple of rooms with a camp bed in one of them might satisfy his own requirements. Above all, the income which provides for these outgoings stops the moment he himself stops working. Unlike the man of business, whose managers, clerks, warehousemen and laborers keep his business going whilst he is in bed or in his club, the doctor cannot earn a farthing by deputy. Though he is exceptionally exposed to infection, and has to face all weathers at

all hours of the night and day, often not enjoying a complete night's rest for a week, the money stops coming in the moment he stops going out; and therefore illness has special terrors for him, and success no certain permanence. He dare not stop making hay while the sun shines; for it may set at any time. Men do not resist pressure of this intensity. When they come under it as doctors they pay unnecessary visits; they write prescriptions that are as absurd as the rub of chalk with which an Irish tailor once charmed away a wart from my father's finger; they conspire with surgeons to promote operations; they nurse the delusions of the malade imaginaire (who is always really ill because, as there is no such thing as perfect health, nobody is ever really well); they exploit human folly, vanity, and fear of death as ruthlessly as their own health, strength, and patience are exploited by selfish hypochondriacs. They must do all these things or else run pecuniary risks that no man can fairly be asked to run. And the healthier the world becomes, the more they are compelled to live by imposture and the less by that really helpful activity of which all doctors get enough to preserve them from utter corruption. For even the most hardened humbug who ever prescribed ether tonics to ladies whose need for tonics is of precisely the same character as the need of poorer women for a glass of gin, has to help a mother through child-bearing often enough to feel that he is not living wholly in vain.

### **THE PSYCHOLOGY OF SELF-RESPECT IN SURGEONS**

The surgeon, though often more unscrupulous than the general practitioner, retains his self-respect more easily. The human conscience can subsist on very questionable food. No man who is occupied in doing a very difficult thing, and doing it very well, ever loses his self-respect. The shirk, the duffer, the malingerer, the coward, the weakling, may be put out of countenance by his own failures and frauds; but the man who does evil skilfully, energetically, masterfully, grows prouder and bolder at every crime. The common man may have to found his self-respect on sobriety, honesty and industry; but a Napoleon needs no such props for his sense of dignity. If Nelson's conscience whispered to him at all in the silent watches of the night, you may depend on it it whispered about the Baltic and the Nile and Cape St. Vincent, and not about his unfaithfulness to his wife. A man who robs little children when no one is looking can hardly have much self-respect or even self-esteem; but an accomplished burglar must be proud of himself. In the play to which I am at present preluding I have represented an artist who is so entirely satisfied with his artistic conscience, even to the point of dying like a saint with its support, that he is utterly selfish and unscrupulous in every other relation without feeling at the smallest disadvantage. The same thing may be observed in women who have a genius for personal attractiveness: they expend more thought, labor, skill, inventiveness, taste and endurance on making themselves lovely than would suffice to keep a dozen ugly women honest; and this enables them to maintain a high opinion of themselves, and an angry contempt for unattractive and personally careless women, whilst they lie and cheat and slander and sell themselves without a blush. The truth is, hardly any of us have ethical energy enough for more than one really inflexible point of honor. Andrea del Sarto, like Louis Dubedat in my play, must have expended on



the attainment of his great mastery of design and his originality in fresco painting more conscientiousness and industry than go to the making of the reputations of a dozen ordinary mayors and churchwardens; but (if Vasari is to be believed) when the King of France entrusted him with money to buy pictures for him, he stole it to spend on his wife. Such cases are not confined to eminent artists. Unsuccessful, unskilful men are often much more scrupulous than successful ones. In the ranks of ordinary skilled labor many men are to be found who earn good wages and are never out of a job because they are strong, indefatigable, and skilful, and who therefore are bold in a high opinion of themselves; but they are selfish and tyrannical, gluttonous and drunken, as their wives and children know to their cost.

Not only do these talented energetic people retain their self-respect through shameful misconduct: they do not even lose the respect of others, because their talents benefit and interest everybody, whilst their vices affect only a few. An actor, a painter, a composer, an author, may be as selfish as he likes without reproach from the public if only his art is superb; and he cannot fulfil his condition without sufficient effort and sacrifice to make him feel noble and martyred in spite of his selfishness. It may even happen that the selfishness of an artist may be a benefit to the public by enabling him to concentrate himself on their gratification with a recklessness of every other consideration that makes him highly dangerous to those about him. In sacrificing others to himself he is sacrificing them to the public he gratifies; and the public is quite content with that arrangement. The public actually has an interest in the artist's vices.

It has no such interest in the surgeon's vices. The surgeon's art is exercised at its expense, not for its gratification. We do not go to the operating table as we go to the theatre, to the picture gallery, to the concert room, to be entertained and delighted: we go to be tormented and maimed, lest a worse thing should befall us. It is of the most extreme importance to us that the experts on whose assurance we face this horror and suffer this mutilation should leave no interests but our own to think of; should judge our cases scientifically; and should feel about them kindly. Let us see what guarantees we have: first for the science, and then for the kindness.

### **ARE DOCTORS MEN OF SCIENCE?**

I presume nobody will question the existence of widely spread popular delusion that every doctor is a titan of science. It is escaped only in the very small class which understands by science something more than conjuring with retorts and spirit lamps, magnets and microscopes, and discovering magical cures for disease. To a sufficiently ignorant man every captain of a trading schooner is a Galileo, every organ-grinder a Beethoven, every piano-tuner a Hemholtz, every Old Bailey barrister a Solon, every Seven Dials pigeon dealer a Darwin, every scrivener a Shakespear, every locomotive engine a miracle, and its driver no less wonderful than George Stephenson. As a matter of fact, the rank and file of doctors are no more scientific than their tailors; or, if you prefer to put it the reverse way, their tailors are no less scientific than they. Doctoring is

an art, not a science: any layman who is interested in science sufficiently to take in one of the scientific journals and follow the literature of the scientific movement, knows more about it than those doctors (probably a large majority) who are not interested in it, and practise only to earn their bread. Doctoring is not even the art of keeping people in health (no doctor seems able to advise you what to eat any better than his grandmother or the nearest quack): it is the art of curing illnesses.

It does happen exceptionally that a practising doctor makes a contribution to science (my play describes a very notable one); but it happens much oftener that he draws disastrous conclusions from his clinical experience because he has no conception of scientific method, and believes, like any rustic, that the handling of evidence and statistics needs no expertness. The distinction between a quack doctor and a qualified one is mainly that only the qualified one is authorized to sign death certificates, for which both sorts seem to have about equal occasion. Unqualified practitioners now make large incomes as hygienists, and are resorted to as frequently by cultivated amateur scientists who understand quite well what they are doing as by ignorant people who are simply dupes. Bone-setters make fortunes under the very noses of our greatest surgeons from educated and wealthy patients; and some of the most successful doctors on the register use quite heretical methods of treating disease, and have qualified themselves solely for convenience. Leaving out of account the village witches who prescribe spells and sell charms, the humblest professional healers in this country are the herbalists. These men wander through the fields on Sunday seeking for herbs with magic properties of curing disease, preventing childbirth, and the like. Each of them believes that he is on the verge of a great discovery, in which Virginia Snake Root will be an ingredient, heaven knows why! Virginia Snake Root fascinates the imagination of the herbalist as mercury used to fascinate the alchemists. On week days he keeps a shop in which he sells packets of pennyroyal, dandelion, etc., labelled with little lists of the diseases they are supposed to cure, and apparently do cure to the satisfaction of the people who keep on buying them. I have never been able to perceive any distinction between the science of the herbalist and that of the duly registered doctor. A relative of mine recently consulted a doctor about some of the ordinary symptoms which indicate the need for a holiday and a change. The doctor satisfied himself that the patient's heart was a little depressed. Digitalis being a drug labelled as a heart specific by the profession, he promptly administered a stiff dose. Fortunately the patient was a hardy old lady who was not easily killed. She recovered with no worse result than her conversion to Christian Science, which owes its vogue quite as much to public despair of doctors as to superstition. I am not, observe, here concerned with the question as to whether the dose of digitalis was judicious or not; the point is, that a farm laborer consulting a herbalist would have been treated in exactly the same way.

## **BACTERIOLOGY AS A SUPERSTITION**

The smattering of science that all—even doctors—pick up from the ordinary newspapers nowadays only makes the doctor more dangerous than he used to be.

Wise men used to take care to consult doctors qualified before 1860, who were usually contemptuous of or indifferent to the germ theory and bacteriological therapeutics; but now that these veterans have mostly retired or died, we are left in the hands of the generations which, having heard of microbes much as St. Thomas Aquinas heard of angels, suddenly concluded that the whole art of healing could be summed up in the formula: Find the microbe and kill it. And even that they did not know how to do. The simplest way to kill most microbes is to throw them into an open street or river and let the sun shine on them, which explains the fact that when great cities have recklessly thrown all their sewage into the open river the water has sometimes been cleaner twenty miles below the city than thirty miles above it. But doctors instinctively avoid all facts that are reassuring, and eagerly swallow those that make it a marvel that anyone could possibly survive three days in an atmosphere consisting mainly of countless pathogenic germs. They conceive microbes as immortal until slain by a germicide administered by a duly qualified medical man. All through Europe people are adjured, by public notices and even under legal penalties, not to throw their microbes into the sunshine, but to collect them carefully in a handkerchief; shield the handkerchief from the sun in the darkness and warmth of the pocket; and send it to a laundry to be mixed up with everybody else's handkerchiefs, with results only too familiar to local health authorities.

In the first frenzy of microbe killing, surgical instruments were dipped in carbolic oil, which was a great improvement on not dipping them in anything at all and simply using them dirty; but as microbes are so fond of carbolic oil that they swarm in it, it was not a success from the anti-microbe point of view. Formalin was squirted into the circulation of consumptives until it was discovered that formalin nourishes the tubercle bacillus handsomely and kills men. The popular theory of disease is the common medical theory: namely, that every disease had its microbe duly created in the garden of Eden, and has been steadily propagating itself and producing widening circles of malignant disease ever since. It was plain from the first that if this had been even approximately true, the whole human race would have been wiped out by the plague long ago, and that every epidemic, instead of fading out as mysteriously as it rushed in, would spread over the whole world. It was also evident that the characteristic microbe of a disease might be a symptom instead of a cause. An unpunctual man is always in a hurry; but it does not follow that hurry is the cause of unpunctuality: on the contrary, what is the matter with the patient is sloth. When Florence Nightingale said bluntly that if you overcrowded your soldiers in dirty quarters there would be an outbreak of smallpox among them, she was snubbed as an ignorant female who did not know that smallpox can be produced only by the importation of its specific microbe.

If this was the line taken about smallpox, the microbe of which has never yet been run down and exposed under the microscope by the bacteriologist, what must have been the ardor of conviction as to tuberculosis, tetanus, enteric fever, Maltese fever, diphtheria, and the rest of the diseases in which the characteristic bacillus had been identified! When there was no bacillus it was assumed that, since no disease could exist

without a bacillus, it was simply eluding observation. When the bacillus was found, as it frequently was, in persons who were not suffering from the disease, the theory was saved by simply calling the bacillus an impostor, or pseudobacillus. The same boundless credulity which the public exhibit as to a doctor's power of diagnosis was shown by the doctors themselves as to the analytic microbe hunters. These witch finders would give you a certificate of the ultimate constitution of anything from a sample of the water from your well to a scrap of your lungs, for seven-and-sixpence. I do not suggest that the analysts were dishonest. No doubt they carried the analysis as far as they could afford to carry it for the money. No doubt also they could afford to carry it far enough to be of some use. But the fact remains that just as doctors perform for half-a-crown, without the least misgiving, operations which could not be thoroughly and safely performed with due scientific rigor and the requisite apparatus by an unaided private practitioner for less than some thousands of pounds, so did they proceed on the assumption that they could get the last word of science as to the constituents of their pathological samples for a two hours cab fare.

### **ECONOMIC DIFFICULTIES OF IMMUNIZATION**

I have heard doctors affirm and deny almost every possible proposition as to disease and treatment. I can remember the time when doctors no more dreamt of consumption and pneumonia being infectious than they now dream of sea-sickness being infectious, or than so great a clinical observer as Sydenham dreamt of smallpox being infectious. I have heard doctors deny that there is such a thing as infection. I have heard them deny the existence of hydrophobia as a specific disease differing from tetanus. I have heard them defend prophylactic measures and prophylactic legislation as the sole and certain salvation of mankind from zymotic disease; and I have heard them denounce both as malignant spreaders of cancer and lunacy. But the one objection I have never heard from a doctor is the objection that prophylaxis by the inoculatory methods most in vogue is an economic impossibility under our private practice system. They buy some stuff from somebody for a shilling, and inject a pennyworth of it under their patient's skin for half-a-crown, concluding that, since this primitive rite pays the somebody and pays them, the problem of prophylaxis has been satisfactorily solved. The results are sometimes no worse than the ordinary results of dirt getting into cuts; but neither the doctor nor the patient is quite satisfied unless the inoculation "takes"; that is, unless it produces perceptible illness and disablement. Sometimes both doctor and patient get more value in this direction than they bargain for. The results of ordinary private-practice-inoculation at their worst are bad enough to be indistinguishable from those of the most discreditable and dreaded disease known; and doctors, to save the credit of the inoculation, have been driven to accuse their patient or their patient's parents of having contracted this disease independently of the inoculation, an excuse which naturally does not make the family any more resigned, and leads to public recriminations in which the doctors, forgetting everything but the immediate quarrel, naively excuse themselves by admitting, and even claiming as a point in their favor, that it is often impossible to distinguish the disease produced by their inoculation and the

disease they have accused the patient of contracting. And both parties assume that what is at issue is the scientific soundness of the prophylaxis. It never occurs to them that the particular pathogenic germ which they intended to introduce into the patient's system may be quite innocent of the catastrophe, and that the casual dirt introduced with it may be at fault. When, as in the case of smallpox or cowpox, the germ has not yet been detected, what you inoculate is simply undefined matter that has been scraped off anything but chemically clean calf suffering from the disease in question. You take your chance of the germ being in the scrapings, and, lest you should kill it, you take no precautions against other germs being in it as well. Anything may happen as the result of such an inoculation. Yet this is the only stuff of the kind which is prepared and supplied even in State establishments: that is, in the only establishments free from the commercial temptation to adulterate materials and scamp precautionary processes.

Even if the germ were identified, complete precautions would hardly pay. It is true that microbe farming is not expensive. The cost of breeding and housing two head of cattle would provide for the breeding and housing of enough microbes to inoculate the entire population of the globe since human life first appeared on it. But the precautions necessary to insure that the inoculation shall consist of nothing else but the required germ in the proper state of attenuation are a very different matter from the precautions necessary in the distribution and consumption of beefsteaks. Yet people expect to find vaccines and antitoxins and the like retailed at "popular prices" in private enterprise shops just as they expect to find ounces of tobacco and papers of pins.

## **THE PERILS OF INOCULATION**

The trouble does not end with the matter to be inoculated. There is the question of the condition of the patient. The discoveries of Sir Almroth Wright have shown that the appalling results which led to the hasty dropping in 1894 of Koch's tuberculin were not accidents, but perfectly orderly and inevitable phenomena following the injection of dangerously strong "vaccines" at the wrong moment, and reinforcing the disease instead of stimulating the resistance to it. To ascertain the right moment a laboratory and a staff of experts are needed. The general practitioner, having no such laboratory and no such experience, has always chanced it, and insisted, when he was unlucky, that the results were not due to the inoculation, but to some other cause: a favorite and not very tactful one being the drunkenness or licentiousness of the patient. But though a few doctors have now learnt the danger of inoculating without any reference to the patient's "opsonic index" at the moment of inoculation, and though those other doctors who are denouncing the danger as imaginary and opsonin as a craze or a fad, obviously do so because it involves an operation which they have neither the means nor the knowledge to perform, there is still no grasp of the economic change in the situation. They have never been warned that the practicability of any method of extirpating disease depends not only on its efficacy, but on its cost. For example, just at present the world has run raving mad on the subject of radium, which has excited our credulity precisely as the apparitions at Lourdes excited the credulity of Roman Catholics.

Suppose it were ascertained that every child in the world could be rendered absolutely immune from all disease during its entire life by taking half an ounce of radium to every pint of its milk. The world would be none the healthier, because not even a Crown Prince—no, not even the son of a Chicago Meat King, could afford the treatment. Yet it is doubtful whether doctors would refrain from prescribing it on that ground. The recklessness with which they now recommend wintering in Egypt or at Davos to people who cannot afford to go to Cornwall, and the orders given for champagne jelly and old port in households where such luxuries must obviously be acquired at the cost of stinting necessities, often make one wonder whether it is possible for a man to go through a medical training and retain a spark of common sense. This sort of inconsiderateness gets cured only in the classes where poverty, pretentious as it is even at its worst, cannot pitch its pretences high enough to make it possible for the doctor (himself often no better off than the patient) to assume that the average income of an English family is about 2,000 pounds a year, and that it is quite easy to break up a home, sell an old family seat at a sacrifice, and retire into a foreign sanatorium devoted to some "treatment" that did not exist two years ago and probably will not exist (except as a pretext for keeping an ordinary hotel) two years hence. In a poor practice the doctor must find cheap treatments for cheap people, or humiliate and lose his patients either by prescribing beyond their means or sending them to the public hospitals. When it comes to prophylactic inoculation, the alternative lies between the complete scientific process, which can only be brought down to a reasonable cost by being very highly organized as a public service in a public institution, and such cheap, nasty, dangerous and scientifically spurious imitations as ordinary vaccination, which seems not unlikely to be ended, like its equally vaunted forerunner, XVIII. century inoculation, by a purely reactionary law making all sorts of vaccination, scientific or not, criminal offences. Naturally, the poor doctor (that is, the average doctor) defends ordinary vaccination frantically, as it means to him the bread of his children. To secure the vehement and practically unanimous support of the rank and file of the medical profession for any sort of treatment or operation, all that is necessary is that it can be easily practised by a rather shabbily dressed man in a surgically dirty room in a surgically dirty house without any assistance, and that the materials for it shall cost, say, a penny, and the charge for it to a patient with 100 pounds a year be half-a-crown. And, on the other hand, a hygienic measure has only to be one of such refinement, difficulty, precision and costliness as to be quite beyond the resources of private practice, to be ignored or angrily denounced as a fad.

## **TRADE UNIONISM AND SCIENCE**

Here we have the explanation of the savage rancor that so amazes people who imagine that the controversy concerning vaccination is a scientific one. It has really nothing to do with science. The medical profession, consisting for the most part of very poor men struggling to keep up appearances beyond their means, find themselves threatened with the extinction of a considerable part of their incomes: a part, too, that is easily and regularly earned, since it is independent of disease, and brings every person born into

the nation, healthy or not, to the doctors. To boot, there is the occasional windfall of an epidemic, with its panic and rush for revaccination. Under such circumstances, vaccination would be defended desperately were it twice as dirty, dangerous, and unscientific in method as it actually is. The note of fury in the defence, the feeling that the anti-vaccinator is doing a cruel, ruinous, inconsiderate thing in a mood of indignant folly: all this, so puzzling to the observer who knows nothing of the economic side of the question, and only sees that the anti-vaccinator, having nothing whatever to gain and a good deal to lose by placing himself in opposition to the law and to the outcry that adds private persecution to legal penalties, can have no interest in the matter except the interest of a reformer in abolishing a corrupt and mischievous superstition, becomes intelligible the moment the tragedy of medical poverty and the lucrativeness of cheap vaccination is taken into account.

In the face of such economic pressure as this, it is silly to expect that medical teaching, any more than medical practice, can possibly be scientific. The test to which all methods of treatment are finally brought is whether they are lucrative to doctors or not. It would be difficult to cite any proposition less obnoxious to science, than that advanced by Hahnemann: to wit, that drugs which in large doses produce certain symptoms, counteract them in very small doses, just as in more modern practice it is found that a sufficiently small inoculation with typhoid rallies our powers to resist the disease instead of prostrating us with it. But Hahnemann and his followers were frantically persecuted for a century by generations of apothecary-doctors whose incomes depended on the quantity of drugs they could induce their patients to swallow. These two cases of ordinary vaccination and homeopathy are typical of all the rest. Just as the object of a trade union under existing conditions must finally be, not to improve the technical quality of the work done by its members, but to secure a living wage for them, so the object of the medical profession today is to secure an income for the private doctor; and to this consideration all concern for science and public health must give way when the two come into conflict. Fortunately they are not always in conflict. Up to a certain point doctors, like carpenters and masons, must earn their living by doing the work that the public wants from them; and as it is not in the nature of things possible that such public want should be based on unmixed disutility, it may be admitted that doctors have their uses, real as well as imaginary. But just as the best carpenter or mason will resist the introduction of a machine that is likely to throw him out of work, or the public technical education of unskilled laborers' sons to compete with him, so the doctor will resist with all his powers of persecution every advance of science that threatens his income. And as the advance of scientific hygiene tends to make the private doctor's visits rarer, and the public inspector's frequenter, whilst the advance of scientific therapeutics is in the direction of treatments that involve highly organized laboratories, hospitals, and public institutions generally, it unluckily happens that the organization of private practitioners which we call the medical profession is coming more and more to represent, not science, but desperate and embittered antiscience: a statement of things which is likely

to get worse until the average doctor either depends upon or hopes for an appointment in the public health service for his livelihood.

So much for our guarantees as to medical science. Let us now deal with the more painful subject of medical kindness.

## **DOCTORS AND VIVISECTION**

The importance to our doctors of a reputation for the tenderest humanity is so obvious, and the quantity of benevolent work actually done by them for nothing (a great deal of it from sheer good nature) so large, that at first sight it seems unaccountable that they should not only throw all their credit away, but deliberately choose to band themselves publicly with outlaws and scoundrels by claiming that in the pursuit of their professional knowledge they should be free from the restraints of law, of honor, of pity, of remorse, of everything that distinguishes an orderly citizen from a South Sea buccaneer, or a philosopher from an inquisitor. For here we look in vain for either an economic or a sentimental motive. In every generation fools and blackguards have made this claim; and honest and reasonable men, led by the strongest contemporary minds, have repudiated it and exposed its crude rascality. From Shakespear and Dr. Johnson to Ruskin and Mark Twain, the natural abhorrence of sane mankind for the vivisector's cruelty, and the contempt of able thinkers for his imbecile casuistry, have been expressed by the most popular spokesmen of humanity. If the medical profession were to outdo the Anti-Vivisection Societies in a general professional protest against the practice and principles of the vivisectors, every doctor in the kingdom would gain substantially by the immense relief and reconciliation which would follow such a reassurance of the humanity of the doctor. Not one doctor in a thousand is a vivisector, or has any interest in vivisection, either pecuniary or intellectual, or would treat his dog cruelly or allow anyone else to do it. It is true that the doctor complies with the professional fashion of defending vivisection, and assuring you that people like Shakespear and Dr. Johnson and Ruskin and Mark Twain are ignorant sentimentalists, just as he complies with any other silly fashion: the mystery is, how it became the fashion in spite of its being so injurious to those who follow it. Making all possible allowance for the effect of the brazen lying of the few men who bring a rush of despairing patients to their doors by professing in letters to the newspapers to have learnt from vivisection how to cure certain diseases, and the assurances of the sayers of smooth things that the practice is quite painless under the law, it is still difficult to find any civilized motive for an attitude by which the medical profession has everything to lose and nothing to gain.

## **THE PRIMITIVE SAVAGE MOTIVE**

I say civilized motive advisedly; for primitive tribal motives are easy enough to find. Every savage chief who is not a Mahomet learns that if he wishes to strike the imagination of his tribe—and without doing that he can rule them—he must terrify or revolt them from time to time by acts of hideous cruelty or disgusting unnaturalness. We



are far from being as superior to such tribes as we imagine. It is very doubtful indeed whether Peter the Great could have effected the changes he made in Russia if he had not fascinated and intimidated his people by his monstrous cruelties and grotesque escapades. Had he been a nineteenth-century king of England, he would have had to wait for some huge accidental calamity: a cholera epidemic, a war, or an insurrection, before waking us up sufficiently to get anything done. Vivisection helps the doctor to rule us as Peter ruled the Russians. The notion that the man who does dreadful things is superhuman, and that therefore he can also do wonderful things either as ruler, avenger, healer, or what not, is by no means confined to barbarians. Just as the manifold wickednesses and stupidities of our criminal code are supported, not by any general comprehension of law or study of jurisprudence, not even by simple vindictiveness, but by the superstition that a calamity of any sort must be expiated by a human sacrifice; so the wickednesses and stupidities of our medicine men are rooted in superstitions that have no more to do with science than the traditional ceremony of christening an ironclad has to do with the effectiveness of its armament. We have only to turn to Macaulay's description of the treatment of Charles II in his last illness to see how strongly his physicians felt that their only chance of cheating death was by outraging nature in tormenting and disgusting their unfortunate patient. True, this was more than two centuries ago; but I have heard my own nineteenth-century grandfather describe the cupping and firing and nauseous medicines of his time with perfect credulity as to their beneficial effects; and some more modern treatments appear to me quite as barbarous. It is in this way that vivisection pays the doctor. It appeals to the fear and credulity of the savage in us; and without fear and credulity half the private doctor's occupation and seven-eighths of his influence would be gone.

### **THE HIGHER MOTIVE. THE TREE OF KNOWLEDGE.**

But the greatest force of all on the side of vivisection is the mighty and indeed divine force of curiosity. Here we have no decaying tribal instinct which men strive to root out of themselves as they strive to root out the tiger's lust for blood. On the contrary, the curiosity of the ape, or of the child who pulls out the legs and wings of a fly to see what it will do without them, or who, on being told that a cat dropped out of the window will always fall on its legs, immediately tries the experiment on the nearest cat from the highest window in the house (I protest I did it myself from the first floor only), is as nothing compared to the thirst for knowledge of the philosopher, the poet, the biologist, and the naturalist. I have always despised Adam because he had to be tempted by the woman, as she was by the serpent, before he could be induced to pluck the apple from the tree of knowledge. I should have swallowed every apple on the tree the moment the owner's back was turned. When Gray said "Where ignorance is bliss, 'tis folly to be wise," he forgot that it is godlike to be wise; and since nobody wants bliss particularly, or could stand more than a very brief taste of it if it were attainable, and since everybody, by the deepest law of the Life Force, desires to be godlike, it is stupid, and indeed blasphemous and despairing, to hope that the thirst for knowledge will either diminish or consent to be subordinated to any other end whatsoever. We shall see later on that the

claim that has arisen in this way for the unconditioned pursuit of knowledge is as idle as all dreams of unconditioned activity; but none the less the right to knowledge must be regarded as a fundamental human right. The fact that men of science have had to fight so hard to secure its recognition, and are still so vigorously persecuted when they discover anything that is not quite palatable to vulgar people, makes them sorely jealous for that right; and when they hear a popular outcry for the suppression of a method of research which has an air of being scientific, their first instinct is to rally to the defence of that method without further consideration, with the result that they sometimes, as in the case of vivisection, presently find themselves fighting on a false issue.

## **THE FLAW IN THE ARGUMENT**

I may as well pause here to explain their error. The right to know is like the right to live. It is fundamental and unconditional in its assumption that knowledge, like life, is a desirable thing, though any fool can prove that ignorance is bliss, and that "a little knowledge is a dangerous thing" (a little being the most that any of us can attain), as easily as that the pains of life are more numerous and constant than its pleasures, and that therefore we should all be better dead. The logic is unimpeachable; but its only effect is to make us say that if these are the conclusions logic leads to, so much the worse for logic, after which curt dismissal of Folly, we continue living and learning by instinct: that is, as of right. We legislate on the assumption that no man may be killed on the strength of a demonstration that he would be happier in his grave, not even if he is dying slowly of cancer and begs the doctor to despatch him quickly and mercifully. To get killed lawfully he must violate somebody else's right to live by committing murder. But he is by no means free to live unconditionally. In society he can exercise his right to live only under very stiff conditions. In countries where there is compulsory military service he may even have to throw away his individual life to save the life of the community.

It is just so in the case of the right to knowledge. It is a right that is as yet very imperfectly recognized in practice. But in theory it is admitted that an adult person in pursuit of knowledge must not be refused it on the ground that he would be better or happier without it. Parents and priests may forbid knowledge to those who accept their authority; and social taboo may be made effective by acts of legal persecution under cover of repressing blasphemy, obscenity, and sedition; but no government now openly forbids its subjects to pursue knowledge on the ground that knowledge is in itself a bad thing, or that it is possible for any of us to have too much of it.

## **LIMITATIONS OF THE RIGHT TO KNOWLEDGE**

But neither does any government exempt the pursuit of knowledge, any more than the pursuit of life, liberty, and happiness (as the American Constitution puts it), from all social conditions. No man is allowed to put his mother into the stove because he desires to know how long an adult woman will survive at a temperature of 500 degrees

Fahrenheit, no matter how important or interesting that particular addition to the store of human knowledge may be. A man who did so would have short work made not only of his right to knowledge, but of his right to live and all his other rights at the same time. The right to knowledge is not the only right; and its exercise must be limited by respect for other rights, and for its own exercise by others. When a man says to Society, "May I torture my mother in pursuit of knowledge?" Society replies, "No." If he pleads, "What! Not even if I have a chance of finding out how to cure cancer by doing it?" Society still says, "Not even then." If the scientist, making the best of his disappointment, goes on to ask may he torture a dog, the stupid and callous people who do not realize that a dog is a fellow-creature and sometimes a good friend, may say Yes, though Shakespear, Dr. Johnson and their like may say No. But even those who say "You may torture A dog" never say "You may torture MY dog." And nobody says, "Yes, because in the pursuit of knowledge you may do as you please." Just as even the stupidest people say, in effect, "If you cannot attain to knowledge without burning your mother you must do without knowledge," so the wisest people say, "If you cannot attain to knowledge without torturing a dog, you must do without knowledge."

### **A FALSE ALTERNATIVE**

But in practice you cannot persuade any wise man that this alternative can ever be forced on anyone but a fool, or that a fool can be trusted to learn anything from any experiment, cruel or humane. The Chinaman who burnt down his house to roast his pig was no doubt honestly unable to conceive any less disastrous way of cooking his dinner; and the roast must have been spoiled after all (a perfect type of the average vivisectionist experiment); but this did not prove that the Chinaman was right: it only proved that the Chinaman was an incapable cook and, fundamentally, a fool.

Take another celebrated experiment: one in sanitary reform. In the days of Nero Rome was in the same predicament as London to-day. If some one would burn down London, and it were rebuilt, as it would now have to be, subject to the sanitary by-laws and Building Act provisions enforced by the London County Council, it would be enormously improved; and the average lifetime of Londoners would be considerably prolonged. Nero argued in the same way about Rome. He employed incendiaries to set it on fire; and he played the harp in scientific raptures whilst it was burning. I am so far of Nero's way of thinking that I have often said, when consulted by despairing sanitary reformers, that what London needs to make her healthy is an earthquake. Why, then, it may be asked, do not I, as a public-spirited man, employ incendiaries to set it on fire, with a heroic disregard of the consequences to myself and others? Any vivisectionist would, if he had the courage of his opinions. The reasonable answer is that London can be made healthy without burning her down; and that as we have not enough civic virtue to make her healthy in a humane and economical way, we should not have enough to rebuild her in that way. In the old Hebrew legend, God lost patience with the world as Nero did with Rome, and drowned everybody except a single family. But the result was that the progeny of that family reproduced all the vices of their predecessors so exactly that the

misery caused by the flood might just as well have been spared: things went on just as they did before. In the same way, the lists of diseases which vivisection claims to have cured is long; but the returns of the Registrar-General show that people still persist in dying of them as if vivisection had never been heard of. Any fool can burn down a city or cut an animal open; and an exceptionally foolish fool is quite likely to promise enormous benefits to the race as the result of such activities. But when the constructive, benevolent part of the business comes to be done, the same want of imagination, the same stupidity and cruelty, the same laziness and want of perseverance that prevented Nero or the vivisector from devising or pushing through humane methods, prevents him from bringing order out of the chaos and happiness out of the misery he has made. At one time it seemed reasonable enough to declare that it was impossible to find whether or not there was a stone inside a man's body except by exploring it with a knife, or to find out what the sun is made of without visiting it in a balloon. Both these impossibilities have been achieved, but not by vivisectors. The Rontgen rays need not hurt the patient; and spectrum analysis involves no destruction. After such triumphs of humane experiment and reasoning, it is useless to assure us that there is no other key to knowledge except cruelty. When the vivisector offers us that assurance, we reply simply and contemptuously, "You mean that you are not clever or humane or energetic enough to find one."

#### CRUELTY FOR ITS OWN SAKE

It will now, I hope, be clear why the attack on vivisection is not an attack on the right to knowledge: why, indeed, those who have the deepest conviction of the sacredness of that right are the leaders of the attack. No knowledge is finally impossible of human attainment; for even though it may be beyond our present capacity, the needed capacity is not unattainable. Consequently no method of investigation is the only method; and no law forbidding any particular method can cut us off from the knowledge we hope to gain by it. The only knowledge we lose by forbidding cruelty is knowledge at first hand of cruelty itself, which is precisely the knowledge humane people wish to be spared.

But the question remains: Do we all really wish to be spared that knowledge? Are humane methods really to be preferred to cruel ones? Even if the experiments come to nothing, may not their cruelty be enjoyed for its own sake, as a sensational luxury? Let us face these questions boldly, not shrinking from the fact that cruelty is one of the primitive pleasures of mankind, and that the detection of its Protean disguises as law, education, medicine, discipline, sport and so forth, is one of the most difficult of the unending tasks of the legislator.

#### OUR OWN CRUELTIES

At first blush it may seem not only unnecessary, but even indecent, to discuss such a proposition as the elevation of cruelty to the rank of a human right. Unnecessary, because no vivisector confesses to a love of cruelty for its own sake or claims any

general fundamental right to be cruel. Indecent, because there is an accepted convention to repudiate cruelty; and vivisection is only tolerated by the law on condition that, like judicial torture, it shall be done as mercifully as the nature of the practice allows. But the moment the controversy becomes embittered, the recriminations bandied between the opposed parties bring us face-to-face with some very ugly truths. On one occasion I was invited to speak at a large Anti-Vivisection meeting in the Queen's Hall in London. I found myself on the platform with fox hunters, tame stag hunters, men and women whose calendar was divided, not by pay days and quarter days, but by seasons for killing animals for sport: the fox, the hare, the otter, the partridge and the rest having each its appointed date for slaughter. The ladies among us wore hats and cloaks and head-dresses obtained by wholesale massacres, ruthless trappings, callous extermination of our fellow creatures. We insisted on our butchers supplying us with white veal, and were large and constant consumers of *pate de foie gras*; both comestibles being obtained by revolting methods. We sent our sons to public schools where indecent flogging is a recognized method of taming the young human animal. Yet we were all in hysterics of indignation at the cruelties of the vivisectors. These, if any were present, must have smiled sardonically at such inhuman humanitarians, whose daily habits and fashionable amusements cause more suffering in England in a week than all the vivisectors of Europe do in a year. I made a very effective speech, not exclusively against vivisection, but against cruelty; and I have never been asked to speak since by that Society, nor do I expect to be, as I should probably give such offence to its most affluent subscribers that its attempts to suppress vivisection would be seriously hindered. But that does not prevent the vivisectors from freely using the "you're another" retort, and using it with justice.

We must therefore give ourselves no airs of superiority when denouncing the cruelties of vivisection. We all do just as horrible things, with even less excuse. But in making that admission we are also making short work of the virtuous airs with which we are sometimes referred to the humanity of the medical profession as a guarantee that vivisection is not abused—much as if our burglars should assure us that they are too honest to abuse the practice of burglary. We are, as a matter of fact, a cruel nation; and our habit of disguising our vices by giving polite names to the offences we are determined to commit does not, unfortunately for my own comfort, impose on me. Vivisectors can hardly pretend to be better than the classes from which they are drawn, or those above them; and if these classes are capable of sacrificing animals in various cruel ways under cover of sport, fashion, education, discipline, and even, when the cruel sacrifices are human sacrifices, of political economy, it is idle for the vivisector to pretend that he is incapable of practising cruelty for pleasure or profit or both under the cloak of science. We are all tarred with the same brush; and the vivisectors are not slow to remind us of it, and to protest vehemently against being branded as exceptionally cruel and its devisors of horrible instruments of torture by people whose main notion of enjoyment is cruel sport, and whose requirements in the way of villainously cruel traps occupy pages of the catalogue of the Army and Navy Stores.

## THE SCIENTIFIC INVESTIGATION OF CRUELTY

There is in man a specific lust for cruelty which infects even his passion of pity and makes it savage. Simple disgust at cruelty is very rare. The people who turn sick and faint and those who gloat are often alike in the pains they take to witness executions, floggings, operations or any other exhibitions of suffering, especially those involving bloodshed, blows, and laceration. A craze for cruelty can be developed just as a craze for drink can; and nobody who attempts to ignore cruelty as a possible factor in the attraction of vivisection and even of antivivisection, or in the credulity with which we accept its excuses, can be regarded as a scientific investigator of it. Those who accuse vivisectors of indulging the well-known passion of cruelty under the cloak of research are therefore putting forward a strictly scientific psychological hypothesis, which is also simple, human, obvious, and probable. It may be as wounding to the personal vanity of the vivisector as Darwin's *Origin of Species* was to the people who could not bear to think that they were cousins to the monkeys (remember Goldsmith's anger when he was told that he could not move his upper jaw); but science has to consider only the truth of the hypothesis, and not whether conceited people will like it or not. In vain do the sentimental champions of vivisection declare themselves the most humane of men, inflicting suffering only to relieve it, scrupulous in the use of anesthetics, and void of all passion except the passion of pity for a disease-ridden world. The really scientific investigator answers that the question cannot be settled by hysterical protestations, and that if the vivisectionist rejects deductive reasoning, he had better clear his character by his own favorite method of experiment.

## SUGGESTED LABORATORY TESTS OF THE VIVISECTOR'S EMOTIONS

Take the hackneyed case of the Italian who tortured mice, ostensibly to find out about the effects of pain rather less than the nearest dentist could have told him, and who boasted of the ecstatic sensations (he actually used the word love) with which he carried out his experiments. Or the gentleman who starved sixty dogs to death to establish the fact that a dog deprived of food gets progressively lighter and weaker, becoming remarkably emaciated, and finally dying: an undoubted truth, but ascertainable without laboratory experiments by a simple enquiry addressed to the nearest policeman, or, failing him, to any sane person in Europe. The Italian is diagnosed as a cruel voluptuary: the dog-starver is passed over as such a hopeless fool that it is impossible to take any interest in him. Why not test the diagnosis scientifically? Why not perform a careful series of experiments on persons under the influence of voluptuous ecstasy, so as to ascertain its physiological symptoms? Then perform a second series on persons engaged in mathematical work or machine designing, so as to ascertain the symptoms of cold scientific activity? Then note the symptoms of a vivisector performing a cruel experiment; and compare them with the voluptuary symptoms and the mathematical symptoms? Such experiments would be quite as interesting and important as any yet undertaken by the vivisectors. They might open a line of investigation which would finally make, for instance, the ascertainment of the guilt

or innocence of an accused person a much exacter process than the very fallible methods of our criminal courts. But instead of proposing such an investigation, our vivisectors offer us all the pious protestations and all the huffy recriminations that any common unscientific mortal offers when he is accused of unworthy conduct.

## ROUTINE

Yet most vivisectors would probably come triumphant out of such a series of experiments, because vivisection is now a routine, like butchering or hanging or flogging; and many of the men who practise it do so only because it has been established as part of the profession they have adopted. Far from enjoying it, they have simply overcome their natural repugnance and become indifferent to it, as men inevitably become indifferent to anything they do often enough. It is this dangerous power of custom that makes it so difficult to convince the common sense of mankind that any established commercial or professional practice has its root in passion. Let a routine once spring from passion, and you will presently find thousands of routineers following it passionlessly for a livelihood. Thus it always seems strained to speak of the religious convictions of a clergyman, because nine out of ten clergymen have no religious convictions: they are ordinary officials carrying on a routine of baptizing, marrying, and churching; praying, reciting, and preaching; and, like solicitors or doctors, getting away from their duties with relief to hunt, to garden, to keep bees, to go into society, and the like. In the same way many people do cruel and vile things without being in the least cruel or vile, because the routine to which they have been brought up is superstitiously cruel and vile. To say that every man who beats his children and every schoolmaster who flogs a pupil is a conscious debauchee is absurd: thousands of dull, conscientious people beat their children conscientiously, because they were beaten themselves and think children ought to be beaten. The ill-tempered vulgarity that instinctively strikes at and hurts a thing that annoys it (and all children are annoying), and the simple stupidity that requires from a child perfection beyond the reach of the wisest and best adults (perfect truthfulness coupled with perfect obedience is quite a common condition of leaving a child unwhipped), produce a good deal of flagellation among people who not only do not lust after it, but who hit the harder because they are angry at having to perform an uncomfortable duty. These people will beat merely to assert their authority, or to carry out what they conceive to be a divine order on the strength of the precept of Solomon recorded in the Bible, which carefully adds that Solomon completely spoilt his own son and turned away from the god of his fathers to the sensuous idolatry in which he ended his days.

In the same way we find men and women practising vivisection as senselessly as a humane butcher, who adores his fox terrier, will cut a calf's throat and hang it up by its heels to bleed slowly to death because it is the custom to eat veal and insist on its being white; or as a German purveyor nails a goose to a board and stuffs it with food because fashionable people eat *pate de foie gras*; or as the crew of a whaler breaks in on a colony of seals and clubs them to death in wholesale massacre because ladies want

sealskin jackets; or as fanciers blind singing birds with hot needles, and mutilate the ears and tails of dogs and horses. Let cruelty or kindness or anything else once become customary and it will be practised by people to whom it is not at all natural, but whose rule of life is simply to do only what everybody else does, and who would lose their employment and starve if they indulged in any peculiarity. A respectable man will lie daily, in speech and in print, about the qualities of the article he lives by selling, because it is customary to do so. He will flog his boy for telling a lie, because it is customary to do so. He will also flog him for not telling a lie if the boy tells inconvenient or disrespectful truths, because it is customary to do so. He will give the same boy a present on his birthday, and buy him a spade and bucket at the seaside, because it is customary to do so, being all the time neither particularly mendacious, nor particularly cruel, nor particularly generous, but simply incapable of ethical judgment or independent action.

Just so do we find a crowd of petty vivisectionists daily committing atrocities and stupidities, because it is the custom to do so. Vivisection is customary as part of the routine of preparing lectures in medical schools. For instance, there are two ways of making the action of the heart visible to students. One, a barbarous, ignorant, and thoughtless way, is to stick little flags into a rabbit's heart and let the students see the flags jump. The other, an elegant, ingenious, well-informed, and instructive way, is to put a sphygmograph on the student's wrist and let him see a record of his heart's action traced by a needle on a slip of smoked paper. But it has become the custom for lecturers to teach from the rabbit; and the lecturers are not original enough to get out of their groove. Then there are the demonstrations which are made by cutting up frogs with scissors. The most humane man, however repugnant the operation may be to him at first, cannot do it at lecture after lecture for months without finally—and that very soon—feeling no more for the frog than if he were cutting up pieces of paper. Such clumsy and lazy ways of teaching are based on the cheapness of frogs and rabbits. If machines were as cheap as frogs, engineers would not only be taught the anatomy of machines and the functions of their parts: they would also have machines misused and wrecked before them so that they might learn as much as possible by using their eyes, and as little as possible by using their brains and imaginations. Thus we have, as part of the routine of teaching, a routine of vivisection which soon produces complete indifference to it on the part even of those who are naturally humane. If they pass on from the routine of lecture preparation, not into general practice, but into research work, they carry this acquired indifference with them into the laboratory, where any atrocity is possible, because all atrocities satisfy curiosity. The routine man is in the majority in his profession always: consequently the moment his practice is tracked down to its source in human passion there is a great and quite sincere poohpoohing from himself, from the mass of the profession, and from the mass of the public, which sees that the average doctor is much too commonplace and decent a person to be capable of passionate wickedness of any kind.



Here then, we have in vivisection, as in all the other tolerated and instituted cruelties, this anti-climax: that only a negligible percentage of those who practise and consequently defend it get any satisfaction out of it. As in Mr. Galsworthy's play *Justice* the useless and detestable torture of solitary imprisonment is shown at its worst without the introduction of a single cruel person into the drama, so it would be possible to represent all the torments of vivisection dramatically without introducing a single vivisector who had not felt sick at his first experience in the laboratory. Not that this can exonerate any vivisector from suspicion of enjoying his work (or her work: a good deal of the vivisection in medical schools is done by women). In every autobiography which records a real experience of school or prison life, we find that here and there among the routineers there is to be found the genuine amateur, the orgiastic flogging schoolmaster or the nagging warder, who has sought out a cruel profession for the sake of its cruelty. But it is the genuine routineer who is the bulwark of the practice, because, though you can excite public fury against a Sade, a Bluebeard, or a Nero, you cannot rouse any feeling against dull Mr. Smith doing his duty: that is, doing the usual thing. He is so obviously no better and no worse than anyone else that it is difficult to conceive that the things he does are abominable. If you would see public dislike surging up in a moment against an individual, you must watch one who does something unusual, no matter how sensible it may be. The name of Jonas Hanway lives as that of a brave man because he was the first who dared to appear in the streets of this rainy island with an umbrella.

### **THE OLD LINE BETWEEN MAN AND BEAST**

But there is still a distinction to be clung to by those who dare not tell themselves the truth about the medical profession because they are so helplessly dependent on it when death threatens the household. That distinction is the line that separates the brute from the man in the old classification. Granted, they will plead, that we are all cruel; yet the tame-stag-hunter does not hunt men; and the sportsman who lets a leash of greyhounds loose on a hare would be horrified at the thought of letting them loose on a human child. The lady who gets her cloak by flaying a sable does not flay a negro; nor does it ever occur to her that her veal cutlet might be improved on by a slice of tender baby.

Now there was a time when some trust could be placed in this distinction. The Roman Catholic Church still maintains, with what it must permit me to call a stupid obstinacy, and in spite of St. Francis and St. Anthony, that animals have no souls and no rights; so that you cannot sin against an animal, or against God by anything you may choose to do to an animal. Resisting the temptation to enter on an argument as to whether you may not sin against your own soul if you are unjust or cruel to the least of those whom St. Francis called his little brothers, I have only to point out here that nothing could be more despicably superstitious in the opinion of a vivisector than the notion that science recognizes any such step in evolution as the step from a physical organism to an immortal soul. That conceit has been taken out of all our men of science, and out of all our doctors, by the evolutionists; and when it is considered how completely obsessed

biological science has become in our days, not by the full scope of evolution, but by that particular method of it which has neither sense nor purpose nor life nor anything human, much less godlike, in it: by the method, that is, of so-called Natural Selection (meaning no selection at all, but mere dead accident and luck), the folly of trusting to vivisectors to hold the human animal any more sacred than the other animals becomes so clear that it would be waste of time to insist further on it. As a matter of fact the man who once concedes to the vivisector the right to put a dog outside the laws of honor and fellowship, concedes to him also the right to put himself outside them; for he is nothing to the vivisector but a more highly developed, and consequently more interesting-to-experiment-on vertebrate than the dog.

### **VIVISECTING THE HUMAN SUBJECT**

I have in my hand a printed and published account by a doctor of how he tested his remedy for pulmonary tuberculosis, which was to inject a powerful germicide directly into the circulation by stabbing a vein with a syringe. He was one of those doctors who are able to command public sympathy by saying, quite truly, that when they discovered that the proposed treatment was dangerous, they experimented thenceforth on themselves. In this case the doctor was devoted enough to carry his experiments to the point of running serious risks, and actually making himself very uncomfortable. But he did not begin with himself. His first experiment was on two hospital patients. On receiving a message from the hospital to the effect that these two martyrs to therapeutic science had all but expired in convulsions, he experimented on a rabbit, which instantly dropped dead. It was then, and not until then, that he began to experiment on himself, with the germicide modified in the direction indicated by the experiments made on the two patients and the rabbit. As a good many people countenance vivisection because they fear that if the experiments are not made on rabbits they will be made on themselves, it is worth noting that in this case, where both rabbits and men were equally available, the men, being, of course, enormously more instructive, and costing nothing, were experimented on first. Once grant the ethics of the vivisectionists and you not only sanction the experiment on the human subject, but make it the first duty of the vivisector. If a guinea pig may be sacrificed for the sake of the very little that can be learnt from it, shall not a man be sacrificed for the sake of the great deal that can be learnt from him? At all events, he is sacrificed, as this typical case shows. I may add (not that it touches the argument) that the doctor, the patients, and the rabbit all suffered in vain, as far as the hoped-for rescue of the race from pulmonary consumption is concerned.

### **"THE LIE IS A EUROPEAN POWER"**

Now at the very time when the lectures describing these experiments were being circulated in print and discussed eagerly by the medical profession, the customary denials that patients are experimented on were as loud, as indignant, as high-minded as

ever, in spite of the few intelligent doctors who point out rightly that all treatments are experiments on the patient. And this brings us to an obvious but mostly overlooked weakness in the vivisector's position: that is, his inevitable forfeiture of all claim to have his word believed. It is hardly to be expected that a man who does not hesitate to vivisect for the sake of science will hesitate to lie about it afterwards to protect it from what he deems the ignorant sentimentality of the laity. When the public conscience stirs uneasily and threatens suppression, there is never wanting some doctor of eminent position and high character who will sacrifice himself devotedly to the cause of science by coming forward to assure the public on his honor that all experiments on animals are completely painless; although he must know that the very experiments which first provoked the antivivisection movement by their atrocity were experiments to ascertain the physiological effects of the sensation of extreme pain (the much more interesting physiology of pleasure remains uninvestigated) and that all experiments in which sensation is a factor are voided by its suppression. Besides, vivisection may be painless in cases where the experiments are very cruel. If a person scratches me with a poisoned dagger so gently that I do not feel the scratch, he has achieved a painless vivisection; but if I presently die in torment I am not likely to consider that his humility is amply vindicated by his gentleness. A cobra's bite hurts so little that the creature is almost, legally speaking, a vivisector who inflicts no pain. By giving his victims chloroform before biting them he could comply with the law completely.

Here, then, is a pretty deadlock. Public support of vivisection is founded almost wholly on the assurances of the vivisectors that great public benefits may be expected from the practice. Not for a moment do I suggest that such a defence would be valid even if proved. But when the witnesses begin by alleging that in the cause of science all the customary ethical obligations (which include the obligation to tell the truth) are suspended, what weight can any reasonable person give to their testimony? I would rather swear fifty lies than take an animal which had licked my hand in good fellowship and torture it. If I did torture the dog, I should certainly not have the face to turn round and ask how any person there suspect an honorable man like myself of telling lies. Most sensible and humane people would, I hope, reply flatly that honorable men do not behave dishonorably, even to dogs. The murderer who, when asked by the chaplain whether he had any other crimes to confess, replied indignantly, "What do you take me for?" reminds us very strongly of the vivisectors who are so deeply hurt when their evidence is set aside as worthless.

#### AN ARGUMENT WHICH WOULD DEFEND ANY CRIME

The Achilles heel of vivisection, however, is not to be found in the pain it causes, but in the line of argument by which it is justified. The medical code regarding it is simply criminal anarchism at its very worst. Indeed no criminal has yet had the impudence to argue as every vivisector argues. No burglar contends that as it is admittedly important to have money to spend, and as the object of burglary is to provide the burglar with money to spend, and as in many instances it has achieved this object, therefore the

burglar is a public benefactor and the police are ignorant sentimentalists. No highway robber has yet harrowed us with denunciations of the puling moralist who allows his child to suffer all the evils of poverty because certain faddists think it dishonest to garotte an alderman. Thieves and assassins understand quite well that there are paths of acquisition, even of the best things, that are barred to all men of honor. Again, has the silliest burglar ever pretended that to put a stop to burglary is to put a stop to industry? All the vivisections that have been performed since the world began have produced nothing so important as the innocent and honorable discovery of radiography; and one of the reasons why radiography was not discovered sooner was that the men whose business it was to discover new clinical methods were coarsening and stupefying themselves with the sensual villanies and cutthroat's casuistries of vivisection. The law of the conservation of energy holds good in physiology as in other things: every vivisector is a deserter from the army of honorable investigators. But the vivisector does not see this. He not only calls his methods scientific: he contends that there are no other scientific methods. When you express your natural loathing for his cruelty and your natural contempt for his stupidity, he imagines that you are attacking science. Yet he has no inkling of the method and temper of science. The point at issue being plainly whether he is a rascal or not, he not only insists that the real point is whether some hotheaded antivivisectionist is a liar (which he proves by ridiculously unscientific assumptions as to the degree of accuracy attainable in human statement), but never dreams of offering any scientific evidence by his own methods.

There are many paths to knowledge already discovered; and no enlightened man doubts that there are many more waiting to be discovered. Indeed, all paths lead to knowledge; because even the vilest and stupidest action teaches us something about vileness and stupidity, and may accidentally teach us a good deal more: for instance, a cutthroat learns (and perhaps teaches) the anatomy of the carotid artery and jugular vein; and there can be no question that the burning of St. Joan of Arc must have been a most instructive and interesting experiment to a good observer, and could have been made more so if it had been carried out by skilled physiologists under laboratory conditions. The earthquake in San Francisco proved invaluable as an experiment in the stability of giant steel buildings; and the ramming of the Victoria by the Camperdown settled doubtful points of the greatest importance in naval warfare. According to vivisectionist logic our builders would be justified in producing artificial earthquakes with dynamite, and our admirals in contriving catastrophes at naval manoeuvres, in order to follow up the line of research thus accidentally discovered.

The truth is, if the acquisition of knowledge justifies every sort of conduct, it justifies any sort of conduct, from the illumination of Nero's feasts by burning human beings alive (another interesting experiment) to the simplest act of kindness. And in the light of that truth it is clear that the exemption of the pursuit of knowledge from the laws of honor is the most hideous conceivable enlargement of anarchy; worse, by far, than an exemption of the pursuit of money or political power, since there can hardly be attained without some regard for at least the appearances of human welfare, whereas a curious

devil might destroy the whole race in torment, acquiring knowledge all the time from his highly interesting experiment. There is more danger in one respectable scientist countenancing such a monstrous claim than in fifty assassins or dynamitards. The man who makes it is ethically imbecile; and whoever imagines that it is a scientific claim has not the faintest conception of what science means. The paths to knowledge are countless. One of these paths is a path through darkness, secrecy, and cruelty. When a man deliberately turns from all other paths and goes down that one, it is scientific to infer that what attracts him is not knowledge, since there are other paths to that, but cruelty. With so strong and scientific a case against him, it is childish for him to stand on his honor and reputation and high character and the credit of a noble profession and so forth: he must clear himself either by reason or by experiment, unless he boldly contends that evolution has retained a passion of cruelty in man just because it is indispensable to the fulness of his knowledge.

#### THOU ART THE MAN

I shall not be at all surprised if what I have written above has induced in sympathetic readers a transport of virtuous indignation at the expense of the medical profession. I shall not damp so creditable and salutary a sentiment; but I must point out that the guilt is shared by all of us. It is not in his capacity of healer and man of science that the doctor vivisects or defends vivisection, but in his entirely vulgar lay capacity. He is made of the same clay as the ignorant, shallow, credulous, half-miseducated, pecuniarily anxious people who call him in when they have tried in vain every bottle and every pill the advertizing druggist can persuade them to buy. The real remedy for vivisection is the remedy for all the mischief that the medical profession and all the other professions are doing: namely, more knowledge. The juries which send the poor Peculiars to prison, and give vivisectionists heavy damages against humane persons who accuse them of cruelty; the editors and councillors and student-led mobs who are striving to make Vivisection one of the watchwords of our civilization, are not doctors: they are the British public, all so afraid to die that they will cling frantically to any idol which promises to cure all their diseases, and crucify anyone who tells them that they must not only die when their time comes, but die like gentlemen. In their paroxysms of cowardice and selfishness they force the doctors to humor their folly and ignorance. How complete and inconsiderate their ignorance is can only be realized by those who have some knowledge of vital statistics, and of the illusions which beset Public Health legislation.

#### WHAT THE PUBLIC WANTS AND WILL NOT GET

The demands of this poor public are not reasonable, but they are quite simple. It dreads disease and desires to be protected against it. But it is poor and wants to be protected cheaply. Scientific measures are too hard to understand, too costly, too clearly tending towards a rise in the rates and more public interference with the insanitary, because insufficiently financed, private house. What the public wants, therefore, is a cheap

magic charm to prevent, and a cheap pill or potion to cure, all disease. It forces all such charms on the doctors.

## THE VACCINATION CRAZE

Thus it was really the public and not the medical profession that took up vaccination with irresistible faith, sweeping the invention out of Jenner's hand and establishing it in a form which he himself repudiated. Jenner was not a man of science; but he was not a fool; and when he found that people who had suffered from cowpox either by contagion in the milking shed or by vaccination, were not, as he had supposed, immune from smallpox, he ascribed the cases of immunity which had formerly misled him to a disease of the horse, which, perhaps because we do not drink its milk and eat its flesh, is kept at a greater distance in our imagination than our foster mother the cow. At all events, the public, which had been boundlessly credulous about the cow, would not have the horse on any terms; and to this day the law which prescribes Jennerian vaccination is carried out with an anti-Jennerian inoculation because the public would have it so in spite of Jenner. All the grossest lies and superstitions which have disgraced the vaccination craze were taught to the doctors by the public. It was not the doctors who first began to declare that all our old men remember the time when almost every face they saw in the street was horribly pitted with smallpox, and that all this disfigurement has vanished since the introduction of vaccination. Jenner himself alluded to this imaginary phenomenon before the introduction of vaccination, and attributed it to the older practice of smallpox inoculation, by which Voltaire, Catherine II. and Lady Mary Wortley Montagu so confidently expected to see the disease made harmless. It was not Jenner who set people declaring that smallpox, if not abolished by vaccination, had at least been made much milder: on the contrary, he recorded a pre-vaccination epidemic in which none of the persons attacked went to bed or considered themselves as seriously ill. Neither Jenner, nor any other doctor ever, as far as I know, inculcated the popular notion that everybody got smallpox as a matter of course before vaccination was invented. That doctors get infected with these delusions, and are in their unprofessional capacity as members of the public subject to them like other men, is true; but if we had to decide whether vaccination was first forced on the public by the doctors or on the doctors by the public, we should have to decide against the public.

## STATISTICAL ILLUSIONS

Public ignorance of the laws of evidence and of statistics can hardly be exaggerated. There may be a doctor here and there who in dealing with the statistics of disease has taken at least the first step towards sanity by grasping the fact that as an attack of even the commonest disease is an exceptional event, apparently over-whelming statistical evidence in favor of any prophylactic can be produced by persuading the public that everybody caught the disease formerly. Thus if a disease is one which normally attacks fifteen per cent of the population, and if the effect of a prophylactic is actually to increase the proportion to twenty per cent, the publication of this figure of twenty per

cent will convince the public that the prophylactic has reduced the percentage by eighty per cent instead of increasing it by five, because the public, left to itself and to the old gentlemen who are always ready to remember, on every possible subject, that things used to be much worse than they are now (such old gentlemen greatly outnumber the *laudatores temporis acti*), will assume that the former percentage was about 100. The vogue of the Pasteur treatment of hydrophobia, for instance, was due to the assumption by the public that every person bitten by a rabid dog necessarily got hydrophobia. I myself heard hydrophobia discussed in my youth by doctors in Dublin before a Pasteur Institute existed, the subject having been brought forward there by the scepticism of an eminent surgeon as to whether hydrophobia is really a specific disease or only ordinary tetanus induced (as tetanus was then supposed to be induced) by a lacerated wound. There were no statistics available as to the proportion of dog bites that ended in hydrophobia; but nobody ever guessed that the cases could be more than two or three per cent of the bites. On me, therefore, the results published by the Pasteur Institute produced no such effect as they did on the ordinary man who thinks that the bite of a mad dog means certain hydrophobia. It seemed to me that the proportion of deaths among the cases treated at the Institute was rather higher, if anything, than might have been expected had there been no Institute in existence. But to the public every Pasteur patient who did not die was miraculously saved from an agonizing death by the beneficent white magic of that most trusty of all wizards, the man of science.

Even trained statisticians often fail to appreciate the extent to which statistics are vitiated by the unrecorded assumptions of their interpreters. Their attention is too much occupied with the cruder tricks of those who make a corrupt use of statistics for advertizing purposes. There is, for example, the percentage dodge. In some hamlet, barely large enough to have a name, two people are attacked during a smallpox epidemic. One dies: the other recovers. One has vaccination marks: the other has none. Immediately either the vaccinists or the antivaccinists publish the triumphant news that at such and such a place not a single vaccinated person died of smallpox whilst 100 per cent of the unvaccinated perished miserably; or, as the case may be, that 100 per cent of the unvaccinated recovered whilst the vaccinated succumbed to the last man. Or, to take another common instance, comparisons which are really comparisons between two social classes with different standards of nutrition and education are palmed off as comparisons between the results of a certain medical treatment and its neglect. Thus it is easy to prove that the wearing of tall hats and the carrying of umbrellas enlarges the chest, prolongs life, and confers comparative immunity from disease; for the statistics show that the classes which use these articles are bigger, healthier, and live longer than the class which never dreams of possessing such things. It does not take much perspicacity to see that what really makes this difference is not the tall hat and the umbrella, but the wealth and nourishment of which they are evidence, and that a gold watch or membership of a club in Pall Mall might be proved in the same way to have the like sovereign virtues. A university degree, a daily bath, the owning of thirty pairs of trousers, a knowledge of Wagner's music, a pew in church, anything, in short, that

implies more means and better nurture than the mass of laborers enjoy, can be statistically palmed off as a magic-spell conferring all sorts of privileges.

In the case of a prophylactic enforced by law, this illusion is intensified grotesquely, because only vagrants can evade it. Now vagrants have little power of resisting any disease: their death rate and their case-mortality rate is always high relatively to that of respectable folk. Nothing is easier, therefore, than to prove that compliance with any public regulation produces the most gratifying results. It would be equally easy even if the regulation actually raised the death-rate, provided it did not raise it sufficiently to make the average householder, who cannot evade regulations, die as early as the average vagrant who can.

## THE SURPRISES OF ATTENTION AND NEGLECT

There is another statistical illusion which is independent of class differences. A common complaint of houseowners is that the Public Health Authorities frequently compel them to instal costly sanitary appliances which are condemned a few years later as dangerous to health, and forbidden under penalties. Yet these discarded mistakes are always made in the first instance on the strength of a demonstration that their introduction has reduced the death-rate. The explanation is simple. Suppose a law were made that every child in the nation should be compelled to drink a pint of brandy per month, but that the brandy must be administered only when the child was in good health, with its digestion and so forth working normally, and its teeth either naturally or artificially sound. Probably the result would be an immediate and startling reduction in child mortality, leading to further legislation increasing the quantity of brandy to a gallon. Not until the brandy craze had been carried to a point at which the direct harm done by it would outweigh the incidental good, would an anti-brand party be listened to. That incidental good would be the substitution of attention to the general health of children for the neglect which is now the rule so long as the child is not actually too sick to run about and play as usual. Even if this attention were confined to the children's teeth, there would be an improvement which it would take a good deal of brandy to cancel.

This imaginary case explains the actual case of the sanitary appliances which our local sanitary authorities prescribe today and condemn tomorrow. No sanitary contrivance which the mind of even the very worst plumber can devise could be as disastrous as that total neglect for long periods which gets avenged by pestilences that sweep through whole continents, like the black death and the cholera. If it were proposed at this time of day to discharge all the sewage of London crude and untreated into the Thames, instead of carrying it, after elaborate treatment, far out into the North Sea, there would be a shriek of horror from all our experts. Yet if Cromwell had done that instead of doing nothing, there would probably have been no Great Plague of London. When the Local Health Authority forces every householder to have his sanitary arrangements thought about and attended to by somebody whose special business it is to attend to such things, then it matters not how erroneous or even directly mischievous



may be the specific measures taken: the net result at first is sure to be an improvement. Not until attention has been effectually substituted for neglect as the general rule, will the statistics begin to show the merits of the particular methods of attention adopted. And as we are far from having arrived at this stage, being as to health legislation only at the beginning of things, we have practically no evidence yet as to the value of methods. Simple and obvious as this is, nobody seems as yet to discount the effect of substituting attention for neglect in drawing conclusions from health statistics. Everything is put to the credit of the particular method employed, although it may quite possibly be raising the death rate by five per thousand whilst the attention incidental to it is reducing the death rate fifteen per thousand. The net gain of ten per thousand is credited to the method, and made the excuse for enforcing more of it.

### **STEALING CREDIT FROM CIVILIZATION**

There is yet another way in which specifics which have no merits at all, either direct or incidental, may be brought into high repute by statistics. For a century past civilization has been cleaning away the conditions which favor bacterial fevers. Typhus, once rife, has vanished: plague and cholera have been stopped at our frontiers by a sanitary blockade. We still have epidemics of smallpox and typhoid; and diphtheria and scarlet fever are endemic in the slums. Measles, which in my childhood was not regarded as a dangerous disease, has now become so mortal that notices are posted publicly urging parents to take it seriously. But even in these cases the contrast between the death and recovery rates in the rich districts and in the poor ones has led to the general conviction among experts that bacterial diseases are preventable; and they already are to a large extent prevented. The dangers of infection and the way to avoid it are better understood than they used to be. It is barely twenty years since people exposed themselves recklessly to the infection of consumption and pneumonia in the belief that these diseases were not "catching." Nowadays the troubles of consumptive patients are greatly increased by the growing disposition to treat them as lepers. No doubt there is a good deal of ignorant exaggeration and cowardly refusal to face a human and necessary share of the risk. That has always been the case. We now know that the medieval horror of leprosy was out of all proportion to the danger of infection, and was accompanied by apparent blindness to the infectiousness of smallpox, which has since been worked up by our disease terrorists into the position formerly held by leprosy. But the scare of infection, though it sets even doctors talking as if the only really scientific thing to do with a fever patient is to throw him into the nearest ditch and pump carbolic acid on him from a safe distance until he is ready to be cremated on the spot, has led to much greater care and cleanliness. And the net result has been a series of victories over disease.

Now let us suppose that in the early nineteenth century somebody had come forward with a theory that typhus fever always begins in the top joint of the little finger; and that if this joint be amputated immediately after birth, typhus fever will disappear. Had such a suggestion been adopted, the theory would have been triumphantly confirmed; for as a

matter of fact, typhus fever has disappeared. On the other hand cancer and madness have increased (statistically) to an appalling extent. The opponents of the little finger theory would therefore be pretty sure to allege that the amputations were spreading cancer and lunacy. The vaccination controversy is full of such contentions. So is the controversy as to the docking of horses' tails and the cropping of dogs' ears. So is the less widely known controversy as to circumcision and the declaring certain kinds of flesh unclean by the Jews. To advertize any remedy or operation, you have only to pick out all the most reassuring advances made by civilization, and boldly present the two in the relation of cause and effect: the public will swallow the fallacy without a wry face. It has no idea of the need for what is called a control experiment. In Shakespear's time and for long after it, mummy was a favorite medicament. You took a pinch of the dust of a dead Egyptian in a pint of the hottest water you could bear to drink; and it did you a great deal of good. This, you thought, proved what a sovereign healer mummy was. But if you had tried the control experiment of taking the hot water without the mummy, you might have found the effect exactly the same, and that any hot drink would have done as well.

## **BIOMETRIKA**

Another difficulty about statistics is the technical difficulty of calculation. Before you can even make a mistake in drawing your conclusion from the correlations established by your statistics you must ascertain the correlations. When I turn over the pages of *Biometrika*, a quarterly journal in which is recorded the work done in the field of biological statistics by Professor Karl Pearson and his colleagues, I am out of my depth at the first line, because mathematics are to me only a concept: I never used a logarithm in my life, and could not undertake to extract the square root of four without misgiving. I am therefore unable to deny that the statistical ascertainment of the correlations between one thing and another must be a very complicated and difficult technical business, not to be tackled successfully except by high mathematicians; and I cannot resist Professor Karl Pearson's immense contempt for, and indignant sense of grave social danger in, the unskilled guesses of the ordinary sociologist.

Now the man in the street knows nothing of *Biometrika*: all he knows is that "you can prove anything by figures," though he forgets this the moment figures are used to prove anything he wants to believe. If he did take in *Biometrika* he would probably become abjectly credulous as to all the conclusions drawn in it from the correlations so learnedly worked out; though the mathematician whose correlations would fill a Newton with admiration may, in collecting and accepting data and drawing conclusions from them, fall into quite crude errors by just such popular oversights as I have been describing.

## **PATIENT-MADE THERAPEUTICS**

To all these blunders and ignorances doctors are no less subject than the rest of us. They are not trained in the use of evidence, nor in biometrics, nor in the psychology of human credulity, nor in the incidence of economic pressure. Further, they must believe,

on the whole, what their patients believe, just as they must wear the sort of hat their patients wear. The doctor may lay down the law despotically enough to the patient at points where the patient's mind is simply blank; but when the patient has a prejudice the doctor must either keep it in countenance or lose his patient. If people are persuaded that night air is dangerous to health and that fresh air makes them catch cold it will not be possible for a doctor to make his living in private practice if he prescribes ventilation. We have to go back no further than the days of *The Pickwick Papers* to find ourselves in a world where people slept in four-post beds with curtains drawn closely round to exclude as much air as possible. Had Mr. Pickwick's doctor told him that he would be much healthier if he slept on a camp bed by an open window, Mr. Pickwick would have regarded him as a crank and called in another doctor. Had he gone on to forbid Mr. Pickwick to drink brandy and water whenever he felt chilly, and assured him that if he were deprived of meat or salt for a whole year, he would not only not die, but would be none the worse, Mr. Pickwick would have fled from his presence as from that of a dangerous madman. And in these matters the doctor cannot cheat his patient. If he has no faith in drugs or vaccination, and the patient has, he can cheat him with colored water and pass his lancet through the flame of a spirit lamp before scratching his arm. But he cannot make him change his daily habits without knowing it.

### **THE REFORMS ALSO COME FROM THE LAITY**

In the main, then, the doctor learns that if he gets ahead of the superstitions of his patients he is a ruined man; and the result is that he instinctively takes care not to get ahead of them. That is why all the changes come from the laity. It was not until an agitation had been conducted for many years by laymen, including quacks and faddists of all kinds, that the public was sufficiently impressed to make it possible for the doctors to open their minds and their mouths on the subject of fresh air, cold water, temperance, and the rest of the new fashions in hygiene. At present the tables have been turned on many old prejudices. Plenty of our most popular elderly doctors believe that cold tubs in the morning are unnatural, exhausting, and rheumatic; that fresh air is a fad and that everybody is the better for a glass or two of port wine every day; but they no longer dare say as much until they know exactly where they are; for many very desirable patients in country houses have lately been persuaded that their first duty is to get up at six in the morning and begin the day by taking a walk barefoot through the dewy grass. He who shows the least scepticism as to this practice is at once suspected of being "an old-fashioned doctor," and dismissed to make room for a younger man.

In short, private medical practice is governed not by science but by supply and demand; and however scientific a treatment may be, it cannot hold its place in the market if there is no demand for it; nor can the grossest quackery be kept off the market if there is a demand for it.

### **FASHIONS AND EPIDEMICS**

A demand, however, can be inculcated. This is thoroughly understood by fashionable tradesmen, who find no difficulty in persuading their customers to renew articles that are not worn out and to buy things they do not want. By making doctors tradesmen, we compel them to learn the tricks of trade; consequently we find that the fashions of the year include treatments, operations, and particular drugs, as well as hats, sleeves, ballads, and games. Tonsils, vermiform appendices, uvulas, even ovaries are sacrificed because it is the fashion to get them cut out, and because the operations are highly profitable. The psychology of fashion becomes a pathology; for the cases have every air of being genuine: fashions, after all, are only induced epidemics, proving that epidemics can be induced by tradesmen, and therefore by doctors.

### **THE DOCTOR'S VIRTUES**

It will be admitted that this is a pretty bad state of things. And the melodramatic instinct of the public, always demanding; that every wrong shall have, not its remedy, but its villain to be hissed, will blame, not its own apathy, superstition, and ignorance, but the depravity of the doctors. Nothing could be more unjust or mischievous. Doctors, if no better than other men, are certainly no worse. I was reproached during the performances of *The Doctor's Dilemma* at the Court Theatre in 1907 because I made the artist a rascal, the journalist an illiterate incapable, and all the doctors "angels." But I did not go beyond the warrant of my own experience. It has been my luck to have doctors among my friends for nearly forty years past (all perfectly aware of my freedom from the usual credulity as to the miraculous powers and knowledge attributed to them); and though I know that there are medical blackguards as well as military, legal, and clerical blackguards (one soon finds that out when one is privileged to hear doctors talking shop among themselves), the fact that I was no more at a loss for private medical advice and attendance when I had not a penny in my pocket than I was later on when I could afford fees on the highest scale, has made it impossible for me to share that hostility to the doctor as a man which exists and is growing as an inevitable result of the present condition of medical practice. Not that the interest in disease and aberrations which turns some men and women to medicine and surgery is not sometimes as morbid as the interest in misery and vice which turns some others to philanthropy and "rescue work." But the true doctor is inspired by a hatred of ill-health, and a divine impatience of any waste of vital forces. Unless a man is led to medicine or surgery through a very exceptional technical aptitude, or because doctoring is a family tradition, or because he regards it unintelligently as a lucrative and gentlemanly profession, his motives in choosing the career of a healer are clearly generous. However actual practice may disillusion and corrupt him, his selection in the first instance is not a selection of a base character.

### **THE DOCTOR'S HARDSHIPS**

A review of the counts in the indictment I have brought against private medical practice will show that they arise out of the doctor's position as a competitive private tradesman:

that is, out of his poverty and dependence. And it should be borne in mind that doctors are expected to treat other people specially well whilst themselves submitting to specially inconsiderate treatment. The butcher and baker are not expected to feed the hungry unless the hungry can pay; but a doctor who allows a fellow-creature to suffer or perish without aid is regarded as a monster. Even if we must dismiss hospital service as really venal, the fact remains that most doctors do a good deal of gratuitous work in private practice all through their careers. And in his paid work the doctor is on a different footing to the tradesman. Although the articles he sells, advice and treatment, are the same for all classes, his fees have to be graduated like the income tax. The successful fashionable doctor may weed his poorer patients out from time to time, and finally use the College of Physicians to place it out of his own power to accept low fees; but the ordinary general practitioner never makes out his bills without considering the taxable capacity of his patients.

Then there is the disregard of his own health and comfort which results from the fact that he is, by the nature of his work, an emergency man. We are polite and considerate to the doctor when there is nothing the matter, and we meet him as a friend or entertain him as a guest; but when the baby is suffering from croup, or its mother has a temperature of 104 degrees, or its grandfather has broken his leg, nobody thinks of the doctor except as a healer and saviour. He may be hungry, weary, sleepy, run down by several successive nights disturbed by that instrument of torture, the night bell; but who ever thinks of this in the face of sudden sickness or accident? We think no more of the condition of a doctor attending a case than of the condition of a fireman at a fire. In other occupations night-work is specially recognized and provided for. The worker sleeps all day; has his breakfast in the evening; his lunch or dinner at midnight; his dinner or supper before going to bed in the morning; and he changes to day-work if he cannot stand night-work. But a doctor is expected to work day and night. In practices which consist largely of workmen's clubs, and in which the patients are therefore taken on wholesale terms and very numerous, the unfortunate assistant, or the principal if he has no assistant, often does not undress, knowing that he will be called up before he has snatched an hour's sleep. To the strain of such inhuman conditions must be added the constant risk of infection. One wonders why the impatient doctors do not become savage and unmanageable, and the patient ones imbecile. Perhaps they do, to some extent. And the pay is wretched, and so uncertain that refusal to attend without payment in advance becomes often a necessary measure of self-defence, whilst the County Court has long ago put an end to the tradition that the doctor's fee is an honorarium. Even the most eminent physicians, as such biographies as those of Paget show, are sometimes miserably, inhumanly poor until they are past their prime. In short, the doctor needs our help for the moment much more than we often need his. The ridicule of Moliere, the death of a well-informed and clever writer like the late Harold Frederic in the hands of Christian Scientists (a sort of sealing with his blood of the contemptuous disbelief in and dislike of doctors he had bitterly expressed in his books), the scathing and quite justifiable exposure of medical practice in the novel by Mr. Maarten Maartens

entitled The New Religion: all these trouble the doctor very little, and are in any case well set off by the popularity of Sir Luke Fildes' famous picture, and by the verdicts in which juries from time to time express their conviction that the doctor can do no wrong. The real woes of the doctor are the shabby coat, the wolf at the door, the tyranny of ignorant patients, the work-day of 24 hours, and the uselessness of honestly prescribing what most of the patients really need: that is, not medicine, but money.

## **THE PUBLIC DOCTOR**

### **What then is to be done?**

Fortunately we have not to begin absolutely from the beginning: we already have, in the Medical Officer of Health, a sort of doctor who is free from the worst hardships, and consequently from the worst vices, of the private practitioner. His position depends, not on the number of people who are ill, and whom he can keep ill, but on the number of people who are well. He is judged, as all doctors and treatments should be judged, by the vital statistics of his district. When the death rate goes up his credit goes down. As every increase in his salary depends on the issue of a public debate as to the health of the constituency under his charge, he has every inducement to strive towards the ideal of a clean bill of health. He has a safe, dignified, responsible, independent position based wholly on the public health; whereas the private practitioner has a precarious, shabby-genteel, irresponsible, servile position, based wholly on the prevalence of illness.

It is true, there are grave scandals in the public medical service. The public doctor may be also a private practitioner eking out his earnings by giving a little time to public work for a mean payment. There are cases in which the position is one which no successful practitioner will accept, and where, therefore, incapables or drunkards get automatically selected for the post, *faute de mieux*; but even in these cases the doctor is less disastrous in his public capacity than in his private one: besides, the conditions which produce these bad cases are doomed, as the evil is now recognized and understood. A popular but unstable remedy is to enable local authorities, when they are too small to require the undivided time of such men as the Medical Officers of our great municipalities, to combine for public health purposes so that each may share the services of a highly paid official of the best class; but the right remedy is a larger area as the sanitary unit.

## **MEDICAL ORGANIZATION**

Another advantage of public medical work is that it admits of organization, and consequently of the distribution of the work in such a manner as to avoid wasting the time of highly qualified experts on trivial jobs. The individualism of private practice leads to an appalling waste of time on trifles. Men whose dexterity as operators or almost divinatory skill in diagnosis are constantly needed for difficult cases, are poulticing whitlows, vaccinating, changing unimportant dressings, prescribing ether drams for

ladies with timid leanings towards dipsomania, and generally wasting their time in the pursuit of private fees. In no other profession is the practitioner expected to do all the work involved in it from the first day of his professional career to the last as the doctor is. The judge passes sentence of death; but he is not expected to hang the criminal with his own hands, as he would be if the legal profession were as unorganized as the medical. The bishop is not expected to blow the organ or wash the baby he baptizes. The general is not asked to plan a campaign or conduct a battle at half-past twelve and to play the drum at half-past two. Even if they were, things would still not be as bad as in the medical profession; for in it not only is the first-class man set to do third-class work, but, what is much more terrifying, the third-class man is expected to do first-class work. Every general practitioner is supposed to be capable of the whole range of medical and surgical work at a moment's notice; and the country doctor, who has not a specialist nor a crack consultant at the end of his telephone, often has to tackle without hesitation cases which no sane practitioner in a town would take in hand without assistance. No doubt this develops the resourcefulness of the country doctor, and makes him a more capable man than his suburban colleague; but it cannot develop the second-class man into a first-class one. If the practice of law not only led to a judge having to hang, but the hangman to judge, or if in the army matters were so arranged that it would be possible for the drummer boy to be in command at Waterloo whilst the Duke of Wellington was playing the drum in Brussels, we should not be consoled by the reflection that our hangmen were thereby made a little more judicial-minded, and our drummers more responsible, than in foreign countries where the legal and military professions recognized the advantages of division of labor.

Under such conditions no statistics as to the graduation of professional ability among doctors are available. Assuming that doctors are normal men and not magicians (and it is unfortunately very hard to persuade people to admit so much and thereby destroy the romance of doctoring) we may guess that the medical profession, like the other professions, consists of a small percentage of highly gifted persons at one end, and a small percentage of altogether disastrous duffers at the other. Between these extremes comes the main body of doctors (also, of course, with a weak and a strong end) who can be trusted to work under regulations with more or less aid from above according to the gravity of the case. Or, to put it in terms of the cases, there are cases that present no difficulties, and can be dealt with by a nurse or student at one end of the scale, and cases that require watching and handling by the very highest existing skill at the other; whilst between come the great mass of cases which need visits from the doctor of ordinary ability and from the chiefs of the profession in the proportion of, say, seven to none, seven to one, three to one, one to one, or, for a day or two, none to one. Such a service is organized at present only in hospitals; though in large towns the practice of calling in the consultant acts, to some extent, as a substitute for it. But in the latter case it is quite unregulated except by professional etiquette, which, as we have seen, has for its object, not the health of the patient or of the community at large, but the protection of the doctor's livelihood and the concealment of his errors. And as the consultant is an

expensive luxury, he is a last resource rather, as he should be, than a matter of course, in all cases where the general practitioner is not equal to the occasion: a predicament in which a very capable man may find himself at any time through the cropping up of a case of which he has had no clinical experience.

## **THE SOCIAL SOLUTION OF THE MEDICAL PROBLEM**

The social solution of the medical problem, then, depends on that large, slowly advancing, pettishly resisted integration of society called generally Socialism. Until the medical profession becomes a body of men trained and paid by the country to keep the country in health it will remain what it is at present: a conspiracy to exploit popular credulity and human suffering. Already our M.O.H.s (Medical Officers of Health) are in the new position: what is lacking is appreciation of the change, not only by the public but by the private doctors. For, as we have seen, when one of the first-rate posts becomes vacant in one of the great cities, and all the leading M.O.H.s compete for it, they must appeal to the good health of the cities of which they have been in charge, and not to the size of the incomes the local private doctors are making out of the ill-health of their patients. If a competitor can prove that he has utterly ruined every sort of medical private practice in a large city except obstetric practice and the surgery of accidents, his claims are irresistible; and this is the ideal at which every M.O.H. should aim. But the profession at large should none the less welcome him and set its house in order for the social change which will finally be its own salvation. For the M.O.H. as we know him is only the beginning of that army of Public Hygiene which will presently take the place in general interest and honor now occupied by our military and naval forces. It is silly that an Englishman should be more afraid of a German soldier than of a British disease germ, and should clamor for more barracks in the same newspapers that protest against more school clinics, and cry out that if the State fights disease for us it makes us paupers, though they never say that if the State fights the Germans for us it makes us cowards. Fortunately, when a habit of thought is silly it only needs steady treatment by ridicule from sensible and witty people to be put out of countenance and perish. Every year sees an increase in the number of persons employed in the Public Health Service, who would formerly have been mere adventurers in the Private Illness Service. To put it another way, a host of men and women who have now a strong incentive to be mischievous and even murderous rogues will have a much stronger, because a much honester, incentive to be not only good citizens but active benefactors to the community. And they will have no anxiety whatever about their incomes.

## **THE FUTURE OF PRIVATE PRACTICE**

It must not be hastily concluded that this involves the extinction of the private practitioner. What it will really mean for him is release from his present degrading and scientifically corrupting slavery to his patients. As I have already shown the doctor who has to live by pleasing his patients in competition with everybody who has walked the hospitals, scraped through the examinations, and bought a brass plate, soon finds



himself prescribing water to teetotallers and brandy or champagne jelly to drunkards; beefsteaks and stout in one house, and "uric acid free" vegetarian diet over the way; shut windows, big fires, and heavy overcoats to old Colonels, and open air and as much nakedness as is compatible with decency to young faddists, never once daring to say either "I don't know," or "I don't agree." For the strength of the doctor's, as of every other man's position when the evolution of social organization at last reaches his profession, will be that he will always have open to him the alternative of public employment when the private employer becomes too tyrannous. And let no one suppose that the words doctor and patient can disguise from the parties the fact that they are employer and employee. No doubt doctors who are in great demand can be as high-handed and independent as employees are in all classes when a dearth in their labor market makes them indispensable; but the average doctor is not in this position: he is struggling for life in an overcrowded profession, and knows well that "a good bedside manner" will carry him to solvency through a morass of illness, whilst the least attempt at plain dealing with people who are eating too much, or drinking too much, or frowsting too much (to go no further in the list of intemperances that make up so much of family life) would soon land him in the Bankruptcy Court.

Private practice, thus protected, would itself protect individuals, as far as such protection is possible, against the errors and superstitions of State medicine, which are at worst no worse than the errors and superstitions of private practice, being, indeed, all derived from it. Such monstrosities as vaccination are, as we have seen, founded, not on science, but on half-crowns. If the Vaccination Acts, instead of being wholly repealed as they are already half repealed, were strengthened by compelling every parent to have his child vaccinated by a public officer whose salary was completely independent of the number of vaccinations performed by him, and for whom there was plenty of alternative public health work waiting, vaccination would be dead in two years, as the vaccinator would not only not gain by it, but would lose credit through the depressing effects on the vital statistics of his district of the illness and deaths it causes, whilst it would take from him all the credit of that freedom from smallpox which is the result of good sanitary administration and vigilant prevention of infection. Such absurd panic scandals as that of the last London epidemic, where a fee of half-a-crown per re-vaccination produced raids on houses during the absence of parents, and the forcible seizure and re-vaccination of children left to answer the door, can be prevented simply by abolishing the half-crown and all similar follies, paying, not for this or that ceremony of witchcraft, but for immunity from disease, and paying, too, in a rational way. The officer with a fixed salary saves himself trouble by doing his business with the least possible interference with the private citizen. The man paid by the job loses money by not forcing his job on the public as often as possible without reference to its results.

## **THE TECHNICAL PROBLEM**

As to any technical medical problem specially involved, there is none. If there were, I should not be competent to deal with it, as I am not a technical expert in medicine: I

deal with the subject as an economist, a politician, and a citizen exercising my common sense. Everything that I have said applies equally to all the medical techniques, and will hold good whether public hygiene be based on the poetic fancies of Christian Science, the tribal superstitions of the druggist and the vivisector, or the best we can make of our real knowledge. But I may remind those who confusedly imagine that the medical problem is also the scientific problem, that all problems are finally scientific problems. The notion that therapeutics or hygiene or surgery is any more or less scientific than making or cleaning boots is entertained only by people to whom a man of science is still a magician who can cure diseases, transmute metals, and enable us to live for ever. It may still be necessary for some time to come to practise on popular credulity, popular love and dread of the marvellous, and popular idolatry, to induce the poor to comply with the sanitary regulations they are too ignorant to understand. As I have elsewhere confessed, I have myself been responsible for ridiculous incantations with burning sulphur, experimentally proved to be quite useless, because poor people are convinced, by the mystical air of the burning and the horrible smell, that it exorcises the demons of smallpox and scarlet fever and makes it safe for them to return to their houses. To assure them that the real secret is sunshine and soap is only to convince them that you do not care whether they live or die, and wish to save money at their expense. So you perform the incantation; and back they go to their houses, satisfied. A religious ceremony—a poetic blessing of the threshold, for instance—would be much better; but unfortunately our religion is weak on the sanitary side. One of the worst misfortunes of Christendom was that reaction against the voluptuous bathing of the imperial Romans which made dirty habits a part of Christian piety, and in some unlucky places (the Sandwich Islands for example) made the introduction of Christianity also the introduction of disease, because the formulators of the superseded native religion, like Mahomet, had been enlightened enough to introduce as religious duties such sanitary measures as ablution and the most careful and reverent treatment of everything cast off by the human body, even to nail clippings and hairs; and our missionaries thoughtlessly discredited this godly doctrine without supplying its place, which was promptly taken by laziness and neglect. If the priests of Ireland could only be persuaded to teach their flocks that it is a deadly insult to the Blessed Virgin to place her image in a cottage that is not kept up to that high standard of Sunday cleanliness to which all her worshippers must believe she is accustomed, and to represent her as being especially particular about stables because her son was born in one, they might do more in one year than all the Sanitary Inspectors in Ireland could do in twenty; and they could hardly doubt that Our Lady would be delighted. Perhaps they do nowadays; for Ireland is certainly a transfigured country since my youth as far as clean faces and pinafores can transfigure it. In England, where so many of the inhabitants are too gross to believe in poetic faiths, too respectable to tolerate the notion that the stable at Bethany was a common peasant farmer's stable instead of a first-rate racing one, and too savage to believe that anything can really cast out the devil of disease unless it be some terrifying hoodoo of tortures and stinks, the M.O.H. will no doubt for a long time to come have to preach to fools according to their folly, promising miracles, and threatening hideous personal

consequences of neglect of by-laws and the like; therefore it will be important that every M.O.H. shall have, with his (or her) other qualifications, a sense of humor, lest (he or she) should come at last to believe all the nonsense that must needs be talked. But he must, in his capacity of an expert advising the authorities, keep the government itself free of superstition. If Italian peasants are so ignorant that the Church can get no hold of them except by miracles, why, miracles there must be. The blood of St. Januarius must liquefy whether the Saint is in the humor or not. To trick a heathen into being a dutiful Christian is no worse than to trick a whitewasher into trusting himself in a room where a smallpox patient has lain, by pretending to exorcise the disease with burning sulphur. But woe to the Church if in deceiving the peasant it also deceives itself; for then the Church is lost, and the peasant too, unless he revolt against it. Unless the Church works the pretended miracle painfully against the grain, and is continually urged by its dislike of the imposture to strive to make the peasant susceptible to the true reasons for behaving well, the Church will become an instrument of his corruption and an exploiter of his ignorance, and will find itself launched upon that persecution of scientific truth of which all priesthoods are accused and none with more justice than the scientific priesthood.

And here we come to the danger that terrifies so many of us: the danger of having a hygienic orthodoxy imposed on us. But we must face that: in such crowded and poverty ridden civilizations as ours any orthodoxy is better than *laissez-faire*. If our population ever comes to consist exclusively of well-to-do, highly cultivated, and thoroughly instructed free persons in a position to take care of themselves, no doubt they will make short work of a good deal of official regulation that is now of life-and-death necessity to us; but under existing circumstances, I repeat, almost any sort of attention that democracy will stand is better than neglect. Attention and activity lead to mistakes as well as to successes; but a life spent in making mistakes is not only more honorable but more useful than a life spent doing nothing. The one lesson that comes out of all our theorizing and experimenting is that there is only one really scientific progressive method; and that is the method of trial and error. If you come to that, what is *laissez-faire* but an orthodoxy? the most tyrannous and disastrous of all the orthodoxies, since it forbids you even to learn.

## **THE LATEST THEORIES**

Medical theories are so much a matter of fashion, and the most fertile of them are modified so rapidly by medical practice and biological research, which are international activities, that the play which furnishes the pretext for this preface is already slightly outmoded, though I believe it may be taken as a faithful record for the year (1906) in which it was begun. I must not expose any professional man to ruin by connecting his name with the entire freedom of criticism which I, as a layman, enjoy; but it will be evident to all experts that my play could not have been written but for the work done by Sir Almroth Wright in the theory and practice of securing immunization from bacterial diseases by the inoculation of "vaccines" made of their own bacteria: a practice

incorrectly called vaccinotherapy (there is nothing vaccine about it) apparently because it is what vaccination ought to be and is not. Until Sir Almroth Wright, following up one of Metchnikoff's most suggestive biological romances, discovered that the white corpuscles or phagocytes which attack and devour disease germs for us do their work only when we butter the disease germs appetizingly for them with a natural sauce which Sir Almroth named opsonin, and that our production of this condiment continually rises and falls rhythmically from negligibility to the highest efficiency, nobody had been able even to conjecture why the various serums that were from time to time introduced as having effected marvellous cures, presently made such direful havoc of some unfortunate patient that they had to be dropped hastily. The quantity of sturdy lying that was necessary to save the credit of inoculation in those days was prodigious; and had it not been for the devotion shown by the military authorities throughout Europe, who would order the entire disappearance of some disease from their armies, and bring it about by the simple plan of changing the name under which the cases were reported, or for our own Metropolitan Asylums Board, which carefully suppressed all the medical reports that revealed the sometimes quite appalling effects of epidemics of revaccination, there is no saying what popular reaction might not have taken place against the whole immunization movement in therapeutics.

The situation was saved when Sir Almroth Wright pointed out that if you inoculated a patient with pathogenic germs at a moment when his powers of cooking them for consumption by the phagocytes was receding to its lowest point, you would certainly make him a good deal worse and perhaps kill him, whereas if you made precisely the same inoculation when the cooking power was rising to one of its periodical climaxes, you would stimulate it to still further exertions and produce just the opposite result. And he invented a technique for ascertaining in which phase the patient happened to be at any given moment. The dramatic possibilities of this discovery and invention will be found in my play. But it is one thing to invent a technique: it is quite another to persuade the medical profession to acquire it. Our general practitioners, I gather, simply declined to acquire it, being mostly unable to afford either the acquisition or the practice of it when acquired. Something simple, cheap, and ready at all times for all comers, is, as I have shown, the only thing that is economically possible in general practice, whatever may be the case in Sir Almroth's famous laboratory in St. Mary's Hospital. It would have become necessary to denounce opsonin in the trade papers as a fad and Sir Almroth as a dangerous man if his practice in the laboratory had not led him to the conclusion that the customary inoculations were very much too powerful, and that a comparatively infinitesimal dose would not precipitate a negative phase of cooking activity, and might induce a positive one. And thus it happens that the refusal of our general practitioners to acquire the new technique is no longer quite so dangerous in practice as it was when *The Doctor's Dilemma* was written: nay, that Sir Ralph Bloomfield Boningtons way of administering inoculations as if they were spoonfuls of squills may sometimes work fairly well. For all that, I find Sir Almroth Wright, on the 23rd May, 1910, warning the Royal Society of Medicine that "the clinician has not yet been prevailed upon to

reconsider his position," which means that the general practitioner ("the doctor," as he is called in our homes) is going on just as he did before, and could not afford to learn or practice a new technique even if he had ever heard of it. To the patient who does not know about it he will say nothing. To the patient who does, he will ridicule it, and disparage Sir Almroth. What else can he do, except confess his ignorance and starve?

But now please observe how "the whirligig of time brings its revenges." This latest discovery of the remedial virtue of a very, very tiny hair of the dog that bit you reminds us, not only of Arndt's law of protoplasmic reaction to stimuli, according to which weak and strong stimuli provoke opposite reactions, but of Hahnemann's homeopathy, which was founded on the fact alleged by Hahnemann that drugs which produce certain symptoms when taken in ordinary perceptible quantities, will, when taken in infinitesimally small quantities, provoke just the opposite symptoms; so that the drug that gives you a headache will also cure a headache if you take little enough of it. I have already explained that the savage opposition which homeopathy encountered from the medical profession was not a scientific opposition; for nobody seems to deny that some drugs act in the alleged manner. It was opposed simply because doctors and apothecaries lived by selling bottles and boxes of doctor's stuff to be taken in spoonfuls or in pellets as large as peas; and people would not pay as much for drops and globules no bigger than pins' heads. Nowadays, however, the more cultivated folk are beginning to be so suspicious of drugs, and the incorrigibly superstitious people so profusely supplied with patent medicines (the medical advice to take them being wrapped round the bottle and thrown in for nothing) that homeopathy has become a way of rehabilitating the trade of prescription compounding, and is consequently coming into professional credit. At which point the theory of opsonins comes very opportunely to shake hands with it.

Add to the newly triumphant homeopathist and the opsonist that other remarkable innovator, the Swedish masseur, who does not theorize about you, but probes you all over with his powerful thumbs until he finds out your sore spots and rubs them away, besides cheating you into a little wholesome exercise; and you have nearly everything in medical practice to-day that is not flat witchcraft or pure commercial exploitation of human credulity and fear of death. Add to them a good deal of vegetarian and teetotal controversy raging round a clamor for scientific eating and drinking, and resulting in little so far except calling digestion Metabolism and dividing the public between the eminent doctor who tells us that we do not eat enough fish, and his equally eminent colleague who warns us that a fish diet must end in leprosy, and you have all that opposes with any sort of countenance the rise of Christian Science with its cathedrals and congregations and zealots and miracles and cures: all very silly, no doubt, but sane and sensible, poetic and hopeful, compared to the pseudo science of the commercial general practitioner, who foolishly clamors for the prosecution and even the execution of the Christian Scientists when their patients die, forgetting the long death roll of his own patients.

By the time this preface is in print the kaleidoscope may have had another shake; and opsonin may have gone the way of phlogiston at the hands of its own restless discoverer. I will not say that Hahnemann may have gone the way of Diafoirus; for Diafoirus we have always with us. But we shall still pick up all our knowledge in pursuit of some Will o' the Wisp or other. What is called science has always pursued the Elixir of Life and the Philosopher's Stone, and is just as busy after them to-day as ever it was in the days of Paracelsus. We call them by different names: Immunization or Radiology or what not; but the dreams which lure us into the adventures from which we learn are always at bottom the same. Science becomes dangerous only when it imagines that it has reached its goal. What is wrong with priests and popes is that instead of being apostles and saints, they are nothing but empirics who say "I know" instead of "I am learning," and pray for credulity and inertia as wise men pray for scepticism and activity. Such abominations as the Inquisition and the Vaccination Acts are possible only in the famine years of the soul, when the great vital dogmas of honor, liberty, courage, the kinship of all life, faith that the unknown is greater than the known and is only the As Yet Unknown, and resolution to find a manly highway to it, have been forgotten in a paroxysm of littleness and terror in which nothing is active except concupiscence and the fear of death, playing on which any trader can filch a fortune, any blackguard gratify his cruelty, and any tyrant make us his slaves.

Lest this should seem too rhetorical a conclusion for our professional men of science, who are mostly trained not to believe anything unless it is worded in the jargon of those writers who, because they never really understand what they are trying to say, cannot find familiar words for it, and are therefore compelled to invent a new language of nonsense for every book they write, let me sum up my conclusions as dryly as is consistent with accurate thought and live conviction.

1. Nothing is more dangerous than a poor doctor: not even a poor employer or a poor landlord.
2. Of all the anti-social vested interests the worst is the vested interest in ill-health.
3. Remember that an illness is a misdemeanor; and treat the doctor as an accessory unless he notifies every case to the Public Health authority.
4. Treat every death as a possible and under our present system a probable murder, by making it the subject of a reasonably conducted inquest; and execute the doctor, if necessary, as a doctor, by striking him off the register.
5. Make up your mind how many doctors the community needs to keep it well. Do not register more or less than this number; and let registration constitute the doctor a civil servant with a dignified living wage paid out of public funds.
6. Municipalize Harley Street.
7. Treat the private operator exactly as you would treat a private executioner.

8. Treat persons who profess to be able to cure disease as you treat fortune tellers.
9. Keep the public carefully informed, by special statistics and announcements of individual cases, of all illnesses of doctors or in their families.
10. Make it compulsory for a doctor using a brass plate to have inscribed on it, in addition to the letters indicating his qualifications, the words "Remember that I too am mortal."
11. In legislation and social organization, proceed on the principle that invalids, meaning persons who cannot keep themselves alive by their own activities, cannot, beyond reason, expect to be kept alive by the activity of others. There is a point at which the most energetic policeman or doctor, when called upon to deal with an apparently drowned person, gives up artificial respiration, although it is never possible to declare with certainty, at any point short of decomposition, that another five minutes of the exercise would not effect resuscitation. The theory that every individual alive is of infinite value is legislatively impracticable. No doubt the higher the life we secure to the individual by wise social organization, the greater his value is to the community, and the more pains we shall take to pull him through any temporary danger or disablement. But the man who costs more than he is worth is doomed by sound hygiene as inexorably as by sound economics.
12. Do not try to live for ever. You will not succeed.
13. Use your health, even to the point of wearing it out. That is what it is for. Spend all you have before you die; and do not outlive yourself.
14. Take the utmost care to get well born and well brought up. This means that your mother must have a good doctor. Be careful to go to a school where there is what they call a school clinic, where your nutrition and teeth and eyesight and other matters of importance to you will be attended to. Be particularly careful to have all this done at the expense of the nation, as otherwise it will not be done at all, the chances being about forty to one against your being able to pay for it directly yourself, even if you know how to set about it. Otherwise you will be what most people are at present: an unsound citizen of an unsound nation, without sense enough to be ashamed or unhappy about it.

## Consumer Engagement and Education

Brokers and other insurance professionals use terms like 'consumer engagement' and 'informed consumer' in two very different – and sometimes opposing – ways. This can create confusion among subscribers and patients, and even among brokers themselves.

To *risk management professionals* – and the medical community - 'informed consumer' means someone who understands treatment options, risks, benefits and trade-offs. An informed consumer - to risk management folks, for example - might prefer a treatment that *differs* from the one recommended by his/her physician.

A case-in-point: an oncologist might recommend a mastectomy for a woman with early stage breast cancer, based on *his* analysis of the risk-reward tradeoffs. Meanwhile the patient might prefer to watch-and-wait before operating based on *her* analysis. Both analyses may be factually correct, but the doctor and patient value the risks and rewards differently.

An informed consumer, from the risk management or medical point-of-view, thus takes an active role his/her own *medical decision making* and is able to make wise medical care decisions.

To *compliance oriented insurance professionals*, 'informed consumer' means a subscriber who understands the component parts of the health insurance policy and the associated regulations about how to use it.

An informed insurance consumer - to the compliance professional, for example - might prefer to compliment a Health Savings Account with a Flexible Spending Account rather than a Health Reimbursement Account, based on some set of specific medical spending habits and needs. Or the informed insurance consumer might prefer a lower-cost policy that pays for medical services on a reference-based model rather than a higher-cost plan that pays everything over the deductible.

This type of informed consumer is one able to make wise *coverage choices* and use the insurance policy most effectively.

This interview highlights these two different definitions of 'informed consumer'. It occurred in 2012 but remains relevant in our current health insurance environment. One specific note though: the 33% waste factor discussed here in 2012 was an overall, somewhat gross estimate. Some commentators continue to think that waste amount remains approximately valid today. Others, using different definitions of 'unnecessary care', have lower estimates. My own take-away: whatever the exact number, it's a lot of care, a lot of money and a lot of unnecessary patient risk.

The unnamed interviewer – a health insurance broker - articulates the *compliance definition*. He wants to help insurance customers understand policy provisions and tax implications so they can use their policies most effectively.



The interviewer initially wants to leave the consumer alone to decide which medical care is necessary and which providers appropriate; he doesn't, initially, adopt the risk manager perspective. He suggests that the traditional broker advisory responsibility ends when the consumer understands policy provisions.

Meanwhile the responder Gary Fradin – a.k.a. me - uses the *risk manager's - or medical – definition* of informed and engaged consumer. I suggest that consumers who are well informed about medical care options will make better choices for themselves, meaning better outcomes at lower costs.

I also suggest that the process of becoming a 'well informed medical consumer' is one that can be taught and learned, though admittedly, it rarely is today. My comments focus on the types of education one needs to become well informed about medical purchasing and suggest that choosing care based on medical quality metrics generally results in lower total care costs, and probably lower insurance costs too.

The savings available from making informed *medical* choices, I suggest, likely exceed the savings available from making informed *insurance* choices.

I wonder who in our medical care system can teach consumers to become well informed about medical care. Doctors? Hospitals? Carriers? Brokers? Or some other entity.

As you read this interview, ask yourself if either definition of 'well informed' is *sufficient* in our evolving healthcare system and market...or if we need to combine *both*.

The interviewer ultimately suggests that wise and innovative brokers will need to combine both definitions of informed and engaged consumers in order to maintain their advisory role. You can sense his discomfort – and also his excitement – about exactly how to do this.

Do you agree? Do you think he's being too aggressive, defining the broker's future role too expansively? Or do you think he's being too conservative by not defining the broker's role expansively enough?

## **Transcript**

**Interviewer:** This morning we're going to spend some time talking about consumer engagement. What does it mean? What is it? So welcome Gary.

As I take a look back in time and think about the notion of Consumer Engagement and Consumer Driven Health Plans, I keep wondering 'what is it'? Ten years ago we saw the introduction of annual deductibles, high deductible health plans sometimes called CDHC or Consumer Driven Healthcare, I think that was the introduction of consumerism in healthcare. The challenge was the lack of data, the lack of information and so forth. So Gary, in your mind, what is consumer engagement?

**Gary Fradin:** Great question. You started off with a hard one.

I think consumer engagement means helping healthcare consumers – patients – make medical decisions the same way they would make car-buying decisions, or refrigerator-buying decisions. Use the same types of criteria, ask the same types of questions and bring all the skills that we have developed as a society that make us great consumers to medical care. I think we'll have tremendous benefits, both for the patients and for healthcare costs.

So I'd say consumerism in medical care means the same thing as consumerism in automobiles and other products.

**Interviewer:** And in automobiles, for those of us buying a new car, you can go online, you can research, you can find out what a dealer paid for the car, the mark-up and all of that.

I think the challenge that we've had in healthcare historically is the lack of information, the costs and quality. So let's talk a little bit about that. What you say seems to be straight-forward, seems to make sense to me in the role that I play as a benefits advisor to companies.

Why is there such a challenge to make it happen? What are the barriers to entry to consumer engagement when it comes to this type of consumerism?

**GF:** Barriers to entry. Tough question.

There are probably lots of barriers to entry. The one that strikes me as most significant is the fact that we have relatively lousy outcome data about medical care. We simply don't know what works well, what works badly, and exactly *how well* it works.

It's like buying a car if you don't know the miles per gallon. Maybe we can get some pricing information. But if a car dealer tells you a car gets good gas mileage, does this mean 16 miles per gallon or 41?

In medical care, we hear things like 'that's a risk factor for having a heart attack' or 'that's a risk factor for cancer' and this is a good treatment. Well...*how much* of a risk factor, *how good* of a treatment and how will it affect me? Those are questions that we're increasingly starting to focus on and we're developing some data to help us get those answers.

**Int:** What's interesting in the role that I play with clients is that consumer engagement really plays out around product design. The various health insurance carriers have created over the past several years, new products designed to engage the consumer. Deductibles, co-insurance and things of that nature. We have products today designed to get consumers to make decisions, to learn where providers fall within certain tiers for example, limited networks.

So from a product standpoint there's this notion of consumer engagement, working with employers and employees to understand product.

From your perspective and the topic that we really want to get into today, beyond insurance products, beyond 'where do I go, what hospital is in-network', you're talking about consumer engagement at the physician level, at the choice level, is there an overabundance of prescriptions, of unnecessary medical care. Let's talk a little bit about that from your perspective.

**GF:** Let me make a couple points because you're raising critical issues here.

One is that researchers estimate, based on lots and lots of medical studies, that we waste up to about 1/3 of all medical spending on unnecessary medical care. That's care that can't help you – because it's unnecessary – but costs you money and could potentially actually harm you.

*That estimate hasn't changed much despite plan design changes.* We still waste up to about a third.

My comment about plan design changes is that carriers and regulators have tried to organize our healthcare delivery system to become more efficient and cut down on unnecessary care through iteration after iteration after iteration over the past over the past 20 or 30 years, and we have always seen healthcare inflation running about double CPI (the Consumer Price Index inflation rate) or about double the GDP growth rate. We haven't seen that fall significantly despite plan design changes.

I don't think this is a regulatory issue – reducing unnecessary care – and I don't think it's a plan design issue, although high deductibles seem to have some impact. I think the way to reduce unnecessary spending is to educate consumers, educate patients and show why it's in their interest not to get unnecessary care. It doesn't benefit them – it might hurt them.

**Int:** Let's talk about that a little bit. My firm provides advice and guidance to clients. We do it at the employer level and at the employee level. We have benefit communication meetings and so forth. From your perspective, what are the tools and resources available? What tools exist to engage consumers outside of products, outside of plan designs?

**GF:** I think that those tools are being developed. We're starting to get the relevant data about quality so people can make medical decisions based on care quality, not necessarily price.

Nobody wants to get bad quality care. Forget price for a moment. I have yet to hear a parent say 'times are tough, we're cutting back on medical care quality for our kids'. I've never heard that. I always hear parents say 'I don't care what it costs, I want my kid to get the best care he or she can get.'

One tool that we've been working on a lot is called the Number Needed to Treat. Teaching consumers to ask their doctor 'what's the Number Needed to Treat with this medication, this medicine or this screening test?' NNT simply tells you how many

people have to have a medical procedure or take a medication in order for 1 person to benefit.

**Int:** Can you give an example.

**GF:** Sure, I can tell you about cholesterol lowering medications. Lots of people think that high cholesterol leads to heart attacks.

Studies have suggested that people with high cholesterol – using all kinds of different definitions of ‘high’ cholesterol, these are generally industry funded studies with, presumably, highly selected data so the numbers may well be skewed – suggest that about 3 people out of 100 with high cholesterol will have a heart attack in the next 5 or so years.<sup>239</sup> Roughly, approximately 3 out of 100. Some studies show somewhat higher rates. These are folks who don’t have heart disease.

If you reduce your cholesterol with a statin, you bring that number from about 3 having a heart attack out of 100 to about 2 having a heart attack out of 100. Again, industry funded studies.

In other words, you have to give 100 people a statin for about 5 years to prevent 1 heart attack. The Number Needed to Treat is about 100.

Let me make 2 points going in 2 different directions here. Some commentators have suggested that insurance not pay for interventions that have a Number Needed to Treat greater than 20. An NNT of 20 means that only 5% of people benefit. So if you learn the Number Needed to Treat, you can learn how efficient or how effective this medical intervention is, so you can choose.

The sister, or cousin if you will, of Number Needed to Treat is Number Needed to Harm.

**Int:** NNH?

**GF:** Yes, NNH. Obviously that tells you how many people have to take the medication for 1 person to be harmed.

Let me tie all this together and suggest that knowing the Number Needed to Treat and Number Needed to Harm is basic medical literacy. If you don’t know these numbers and you can’t discuss them, then you’re medically illiterate. It’s sort of like an accountant saying ‘you made money, but I don’t know what your earnings per share were, or exactly how much you made’.

**Int:** So is your expectation that individual consumers should know their own NNT and NNH information and should know these facts and be able to go into a physician and discuss them?

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<sup>239</sup> This specific estimate comes from number in an ad that ran in several newspapers in the 2004 – 2007 time frame.

I guess I'll use myself as an example. I happen to have had, 2 days ago, my annual physical. I went in and had my 12 minutes with my doctor and part of the discussion was, ironically, around cholesterol. There have been a lot of articles about cholesterol and statins and the danger of them.

I thought I was being a good consumer, I thought I was engaging by simply asking my doctor and challenging the notion of whether or not I should remain on a statin. And my doctor's comment to me was that the belief still is that the rewards of being on a statin outweigh the risks.

My doctor went on to say 'if it's of any help, I too am on a statin and have been, so I would not be prescribing something to you that I myself am actually not engaged in taking.'

From my standpoint as someone who is in this industry and do what I do, I felt that I had become a better consumer, that I engaged in the process more by asking questions and actually challenging the notion of remaining on this, asking about the risks and rewards. I'm not sure that many people take the step that I took.

But I get the sense from our discussion certainly that there's more to do, more questions to ask and that I should be armed with NNTs and NNHs and so forth. Is that true?

**GF:** I think so.

First, let me make one point very strongly: if you're comfortable with your doctor, do what your doctor says. I in no way want to make people uncomfortable. That is dysfunctional all the way through.

But I hesitate to rely very much on your doctor's story about himself. Your doctor may have different risk tolerances from you. He may have different orientations. Different family background and genetics. He may or may not exercise the same as you. He may have all kinds of different risk factors. And his decision criteria may not be the same as yours.

To some extent, and I don't want to belittle doctors, I'm not trying to do that, but to some extent this is like when you buy a used car and you go to a dealer with lots and lots of high quality used cars. You look at a Ford Taurus. The salesman says 'well, I drive a Ford Taurus' suggesting a personal endorsement for how good this car is. OK, but I don't know how he made his decision. Does he drive young kids around? Does he schlep hockey equipment? Is his wife a baker and he makes deliveries for her? Did he get a particularly good deal on a used Taurus, when, perhaps, he would have preferred a Honda Civic? I don't know how he made his decision.

And I don't know how your doctor made his statin decision. Lots of studies suggest that when patients are well informed about their treatment options, they often choose differently from their doctors. That's why I think you have to know what the outcome numbers are.

Remember, doctors learn how to calculate the Number Needed to Treat and Number Needed to Harm in medical school. But they don't talk to patients about it because they figure that in 12 minutes, they don't have time to teach this to a patient.

But if you go in and ask the question, and say 'I will take a medication that you prescribe, but I want to know the NNT, I want to know the Number Needed to Treat so I know how well it works. In fact, I want to know the Number Needed to Treat for 2 or 3 different options, and then I want to choose the best. And I don't want to take a medication if you don't know how well it's going to work for me.' That's how I would like to see consumers engage with their doctors.

**Int:** And I like it. I truly do. The question is how to get consumers to be able to take that step, to have the comfort and the confidence to be able to challenge their physician, question their physician – and I don't mean that in a negative or derogatory sense – but to give them the comfort and the confidence.

**GF:** Yes. Let me turn this into a question for you. We're in a high deductible world where people try to spend their money 'more wisely'. To do this, somebody has to educate people about *how* to spend their money more wisely.

Where in our healthcare distribution system does that entity lie?

- Is it physicians – you have 12 minutes per year. Is that the right entity?
- Is it the hospital – are they going to teach you which questions to ask about your medical care?
- Is it the insurance carrier? The problem with the carrier is we all know why a carrier would tell you about unnecessary care. They want to save money. Or, at least, that's the cynical public perception.
- Is it the employer, who's probably pretty busy making widgets. They don't have a lot of extra resources to teach about medical care.

Where in our healthcare distribution system – our medical distribution system – is there an entity that can take on the responsibility of doing this teaching so we can reduce the waste factor, besides the broker?

**Int:** I don't think there is, and I think that of all the stakeholders, the various people involved in the process, none others of them have the ability, the bandwidth, the time to do that, and I think you make a very valid point.

It's just an interesting dynamic that for 20 years I've been in the business. We provide advice and guidance and council to employers, more and more to employees, now the notion of wellness which engages a whole different element to all this.

Now all of a sudden, in the role that we play, thinking about education and engagement at a completely different level. To talk about NNTs and NNHs, what questions to ask

your provider. It's a completely different way to proceeding, a completely different approach. And at the same time, critically important.

**GF:** Let me ask you a question.

**Int:** Please.

**GF:** You said that at your physical a couple days ago was the first time you pushed back and challenged your doctor. Why? You've had a physical presumably every year for many years. Why now? What happened this year?

**Int:** A little more knowledge, a little more understanding. Certainly the likes of folks like you. News and information is becoming greater. I don't simply want to take the status quo as many of us have done, when the doctor gives a prescription we take it without asking.

I think the notion of statins and harms and long term effects have really resonated with me and have caused me to push back on that particular item.

I think in general, we can all agree that our healthcare system is flawed, at many levels.

You mentioned waste before, 33% waste. Above and beyond all of that, for me to go in once a year for my personal health, and literally have about 12 minutes to ask questions, review data, update personal information and all that to me is challenging and troubling. I need to become my biggest and my own advocate for my own healthcare.

And I think getting back to your original question 'why this year?' I think because more information is available. We are changing and I think there's a dynamic going on in our industry where we need to challenge where we need to be, in the role that we play providing advice and guidance beyond product, beyond solution, beyond all of that to provide advice and guidance at the employee level.

**GF:** I think it's really interesting when you make the point about more information becoming available. That resonates with me. More and more information is becoming available to consumers. I think we run the risk of having information overload. The question is 'what information is really useful?' What information is bogus or biased or not terribly useful? How does a consumer figure that out?

**Int:** That's a complete struggle for me and I'm sure for just about every consumer. What is the right information? If I read the Harvard Business Journal, that's one piece of information. If I read another article, another book...it's very challenging to know what information is accurate. From which stakeholders does this information come and is there any bias or connection back to a provider or manufacturer?

Maybe I can turn this back to a question for you. As a consumer, how do I navigate my way through the various information channels to arrive at what I think is good, solid accurate information so that I can make good, solid, accurate personal choices?

**GF:** I think that's the question that highlights the broker's role.

A broker clearly can't give medical advice. They're not licensed for this. And a broker can't say 'here is a procedure that works and here is a procedure that doesn't work' according to some study. That's not the broker's role.

It seems to me that the broker's future role and the growth of this part of the business is teaching people the questions to ask. If you ask the right question, you have a pretty good chance of getting a good answer. But if you don't ask the right questions, then you may get all kinds of misinformation or confusing information or biased information.

I think we, the industry, needs to simplify the questioning process by teaching people to ask questions about the Number Needed to Treat and Number Needed to Harm.

I guess my feeling is that if brokers can put on consumer engagement programs and courses for their subscribers that help people ask the right questions of their doctors, then we've gone a big step. We've made progress. And Step 2 I can't tell you about yet. I don't know what it is!

**Int:** Going back to your question - when you have all these stakeholders and providers being part of the equation, who is best served to do it – for someone who spent 20 years in this business, I have an initial challenge, internally, to think that I am the one, and my firm is the one, to provide consumer engagement at a level that gets so specific to medical care and so forth.

At the same time, I can see the validity to this and that many of us can't hide behind the notion that consumer engagement is teaching and educating about product and all of the elements that go along with that. It's a challenge. It's a shift in thinking for me.

**GF:** Do you think, as a business owner, you can avoid getting involved in this kind of consumer education?

**Int:** I don't. I truly don't.

The question is when? How quickly? How broad of a spectrum? How deeply? It's a challenge. I say this openly, it's really a shift. It's a mental shift to think of the role that we play and how we will engage the consumer at a completely different level.

At the same time, it's tremendously exciting.

And then beyond all of that, the complexities to everybody. As we sit in the roles that we play as advisors to employers and employees, you have new products – with all sorts of functionality and limitations, with tiers and networks, and the account based elements of HSAs, HRAs and all that. It has become so complicated. My point being that complexities at the product level and at the distribution level are just immense and enormous, and then you fold in another component and layer.



I guess trying to understand it and articulate it, and taking it back to the role that we play, I have to wonder and ask 'how do we do this?' What is the first, best step for us to do it? I guess I'll put that to you. There was a question, or at least a thought of a question in all that.

**GF:** I think it's very thought provoking. I don't have an answer. As you were talking, I was thinking about that famous Chinese curse or blessing 'May you live in interesting times.' Yes, it is tough to navigate the future.

Look, it's always tough to navigate. It's always tough to run a small business. I guess the first step I would say to brokers who want to get into this brave new world is to become familiar with some of these consumer aids, these medical decision making aids, to become familiar with this part of the business, and on a case-by-case basis work it in. I wish I had a better and more complete answer.

**Int:** But I think that your answer is representative of the stage we're at in the development of all this. I truly do.

One of the things that comes to my mind, and I certainly want to garner your perspective on, is this notion of cost and quality. It's at times such a nebulous thing, where many carriers, going back to the product designs, and consumer engagement at the product level, is about cost and quality.

Your thoughts on cost vs. quality, the importance of it. Is cost a real driver and issue or do you believe quality prevails, that someone is going to request and require quality without much notion of cost?

**GF:** I think transparency is clearly both. You have to know price. You don't want to get the same quality for \$2000 that you can buy for \$600.

But I think that the first step, the driving force, is quality. Everyone wants the best medical care they can get for themselves and their family. One of the reasons that so many people use expensive hospitals is that we equate higher costs with better quality care. Or high credentials with better quality. Or medical school affiliation with better quality. I think people want quality. Then, if you find 2 procedures that have the same NNT and the same outcomes, then sure, go for the least expensive one.

I would warn people against assuming that you can learn something about the care quality from the price, because you can't. A broker once said to me 'this quality information is too complicated. If you assume the quality is all the same, then you can shop based on price'. My response was 'besides that Mrs. Kennedy, how was your trip to Dallas? I heard you had a nice breakfast.'

The ballgame is quality. And price is a secondary consideration. I have yet to meet a person who wants poor medical care, and I have yet to meet someone who wants the cheapest *unnecessary* medical care. I only meet people who want good, necessary care.

**Int:** I think you bring up a great point, and the challenge that we see every day is also the waste in care. People don't want bad care, but I think it still goes back to waste. It goes back to that 33% waste factor, it goes back to how the system is currently structured, and I think that is a tremendous challenge. The complexities of the system. Waste continues to be an issue.

But getting back to your NNT, unnecessary care ideas, are these regional? National? International? Is this about how our healthcare is structured here or is it relevant beyond state and even national boundaries?

**GF:** I think all healthcare consumers in all countries have the same questions. I think all parents want good care for their kids, all sick people want good care for themselves, and if you're in a government funded system, a privately funded system, or a mixed system, you as the consumer still have the responsibility for asking the right questions and getting the best care for yourself. So I don't think the structure of the system matters for consumer responsibility and engagement. I think people are all the same – they all want good medical care. No one wants to have unnecessary care that won't help them but might harm them.

Research is currently being done on all these different kinds of metrics all over the world, with researchers having the same fundamental question: how can we identify good, high quality, necessary care as opposed to poor, unnecessary, low quality, wasteful care. Everyone is interested in the same thing.

My guess would be that there will be an explosion of knowledge in this whole quality arena in the next decade or so. The early adopter brokers who start to educate their clients now, start to learn the programs now, start to learn what this is all about now will put themselves in an awfully strong position as all of this evolves to capitalize on it and grow their businesses in the future.

**Int:** I think that's a great point. I think that's something that brokers like me need to be mindful of. We have been, and continue to be moving away from product based sales, product based advice and guidance to become a true benefits consultant. I think it's a tremendous opportunity personally for those willing to engage.

**GF:** It's exciting.

**Int:** It's tremendously exciting. I think we as brokers have a role to play and I think a unique one. The other stakeholders that we don't believe are equipped to participate in this consumer engagement process, my hope is that that changes at least in some capacity. We really need them to be part of the equation in some way, shape or form, so this becomes a collaboration.

**GF:** I would agree with that.

**Int:** This has been a tremendous dialogue.

**GF:** Yes, it's been interesting. You asked good questions.

**Int:** Thanks. Hopefully this has been useful for people who want to learn more about the consumer engagement process.

We've discussed a tremendous spectrum of what it means and what it is. Historically, engagement has been around product – how can we engage consumers around products, so they best utilize the plan that they have chosen.

But today we've discussed taking this to a different level and really getting to the medical aspect of consumerism and consumer engagement...asking questions, understanding outcomes, a completely different aspect to the world of healthcare as it stands today. Gary, thank you for your time, your comments, your insights...

## Community Health and Economic Prosperity

The US Surgeon General regularly publishes reports including ‘Advisories’. These are public statements that highlight specific health issues and call for public attention and action. The Advisory below discusses Community Health and Economic Prosperity. It was published in 2021.

Consider this chapter in two ways: first, as a discussion of community health and economic prosperity; second as an example of Surgeon General Advisories. We plan that a future text will include many more Advisories covering many more topics.

### A Report of the Surgeon General

National Center for Chronic Disease Prevention and Health Promotion (US) Office on Smoking and Health.

Washington (DC): [US Department of Health and Human Services](#); 2021 Jan.

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This report identifies, for illustrative purposes, the names of businesses and organizations and highlights business practices and performance. Such identification does not (a) suggest that every aspect of the business, organization, practice, or performance is exemplary or (b) constitute endorsement by the U.S. Department of Health and Human Services. Further, any views expressed by such businesses or organizations do not necessarily represent the views or positions of the U.S. Department of Health and Human Services.

The health of Americans is not as good as it could be and is worse than the health of populations of other wealthy nations. America’s lower health status, referred to as the

U.S. health disadvantage, inflicts costs on individuals, families, businesses, and society. The coronavirus pandemic of 2020 exposed additional costs as the virus claimed more lives among those with certain underlying conditions—such as obesity and diabetes that are found in greater proportion among Americans than among residents of many other wealthy countries—and disrupted the economy to such a grave extent that access to healthcare coverage was diminished, as millions of individuals lost employer-sponsored health insurance, and preventive services were interrupted. For businesses, the U.S. health disadvantage increases healthcare costs, lowers productivity and competitiveness, and compromises business success and growth. This report strives to convince business leaders of the importance of community health to the bottom lines of businesses and to the health of the economy. The report (a) highlights the U.S. health disadvantage and the importance of strengthening communities and improving the health of residents, and (b) offers recommendations for how businesses can address the U.S. health disadvantage by engaging with and investing in communities, while creating value, lowering business costs, and improving the health of employees and other stakeholders. Given the power of business in American society, efforts to improve community health and recover and then extend economic prosperity will be insufficient without actions by business leaders.

### **Message From Alex M. Azar II, Secretary, U.S. Department of Health and Human Services**

The past year was one of the most challenging that America has faced in modern times. The COVID-19 pandemic is one of the greatest public health threats ever to confront our country. It has devastated our economy and driven unemployment to record highs.

These challenges remind us that health and the economy are so often linked together. Congress passed historic levels of support to address the economic costs of the pandemic and to fund the public health response, but low-income Americans have not seen the full benefit of the economic recovery and continue to suffer more severe illness from COVID-19, in part because of preexisting health conditions they experience at rates that are higher than those among Americans who are better off.

Health disparities arise not just from unequal access to healthcare but also from unequal access to economic opportunity, meaningful work, stable families, livable housing, reliable transportation, quality education, and thriving communities.

Healthier people means a stronger economy, but a stronger economy also means healthier people. Those of us who care about both health and prosperity—in the public and private sectors—must recognize this connection and engage on both causes. That is the core insight of this historic publication, *Community Health and Economic Prosperity: Engaging Businesses as Stewards and Stakeholders—A Report of the Surgeon General*.

This effort emphasizes the inextricable and mutually reinforcing link between physical, mental, and community health and economic prosperity. It calls on private sector businesses, in particular, to engage with and invest in communities to improve health and foster prosperity.

Of the social determinants of health that our department focuses on, one of the greatest is simply access to economic opportunity. We know that economic opportunity—as well as the stable families, healthy environments, and strong communities it supports (what this report calls the “vital conditions”)—is good for health. But too many Americans are born into and grow up in low-opportunity neighborhoods. This creates costs for businesses and for society, as so many Americans never achieve their potential in the workforce, are unable to reach independence, and see their health and the health of their loved ones suffer as a result.

By working together, with deep engagement from the private sector, we can build a healthier society that is rich with opportunity for everyone. This Surgeon General’s report offers a way forward for the United States to recover from the COVID-19 pandemic and to build a healthier, more prosperous future for all Americans.

## **Executive Summary**

The health of Americans is not as good as it could be and is worse than the health of populations of other wealthy nations. America’s lower health status, referred to as the U.S. health disadvantage, inflicts costs on individuals, families, businesses, and society. The coronavirus pandemic of 2020 exposed additional costs as the virus claimed more lives among those with certain underlying conditions—such as obesity and diabetes that are found in greater proportion among Americans than among residents of many other wealthy countries—and disrupted the economy to such a grave extent that access to healthcare coverage was diminished, as millions of individuals lost employer-sponsored health insurance, and preventive services were interrupted. For businesses, the U.S. health disadvantage increases healthcare costs, lowers productivity and competitiveness, and compromises business success and growth. This report strives to convince business leaders of the importance of community health to the bottom lines of businesses and to the health of the economy. The report (a) highlights the U.S. health disadvantage and the importance of strengthening communities and improving the health of residents, and (b) offers recommendations for how businesses can address the U.S. health disadvantage by engaging with and investing in communities, while creating value, lowering business costs, and improving the health of employees and other stakeholders. Given the power of business in American society, efforts to improve community health and recover and then extend economic prosperity will be insufficient without actions by business leaders.

The U.S. health disadvantage has its roots in communities where the vital conditions that shape health are unmet. The seven vital conditions that shape health, wealth and, well-being are

- Basic needs for health and safety, such as clean air and water, nutritious food, and a safe environment;
- Meaningful work and wealth, including employment, job training, and financial savings and security;
- Humane housing, such as safe structures; affordable costs; diverse neighborhoods; and proximity to work, school, and recreation;
- Reliable transportation, including efficiencies in time and energy use and opportunities for active transportation;
- A thriving natural world, such as a healthy environment and green spaces, and protections from such threats as heat and wind;
- Life-long learning, including literacy and numeracy skills, quality early child education, elementary and high school education, and access to career and adult education; and
- Belonging and civic muscle, conveying a sense of inclusion and the power to influence the policies and practices that shape the world.

These vital conditions shape health and well-being through biologic and social mechanisms. Low-opportunity neighborhoods that lack some or all of the vital conditions are plentiful across the United States. These neighborhoods exist in every state and are often found very close to high-opportunity neighborhoods. People are more likely to be healthy and skilled and participate in the labor force when they grow up and live in thriving neighborhoods, where the vital conditions are met. Thus, improving the vital conditions, equitably for all Americans, can improve health, wealth, and well-being and contribute to individual, business, and community success. Although people and governments are interested in improving the vital conditions, businesses have a particular interest because doing so promotes a rich local network of businesses, suppliers, employees, colleagues, and clients, and creates (a) healthier employees (and families) with more skills and greater productivity and (b) wealthier, more financially stable consumers with more discretionary income and a greater ability to engage in the marketplace. The community assets that comprise the vital conditions that shape health, wealth, and well-being create an excellent environment for private enterprise. Strengthening these assets promotes a thriving local network of businesses, suppliers, employees, colleagues, customers, and clients.

Unmet vital conditions in communities across the United States harm health and diminish economic opportunity. Economic mobility—the ability to climb the economic ladder and the ability of children to grow up and earn more money than their parents—is

lower in the United States than in other wealthy countries. Unmet vital conditions, including lack of economic opportunity, diminish the life chances of Americans who experience them. Improving the vital conditions may be a promising strategy for promoting socioeconomic mobility.

Improving educational opportunities (from early child development to higher education and career development) and economic opportunities (jobs, job skills, career pathways, and family-sustaining incomes) improve health and may also be a promising strategy for promoting socioeconomic mobility. Income inequalities and lack of economic opportunities have been linked to a focus on profits for business at the expense of broader societal value. Restoring economic opportunity and mobility to more Americans results in higher incomes and standards of living, more prepared workers, greater discretionary consumption, and more social cohesion—all of which would have positive implications for communities, businesses, and economic prosperity.

Business has long been a force for good in American society and around the world. Business and society are mutually dependent and best thrive together. Businesses produce wealth, create value, provide jobs, pay taxes, offer goods and services, and bring innovations to the marketplace. However, some business practices, such as a narrow focus on profit at the expense of health, the environment, and other critical common goods, have harmed both society and business. As a result, the American dream is fading for many Americans—particularly African Americans, Hispanic Americans, American Indians and Alaska Natives, and people with low incomes. Businesses can be a force in reversing this situation.

The growth in transparency, the increased recognition of interdependence between business and society, and consumers' growing attention to values each pose threats and opportunities to a business's reputation, brand, and long-term success. Businesses are looking carefully at these threats and opportunities and increasingly choosing to align business values, policies, investments, and actions with the expectations of consumers and the public. Businesses are undertaking this alignment in ways that solve business problems, create shared value for business and society, and earn profits by meeting the needs of multiple stakeholders, each of which is essential to business success. These stakeholders include employees, suppliers, customers, and communities, as well as investors and shareholders.

A stakeholder approach provides a framework for this alignment. According to stakeholder theory, businesses exist to create value for the groups who make the business “a going concern”—that is, the groups that are part of the cooperative scheme that allows a firm to come into being and to be successful over time. Stakeholder firms (firms that have implemented the principles of stakeholder theory) tend to achieve better business outcomes, including greater innovation and higher profits, than firms that have not embraced a stakeholder approach. Stakeholder theory offers a constructive view of



business, and a way of understanding and operating a business by rewarding stakeholders and creating value for people and communities.

Organizations in the field of community development and community finance have been working for decades to bring opportunity to communities. These are mission-driven enterprises that foster vibrant economic, social, and health conditions to increase opportunities for people with low incomes. Businesses can partner with these organizations to address the vital conditions and help meet the need for a healthy, skilled labor force and financially secure workers and consumers. The human capital potential that could be unleashed if *every person* had access to thriving neighborhoods would transform America's communities, businesses, and economy. Such transformation requires investments and partnerships across the public, private, and nonprofit sectors. Community development organizations are prepared to partner on such investments.

Community development and community finance organizations leverage public, private, and philanthropic investments to develop real estate (such as affordable housing), promote small businesses and entrepreneurship, and strengthen human capital (e.g., through early childhood education and workforce training). Community development actors include community development corporations, affordable housing developers, community development financial institutions (CDFIs), nonprofit service providers, and community members.

CDFIs invest in people and places that lack access to safe, affordable financial products and services. CDFIs are working to close wealth gaps across America by investing in the engines that create mobility from poverty, such as good schools, safe and affordable housing, early childcare and education, access to healthy food, and quality healthcare. Businesses and other investors seeking careful, knowledgeable investors in underserved areas can partner with CDFIs to raise capital for community investments.

The current scale of community development is insufficient to address the many complex causes of poverty and to ensure the vital conditions that shape health, wealth, and well-being are met for all Americans. Addressing poverty and meeting the vital conditions are in the direct interest of stakeholders beyond the field of community development, including government officials, businesses and business owners, educators, and healthcare providers and payers. New business models are needed to closely align the financial interests of those who benefit from a healthier, more productive population and those who create the conditions that promote human flourishing.

In addition to community development actors, businesses that would like to invest in or engage with communities can collaborate with a variety of other partners, including social enterprises, public health departments, philanthropic foundations, and anchor institutions.

- Social enterprises are in the business of knowing communities and effecting change to make them stable and help them thrive, all while operating a successful company. Their goal is to achieve a positive societal impact within the requirements of the market.
- Public health departments collaborate with a variety of organizations to meet shared goals and address the vital conditions that shape health. They can be creative, dependable, and effective partners of businesses.
- Foundations and philanthropies are critical partners at the local, regional, or national levels, bringing rich community knowledge, long-standing relationships, and a range of resources, including investment resources, to achieve shared goals.
- Anchor institutions are place-based economic engines with an embedded social mission that is inextricably linked to the long-term well-being of surrounding communities. Businesses can join with—or become—anchor institutions as they work to increase local hiring and procurement and support equitable economic development.

Data are critical to better understand community needs, begin to address the U.S. health disadvantage, and monitor the impact of business investments. As partners in a data-driven approach to community engagement and investment, businesses can help to identify strategies that create a healthier workforce and more prosperous communities and to monitor their progress in achieving specific outcomes. Data-driven approaches offer businesses and employers a pathway to make broader improvements and measure their contributions and returns in the context of the larger ecosystem of communities and society.

The report concludes that businesses and employers serve communities as one of the many stakeholders whose engagement businesses require for their long-term success, and whose interests stakeholder businesses seek to enhance. Because the vital conditions that all people depend on to reach their potential are not shared equitably and are currently threatened in many U.S. communities, businesses have an opportunity to play a more vigorous role in reversing the U.S. health disadvantage and helping to assure fair opportunities for people and businesses and across society.

Greater engagement with stakeholders; greater investment with community development, community finance, and other partners; and greater attention to aligning private value and public good are required to secure a healthier and more prosperous shared future. Markets often reward products that undermine health and well-being and do not place enough value on the vital conditions that actually enhance feelings of freedom, security, justice, connection, and self-determination. A challenge for business and society is to bring values for health, wealth, and well-being into the marketplace.

The videotaped killing of George Floyd while in the custody of the Minneapolis police on May 25, 2020, and the resulting public protests and social unrest that erupted all over the world underscore the need to ensure that there is not a misperceived optimistic tone regarding this task. This report recognizes that inequality, racism, and discrimination in society, in social institutions, in the criminal justice system—and everywhere—is not a new issue in 2020. The root causes of inequality have been present since the founding of our country. This report asks what businesses and their leaders can do to address the causes and consequences of inequality. This will not be easy or quick.

The future of society holds either greater fragmentation or greater recognition and bolstering of interdependence. Making progress toward a more equitable, just, and prosperous future that is built upon a shared understanding of our interdependence, requires an expanding network of entrepreneurs, business leaders, elected officials, community leaders, developers and changemakers, and everyday people—who act as stakeholders, stewards, and creators of shared value—to push forward a transformation from fragmentation and discord to interdependence and inclusion. Given the powerful role of business in the United States, even sweeping efforts to strengthen and sustain community health and economic prosperity will not be enough without associated actions by businesses.

## **Report Recommendations**

The Surgeon General recommends the following actions to strengthen community health and economic prosperity, develop a competitive business advantage, and build resilience, for both community and business. These approaches can help companies account for the interdependence between business and society, and between community health and economic prosperity, when making business decisions. These strategies can help address the U.S. health disadvantage and help to ensure that the vital conditions are met for all Americans.

### **1. Learn More About Your Stakeholders**

Valuing the needs and interests of all stakeholders, and avoiding prioritizing one stakeholder at the expense of another, helps ensure success.

- **Fully understand the cost of poor health and other community challenges and the impact of these challenges on your company.** Understanding the world you live in and developing business models that work to enhance that world help make explicit the connections among good business practices, profitability, and responsibility to community and society.
- **Join the dialogue on community health, wealth, and well-being.** Engage in conversations about how to create a more equitable, just, and prosperous society, including addressing health, wealth and well-being gaps across communities. View problems, policy options, and solutions from the perspective of the well-being of others.

- **Meaningfully engage all stakeholders on ways to optimize value.** Meaningfully engaging each stakeholder brings innovative ideas to the fore, increases productivity and commitment to the enterprise, improves business practices, and creates more sustainable operations.
- **Identify the interdependencies between your company and your stakeholders and between your business and society, and work toward ways of operating that benefit these stakeholders and society.** Paying attention to these interdependencies and delivering value to multiple stakeholders can help a business succeed.

## 2. Foster a Culture of Stewardship

Stewardship refers to a company managing its impact on society. This requires addressing problems at a systems level—through policy, investment, and education, for example.

- **Embrace the positive role of business to strengthen communities.** Businesses are perhaps the most powerful institutions on earth. Wielding that power for good has been a successful strategy for business.
- **Support local, state, and federal policies that meaningfully increase economic opportunities and equitably improve the health of communities, employees, and families.** Businesses have a powerful voice that can shape policy, including spending and implementing policies that have equitable impacts, with the most beneficial impacts on those most in need.
- **Use hiring and procurement tools to strengthen communities and explore opportunities to unleash untapped potential at the local level.** Strengthening local business relationships can help improve hiring and address supply-chain problems while also strengthening communities.
- **Invest business profits in strengthening communities.** Businesses can invest in other businesses, entrepreneurs, community development, and more, while prioritizing investments that meet a community need and support commercial success.

## 3. Develop Strategic Cross-Sector Partnerships

Most efforts to improve community health, wealth, and well-being involve partnerships that bring a range of expertise and additional resources. Effective partners for business include community development organizations, philanthropic foundations, local government agencies, and other businesses.

- **Collaborate with local, regional, and national partners from across sectors to implement effective solutions.** Complex societal challenges—like opioid misuse, disengaged young people, and even lack of access to broadband

Internet in rural areas—demand the resources, know-how, and creativity that multiple organizations working together provide.

- **Partner with community development corporations and community development financial institutions.** Collaborating with these partners brings specialized skills, financial capabilities, and deep community knowledge and trust.

#### **4. Measure Performance Using Meaningful Indicators of Community Health and Well-Being**

Many companies have key performance indicators to evaluate performance in major areas of business operations. Consider whether your company's performance metrics can be improved by including community health indicators.

- **Ensure that philanthropic giving strengthens community health and economic prosperity.** Businesses can help to ensure that their charitable contributions benefit the community by focusing their investment portfolios and holding themselves accountable for outcomes.
- **Redefine productivity in the value chain to include the economic costs from societal problems.** Societal problems create economic costs in a company's value chain. Addressing problems in the value chain—for example, by using resources more efficiently or implementing stronger employee health and safety protections—can optimize productivity and benefit both business and society.
- **Align wages, salaries, and benefits with the needs of a healthy, equitable, and prosperous society.** A job can be one of the most fulfilling aspects of life, bringing meaning and purpose to employees and their families. But jobs can also be dangerous, demoralize workers, and keep workers and families in poverty. Improving wages, salaries, benefits, and working conditions can turn an arduous and repetitive job into an opportunity and a livelihood.
- **Create shared value for companies and communities by combining social purpose with business opportunities.** Shared value happens when profitable business strategies produce real societal benefits. Business can uncover these opportunities by choosing to help solve a particular social problem and doing so in a way that creates or augments a business opportunity.

These recommendations offer opportunities for businesses, working together with others, to more purposefully embrace their roles as stakeholders in a society that works for everyone. With growing awareness of interdependence, greater engagement of all stakeholders, and an alignment of business earnings and societal gains, such partnerships and investments can ripen into healthier people and communities, a more

equitable and just society, and a sustainably prosperous economy upon which everyone depends.

## **Foreword From the Surgeon General**

This report was largely written in fall 2019, when the economy was booming and unemployment was at an all-time low. Long before then, the United States was struggling with what many call the U.S. health disadvantage—that is, on average, the health of Americans is worse than the health of people in other wealthy countries, even as we spend more on healthcare than any other country. Within the United States, there are also clear differences in health status and access to healthcare across geographic settings and racial and ethnic groups. The original intent and message of our report was to communicate that health and the economy are inextricably linked, meaning we cannot have healthy communities without a prosperous economy, and we cannot have a prosperous economy without healthy communities. Strengthening the health of communities, in turn, requires eliminating the causes of the gaps in health status and gaps in access to care within and across our communities. We focused the report on the role of businesses in contributing to both community health and economic prosperity. We set out to make the case for greater business engagement with and investment in communities—especially those most vulnerable—not just because it is a good thing to do for the sake of others, but also because it is in the self-interest of businesses to do so.

Then the world changed. A novel coronavirus emerged in China and spread rapidly around the world. By early spring 2020, many Americans were staying home, and many nonessential businesses had closed their doors. Infection and death rates climbed, and the economic news turned grim. And yet, the message of our report endures and resonates even more profoundly: Health and the economy are inextricably linked. We cannot have one without the other. This interdependence—between health and the economy, and among all of us who make up society—has been neglected for too long. We now are seeing in very tangible and historic ways that our nation cannot maintain one without the other and cannot maintain either without including all of us.

Two trends characterize health in the United States. First, overall health in the wealthiest country on the planet is far from optimal and in many instances is getting worse, especially among the working-age population. Second, spending on medical care continues to go up. We pay more for healthcare than any other country in the world, but our health outcomes are not commensurate. Indeed, on some measures—like obesity, diabetes, infant mortality, and even life expectancy—outcomes are far worse in the United States than they are in many other nations.

The impetus for this report came from the observation that, even as they create suffering and hardship for individuals and families, the overall health of the U.S.

population and the increasing cost of healthcare in the United States are also particularly burdensome to businesses. The success of businesses depends on a healthy and productive workforce, and businesses pay about 20% of the nation's medical care costs by virtue of providing health insurance to employees and their dependents. Yet all this spending on healthcare by individuals, families, employers, and the government is not resulting in better health or longer life.

I am interested in what businesses can be doing to alter this reality—not just for the sake of improving health and controlling healthcare costs, but for the sake of improving their own long-term economic viability. How can businesses improve the health of their communities—including the health of current and future employees—while trying to control one of their largest business expenses, their growing and unsustainable healthcare costs?

Health and the economy are inextricably linked. We cannot have one without the other. This interdependence—between health and the economy, and among all of us who make up society—has been neglected for too long. We now are seeing in very tangible and historic ways that our nation cannot maintain one without the other and cannot maintain either without including all of us.

Exploring the role of business in health and society is not a typical topic for a Surgeon General's report or a customary line of inquiry for public health. However, it brings into view a set of practical solutions that businesses can employ to help address the U.S. health disadvantage. This report explores

- The U.S. health disadvantage and the burden it places on our businesses and our economy (in addition to our people and families);
- How communities can become (or improve as) places that nurture health, wealth, and well-being and offer children and families opportunities to thrive; and
- The meaning and role of businesses in the United States, and how businesses can create value for both themselves and their communities by helping to address the conditions that drive poor health and create the conditions that help people thrive.

This report describes the activities of community changemakers who can partner with businesses to engage stakeholders, create shared value, and steward systems that improve community health and increase economic prosperity. Finally, this report offers a vision for the future where businesses that wish to create value, enhance profit, and thrive over the long term, choose to invest in the health, wealth, and well-being of their stakeholders—employees, customers, suppliers, communities, investors, and shareholders—without whom those very businesses could not exist.

Businesses cannot prosper for long when society struggles. Certainly, the coronavirus pandemic of 2020 has made that clear. Businesses have had to adapt; many will

recover, but some will not succeed. All should be concerned with strengthening our nation's health and resiliency, so that any future economic downturn resulting from a health threat is less severe.

Some businesses have figured out ways to maintain, and even increase, profits while also addressing community needs and contributing to social progress. To succeed over the long term, businesses and those who invest in them have both a responsibility and a competitive interest to make money in ways that contribute to the health, wealth, and well-being of all. This report seeks to point the way for more businesses to do so, and to shine a light on specific strategies that are already showing results.

By integrating these approaches into business operations, many businesses have succeeded at what is the essence of capitalism—generating a profit while delivering the greatest societal gains—thus creating value for company and community. I believe doubling down on this purpose will improve community health *and* increase economic prosperity for all, help to right the U.S. health disadvantage, and help to control the costs of medical care.

I challenge business leaders and policymakers across the country to work toward ensuring business returns are commensurate with societal gains. That is what we should all envision as capitalism at its best.

- **Jerome M. Adams, M.D., M.P.H.**

Vice Admiral, U.S. Public Health Service

Surgeon General of the United States

## **CHAPTER 1The U.S. Health Disadvantage and Why It Matters to Business**

### **OVERVIEW**

A thriving economy requires a healthy workforce. Ongoing public health threats—like addiction, obesity, and rising midlife mortality among working-age Americans—create obstacles for businesses to have a healthy workforce. This chapter shows how a web of social and economic conditions contributes to poor health and connects the health and prosperity of everyday people to a competitive economy.

### **KEY TAKEAWAYS**



The health of Americans is poor relative to residents of other wealthy nations. This is referred to as “the U.S. health disadvantage.”

- The prevalence of poor health conditions, from diabetes to alcohol-related car crashes, is higher in the United States than in other wealthy countries, which has



clear implications for U.S. healthcare costs, labor productivity, and labor availability.

- On average, people born in the United States have lower life expectancies than those born in other wealthy countries.
- U.S. workers are less healthy and have less access to and pay more for healthcare than workers in other wealthy countries.



### The U.S. health disadvantage

- Increases costs for businesses, lowers productivity and competitiveness, and compromises business success and growth; and
- Has its roots in poor conditions in neighborhoods and communities where the vital conditions that shape health are unmet for some residents.

### Introduction

Many Americans believe they enjoy better health than people in other wealthy countries and have access to the best healthcare system in the world. Neither assumption is true. On average, people in the United States have poorer health—shorter lives and more illness—and experience greater *health inequity* (avoidable differences across groups) than their counterparts in other wealthy countries. In the United States, the difference in how long Americans live and how healthy they are, among various groups (such as racial/ethnic or income groups), is greater than that of populations in many other wealthy countries, and that difference is widening with time. Furthermore, many Americans cannot fully access the U.S. healthcare system, including 28.9 million non-elderly Americans who lacked health insurance in 2019. A person's ability to receive quality healthcare in America is not universal, even as the United States spends more on healthcare than any other country. The gap between U.S. spending on healthcare and that of other wealthy nations has widened over time. In 2018, healthcare expenditures were 2.6 times higher in the United States (\$10,586 per person) than the average of healthcare expenditures of member nations of the Organisation for Economic Co-operation and Development (OECD) (\$3,994 per person) ([Figure 1.1](#)). The high level of U.S. spending on healthcare is ineffective, inefficient, and costly. OECD countries that spend less on healthcare than the United States have healthier populations and greater life expectancies.



### Figure 1.1

Health expenditure per capita, 2018 (or nearest year) by country and the OECD average. *Note: OECD* = Organisation for Economic Co-operation and Development

The paradox of poor health in a country that spends far more on healthcare than any other country is partly explained by the lack of access to healthcare, but is more fully explained by the fact that *health is about more than just healthcare*. The conditions that shape health are *outside the clinic*—where people live, grow, learn, work, and age—and not inside the clinic, where clinicians and staff do their work. In fact, healthcare is estimated to account for only 10–20% of health outcomes. The takeaway for employers is clear: *The health of workers and the costs of their healthcare are shaped by the conditions in which employees live and return to after work—in their homes and neighborhoods*. Today's business leaders can play a meaningful role in the lives of their employees, consumers, and community members. By investing in the health and well-being of communities across the country, businesses have the potential to change the trajectory of wellness for generations to come.

Health is about more than just healthcare ... [it's about] where people live, grow, learn, work, and age.

The health of Americans is vital to individuals, families, communities, businesses, the economy, and national security. U.S. employers depend on a healthy workforce to maximize productivity and minimize healthcare costs. In a global marketplace, an unhealthy workforce and high healthcare costs put U.S. businesses at a competitive disadvantage with businesses located in countries with healthier people. Population health also affects the consumer market, whereby the demand for nonessential products and services suffers when families are struggling with illnesses and much of their disposable income is required for medical expenses.

The U.S. health disadvantage threatens the country's global competitiveness and national security, as well as the hopes and prospects of future generations.

The term "U.S. health disadvantage" refers to the lower health status of Americans and the uniqueness of the United States among populations of wealthy nations. Although leaders in public health and medicine have been concerned about the consequences of an unhealthy population, the consequences are increasingly drawing the attention of business leaders, economists, and public officials. Today's business leaders are concerned about the larger economic impacts of a workforce that is dying prematurely, suffering from high rates of disease and disability, and generating high healthcare costs. The U.S. health disadvantage threatens the country's global competitiveness and national security, as well as the hopes and prospects of future generations.

### **Scope of the U.S. Health Disadvantage**

In 2018, news outlets reported that U.S. life expectancy (how long a newborn can expect to live) was decreasing for the first time in generations. The reports grew out of studies from the Centers for Disease Control and Prevention that U.S. life expectancy had decreased for three consecutive years. This news highlighted the reversal of a longstanding trend of increasing life expectancy for much of the past century<sup>1</sup> due to improvements in the conditions that shape health and to advances in medicine and medical care. However, this is not the news story in other wealthy countries, where life expectancy continues to increase.

- **The downturn in the health status of Americans is not new.** For much of the twentieth century, U.S. life expectancy had been among the highest in the world, and for many years exceeded the average life expectancy of people living in other wealthy countries (i.e., member nations of OECD). The U.S. health disadvantage emerged in the 1980s, when the increase in life expectancy in the United States slowed down, increasing more slowly than in other OECD countries ([Figure 1.2](#)). By 1998, the increase fell below the OECD average. By 2005, the 15-year survival rate of 45-year-old White women in the United States was lowest among 12 comparison countries. In 2015, U.S. life expectancy ranked last among industrialized nations ([Table 1.1](#)), and this trend continues. The recent decline in U.S. life expectancy stems from an increase in deaths among working-age adults (25–64 years of age); the risk of death among this population has generally increased since 2010 ([Figure 1.3](#)). U.S. workers are also less healthy and more likely to die earlier than workers in other wealthy countries. Children born in the United States are on course, on average, to die earlier than children born in other wealthy countries.

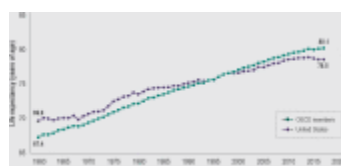


**Figure 1.2**

Life expectancy at birth in the United States and member countries of OECD, 1960–2017. *Note:* OECD = Organisation for Economic Co-operation and Development.

| A. Males    |                            | B. Females  |                            |
|-------------|----------------------------|-------------|----------------------------|
| Country     | Life expectancy (in years) | Country     | Life expectancy (in years) |
| Japan       | 80.8                       | Japan       | 82.5                       |
| Switzerland | 80.8                       | Spain       | 82.0                       |
| Norway      | 80.5                       | France      | 81.5                       |
| Australia   | 80.4                       | Switzerland | 81.0                       |
| Sweden      | 80.4                       | Italy       | 80.5                       |
| Italy       | 80.3                       | Australia   | 80.0                       |

**Table 1.1**

Life expectancy at birth among males and females in 17 high-income countries, 2015.



**Figure 1.3**

Death rate among U.S. working-age adults (25–64 years of age), 1999–2018.

- The U.S. health disadvantage extends beyond lower life expectancy.** The prevalence of poor health conditions, from diabetes to alcohol-related car crashes, is higher in the United States than in other wealthy countries, which has clear implications for U.S. healthcare costs, labor productivity, and labor availability. Six of 10 Americans have at least one chronic condition and 4 of 10 have two or more chronic conditions, including 18% of Americans 18–44 years of age and 50% of Americans 45–64 years of age. Some studies have reported that Americans are feeling less healthy and are experiencing a decline in mental health and increasing rates of depression (primarily among adolescents and young adults). Meanwhile, participation by U.S. men in the labor force has plummeted from a high of 86.4% in 1950 to an estimated 68.2% in 2020. Although increased participation in the labor force over time by U.S. women has made up for some of the decline in men’s participation, women’s labor force participation has declined from a peak of 60.2% in 2000 to an estimated 57.4% in 2020<sup>2</sup> [Figure 1.4](#)).



**Figure 1.4**

U.S. labor force participation, 1950–2010, and projected, 2020–2030.

- The U.S. health disadvantage affects much of the population.** The higher (worse) age-specific death rates in the United States drive the shorter (worse) life expectancy. These worse death rates affect young, middle-aged, and older people; males and females from infancy to 75 years of age; and all races and social classes. For example, the death rate among non-Hispanic White Americans is lower (better) than rates among most minority and low-income Americans. However, the death rate of non-Hispanic White Americans is higher (worse) than the death rate of non-Hispanic Whites in other wealthy nations. The death rate among U.S. White males and females in every age group younger than 55 ranks 16th or 17th (worst) out of 17 peer countries. High-income

Americans, people with health insurance, college graduates, and those with healthier behaviors also fare worse than their counterparts in other wealthy countries: These Americans also have higher infant mortality, more chronic diseases, and lower life expectancy.

- **The U.S. health disadvantages are diverse.** Compared with populations in other wealthy countries, Americans across income levels and racial/ethnic groups suffer and die at higher rates from a broad range of diseases and injuries—including heart, lung, and kidney disease; obesity; diabetes; car crashes; drug overdoses; and shootings—and from adverse birth outcomes (e.g., infant mortality), adolescent pregnancy, and HIV and AIDS.

These outcomes persist despite America's large investments in healthcare, which vastly exceed the levels in which other countries invest in their own healthcare systems. Unless circumstances change, estimates suggest that the U.S. health disadvantage will continue to worsen, as it did during the coronavirus pandemic of 2020. The coronavirus was especially dangerous to people with existing chronic conditions and subjected Americans to the health complications from the economic downturn brought on by the pandemic.

### Explaining the U.S. Health Disadvantage

The question of *why* Americans live shorter lives and have poorer health than people in other wealthy nations can be explained by how the United States differs from other wealthy countries in five areas:

- **Public policies and spending:** Public policies and spending set the context for the other four differences. Health and quality of life are linked to many U.S. public policies and personal ideologies that influence those policies, including (a) America's approach to governance and the decentralized influence of the states and (b) Americans' unique concerns about the size of government, the amount of regulation, levels of taxation, gun rights, and other issues that affect public policies—specifically, the generosity of social welfare programs and investments in education, housing, and public health and other social needs.
- **Social and economic factors:** Income and education are among the most important social and economic factors related to health. Compared with other wealthy nations, the United States has higher levels of income inequality, poverty, child poverty, single-parent households, divorce, and incarceration. The United States has lost its leadership position in education, ranking 24th in science and reading and 38th in math, behind such countries as Vietnam, Estonia, and Slovenia.
- **Social and physical environments:** The built environment in U.S. cities, suburbs, and rural and tribal areas is designed for automobiles rather than pedestrians, cyclists, and public transit; and Americans are exposed to greater

instances of violence and residential segregation than their peers in other wealthy nations.

- **Individual behaviors:** Compared with their peers in other wealthy countries, Americans have lower rates of smoking<sup>3</sup> and problem drinking, but they consume more calories per person, are less likely to fasten seat belts in vehicles, have more motor vehicle crashes involving alcohol, are more likely to own firearms, and are more likely to use and misuse drugs.
- **Healthcare:** Unlike other wealthy nations, the United States does not offer universal access to healthcare. The U.S. healthcare system struggles with deficiencies in quality, fragmentation, and poor coordination of care; and it ranks poorly when compared with healthcare systems in other wealthy nations. Finally, health insurance in the United States is often tied to employment. When employment is disrupted, such as that caused by the coronavirus pandemic, many workers lose their health insurance coverage, often at a time of high need.

Lower spending on social services may also contribute to the U.S. health disadvantage. Major investments in social, economic, and environmental development in the 1930s and 1960s have not been replicated in recent decades. Between 1962 and 2017, the share of federal spending on social and economic investments (e.g., in education) decreased by 59%. During the same period, spending on programs that provide direct cash transfer and healthcare-related costs (e.g., Medicare and Medicaid) increased by 162%. Spending more on healthcare does not necessarily lead to better health. In fact, populations in countries that prioritize spending on social services over spending on healthcare have higher life expectancy. The same is true across the United States, where populations in states that dedicate a large proportion of their budgets to social services have higher life expectancy.

More recently, research attention has focused on another component of the explanation. Racism and bias is increasingly identified as an important contributing cause of poor health outcomes for such population groups as people of color in the United States. Structural, cultural, and interpersonal racism and bias have been shown to affect health, wealth, and well-being through socioeconomic, psychosocial, policy, and opportunity pathways, which are often intertwined. For example, residential housing segregation, unequal treatment within the criminal justice system, and lack of access to credit and capital have the effect, individually and together, of concentrating poverty, limiting access to quality education, and limiting employment and economic opportunities. Each of these contributes to poorer health outcomes. Racism and bias in the diagnosis and treatment of disease also contributes to poorer health outcomes.

The relationships among these areas are complex. Although healthcare is important when people are ill, research shows that unhealthy behaviors (e.g., smoking, lack of physical activity) contribute significantly to disease and death. Some studies attribute 40% of U.S. deaths to unhealthy behaviors, which, in turn, are influenced by the

physical and social environments. People can make choices from only the options that are available to them; they cannot eat well if healthy foods are not available or walk to the store or park if the neighborhood is not safe. The physical environment—or the built environment—includes parks, housing, and transportation resources. The social environment includes the connections, networks, people, and institutions through which people interact (e.g., schools, employers, banks, libraries, and community centers). These interactions can either promote or damage health. Health-promoting conditions include social support, safety, and social connection. Health-damaging conditions include social isolation, discrimination, segregation, and trauma.

Social and economic factors—such as education, income, and poverty—rank among the most influential drivers of health, because socioeconomic resources enable people to pursue healthy behaviors, live in neighborhoods with desirable physical and social environments, and access healthcare. In an economy that depends on a skilled and knowledgeable workforce, like the United States economy, quality education may be the most important driver of health and economic opportunity.

Decisions on public policies and spending greatly influence the other four areas. Policies (or lack of policies) can determine a person's opportunities and whether gaps in opportunities shrink or grow. Decisions that are made by government and the private sector at the national, state, and local levels determine whether

- The environment is healthy and safe, including clean air and water; a built environment that promotes physical activity; access to healthy foods, quality and affordable housing, reliable transportation to jobs, education, and services; and a social environment that is free of violence, trauma, and discrimination;
- Policies are instituted to encourage healthy behaviors, including avoiding smoking and misuse of alcohol and other drugs;
- People have access to affordable, high-quality healthcare; and
- The social and economic status of American families—such as children's education, access to jobs with a livable wage, and income and savings—allows them to afford the conditions that shape good health.

Many Americans, including those in middle- and low-income households, and especially racial/ethnic minorities, have faced prolonged periods of economic stress, wage stagnation, and decreased social mobility (the inability to climb the economic ladder). These mounting stresses, which can be mitigated by better policies, contribute to poor health. The coronavirus pandemic of 2020 exacerbated and accelerated these economic and social stressors.

### **Why Does the U.S. Health Disadvantage Matter to Businesses and the Economy?**

The U.S. health disadvantage has major implications for businesses and employers due to the adverse effects on the health of workers and their dependents. Employers share

the burden as chronic diseases, such as obesity and diabetes, grow in prevalence in the workforce and among dependents. This poor health generates costs for employers, such as greater healthcare expenses; while higher rates of disability (as defined by the Social Security Administration), absences for illness and medical appointments (for themselves and dependent family members), and presenteeism (i.e., working while sick) generate indirect costs that reduce workforce productivity and contribute to declines in labor force participation. For example, the average full-time worker with diabetes misses an estimated 5.5 workdays per year; unplanned absences for this disease cost U.S. employers \$20 billion annually in lost productivity. The indirect costs of diabetes to employers may approach \$90 billion per year ([Table 1.2](#)).

Table 1.2 Indirect costs to U.S. employers due to diabetes

| Problem                                                    | Productivity losses |     |
|------------------------------------------------------------|---------------------|-----|
| Reduced productivity days among persons not in labor force | 14 million days     | 2.3 |
| Work days absent                                           | 14 million days     | 3.3 |
| Mortality                                                  | 277,000 deaths      |     |
| Reduced performance at work                                | 114 million days    |     |
| Reduced labor force participation                          | 182 million days    |     |

**Table 1.2**

Indirect costs to U.S. employers due to diabetes.

Many American companies are discovering that there are economic benefits in the choice to address the vital conditions required for health ([Boxes 1.1a](#) and [1.1b](#)). Poor education, unstable housing, and food insecurity affect the health status of workers and their productivity on the job. In a knowledge-based economy, businesses already understand the value of an educated and skilled workforce, but the larger health benefits of education may not be fully appreciated—nor is the price tag for gaps in education. Workers with less education or income are more likely to have chronic illnesses and complications, higher healthcare costs and more absenteeism and presenteeism. Even the ability to conduct manual labor, such as lifting packages or climbing stairs, varies by level of education ([Figure 1.5](#)). Lower income adds to psychological distress, an important consideration in an era of increasing deaths from drug use, problem alcohol use, and suicide. The opioid epidemic, a phenomenon with far less impact on businesses in other countries,<sup>4</sup> costs U.S. employers billions of dollars per year in healthcare costs and lost productivity.

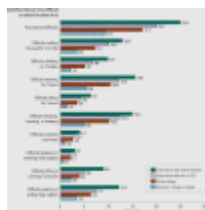


**Figure 1.5**

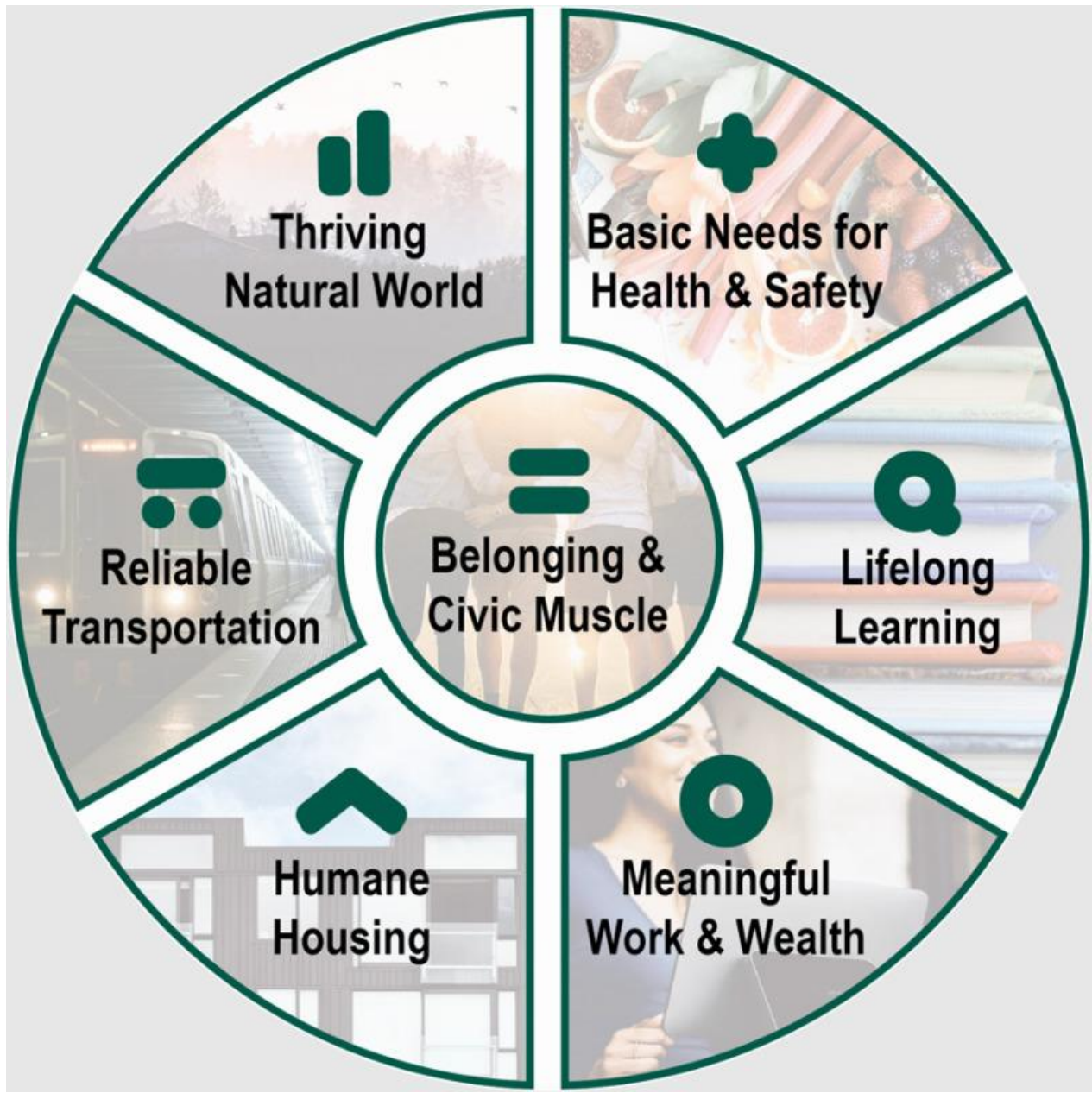


Age-adjusted prevalence (%) of difficulties with physical functioning among U.S. adults, 18 years of age and older, by level of education, 2017. *Note: GED = General Education Diploma.*

### **BOX 1.1A WHAT ARE VITAL CONDITIONS FOR HEALTH, WEALTH, AND WELL-BEING?**

Our ability to survive and thrive—as individuals, institutions, industries, and even as a nation—depends on having a consistent set of *vital conditions*, such as clean air, fair pay, humane housing, early education, routine healthcare, and other pragmatic necessities (see [graphic below](#)). The status and quality of the vital conditions shape each person’s ability to attain his or her best possible health, wealth, and well-being. Everyone—including the public, private, and nonprofit sectors and individuals, families, and communities—has a role to play in assuring the vital conditions, equitably, for all Americans.

When any of the vital conditions is not met, a variety of threats predictably arise. Those threats drive demand for urgent services that people facing adversity might need temporarily to regain their best possible health, wealth, and well-being ([Box 1.1b](#)). If services are unavailable or inadequate, the consequences of unmet vital conditions may be devastating to individuals, families and communities, and the costs, which are considerable, are borne by society. Everyone pays.



### **The Seven Vital Conditions**

The changing states of these vital conditions and urgent services shape the prospects for people and places across the United States, now and for generations to come.

People have no say in the vital conditions that they inherit from their predecessors. At the same time, people today can transform current and future vital conditions, for better or for worse.

*Note:* Belonging and Civic Muscle forms the core of the other elements because it is both a vital condition unto itself and a practical capacity expressed through every other

kind of work. Graphic of the seven vital conditions is adapted with permission from WE in the World, on behalf of the WIN Network, Rippel Foundation, and Well Being Trust.

### **BOX 1.1BA DEEPER LOOK AT THE VITAL CONDITIONS**

The vital conditions that shape each person's ability to attain his or her best possible health, wealth, and well-being are defined in greater detail (in teal). When one or more vital condition is unmet, the demand for urgent services increases (in orange). Unmet vital conditions can be devastating to individuals, families, and communities and generate costs that are borne by all of society. Although the lack of a specific vital condition does not result in a specific urgent need, the adversity that results from one or more vital conditions being unmet can create any number of urgent needs, some of which are illustrated here. Belonging and civic muscle (in blue) is both a vital condition and component of each vital condition. When belonging and civic muscle are strong, assuring the vital conditions becomes easier.

| Investments to Assure Vital Conditions                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                            | Services to Address Urgent Needs                                                                                                  |                                                                                                                                                                                                                         |
|-----------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Properties of places and institutions that all people need all the time to be healthy and well                                    |                                                                                                                                                                                                                                                                                                                                                                                                                            | Services that anyone under adversity may need temporarily to regain or restore health and well-being                              |                                                                                                                                                                                                                         |
|  <p><b>Basic Needs for Health and Safety</b></p> | <p><b>Basic requirements for health and safety</b></p> <ul style="list-style-type: none"> <li>• Adequate air and water</li> <li>• Nutritious food</li> <li>• Routine physical activity</li> <li>• Sufficient sleep</li> <li>• Safe, satisfying sexuality and reproduction</li> <li>• Freedom from crime, injury, violence, traumatic stress, and addiction</li> <li>• Routine health care (physical and mental)</li> </ul> |  <p><b>Acute Care for Illness or Injury</b></p> | <p><b>Acute and post-acute care for physical and mental illness</b></p> <ul style="list-style-type: none"> <li>• Emergency medical services</li> <li>• Acute hospitalization</li> <li>• Trauma-informed care</li> </ul> |
|  <p><b>Lifelong Learning</b></p>                | <p><b>Continuous learning, education, and literacy</b></p> <ul style="list-style-type: none"> <li>• Cognitive, social, and emotional abilities</li> <li>• Early childhood experiences</li> <li>• Elementary and high school</li> <li>• Higher education</li> <li>• Career and adult education</li> </ul>                                                                                                                   |  <p><b>Addiction Treatment</b></p>             | <p><b>Services to stop addictive behavior and begin recovery</b></p> <ul style="list-style-type: none"> <li>• Substance abuse treatment and support</li> </ul>                                                          |
|  <p><b>Meaningful Work and Wealth</b></p>      | <p><b>Rewarding work, careers, and standards of living</b></p> <ul style="list-style-type: none"> <li>• Job training/retraining</li> <li>• Well-paying, fulfilling jobs</li> <li>• Family and community wealth</li> <li>• Savings and limited debt</li> </ul>                                                                                                                                                              |  <p><b>Crime Response</b></p>                 | <p><b>Efforts to fairly adjudicate alleged violations of the law</b></p> <ul style="list-style-type: none"> <li>• Police, fire, and first responders</li> <li>• Courts</li> <li>• Incarceration</li> </ul>              |
|  <p><b>Humane Housing</b></p>                  | <p><b>Humane, consistent housing</b></p> <ul style="list-style-type: none"> <li>• Adequate space per person</li> <li>• Safe structure</li> <li>• Affordable costs</li> <li>• Diverse neighborhood (without gentrification, segregation, and concentrated poverty)</li> <li>• Close to work, school, food, and recreation/nature</li> </ul>                                                                                 |  <p><b>Homeless Services</b></p>              | <p><b>Short-term housing for people experiencing homelessness</b></p> <ul style="list-style-type: none"> <li>• Emergency shelters</li> </ul>                                                                            |

Like economic and social status, geography also plays a role in health. Today's business leaders must consider the disparate living and health conditions to which their workers return at the end of their workday. The vital conditions in employees' neighborhoods—from the quality of housing and drinking water to the amount of green space to instances of racial segregation—affect health at the worksite and the cost of healthcare. Different conditions in different neighborhoods mean that two workers at the same company will have different educational and economic opportunities, community supports, health statuses, disease risks, and life expectancies—for themselves and their children.

The bottom line is clear: Businesses have an economic interest in improving the vital conditions in workers' neighborhoods and in working with community partners to maintain or create an environment that is healthy and safe. The same conditions that shape health are also the features that enable employers to attract and retain talented workers. Such conditions include good schools, resources for sports and physical activities (e.g., parks, playgrounds), modern, efficient infrastructure (quality affordable housing, broadband Internet access, transportation), and healthy social environments (e.g., lack of segregation and violence). Businesses have powerful incentives to act to improve the vital conditions that shape health ([Box 1.2](#)).

The bottom line is clear: Businesses have an economic interest in improving the vital conditions in workers' neighborhoods and in working with community partners to maintain or create an environment that is healthy and safe.

### **BOX 1.2 INCENTIVES FOR BUSINESSES TO IMPROVE THE VITAL CONDITIONS THAT SHAPE HEALTH**

The National Business Coalition on Health described the incentives for businesses to invest in building healthy communities:

- “Improve the health status, and therefore the productivity, of an employer's current and future workforce;
- Control direct (healthcare) and indirect (absenteeism, disability, presenteeism) costs to the employer;
- Create both the image and the reality of a healthy community that may help recruitment and retention of workforce talent in tight labor markets;
- Increase the buying power and consumption level for business products, in particular nonmedical goods and services, by improving the health and wealth of a community;
- Strengthen an employer's brand and recognition in the community;
- Generate, for individual business leaders, positive feelings of civic pride and responsibility and of being a constructive member of the community;



- Channel corporate philanthropy in a direction that will improve community relations, goodwill, or branding with the potential for a positive return for the business enterprise;
- Help create public and private partnerships and a multistakeholder community leadership team that can become the foundation for collaboration, cooperation, and community-based problem-solving for many other issues affecting the business community, such as economic development and education.”

The decline in U.S. health transcends the business environment and affects the nation’s economy. For example, state and local economies suffer when poor health and living conditions make it difficult to attract new industries or force companies to relocate, taking jobs with them. The same adverse conditions that affect the health of a community also stifle upward mobility and the well-being of communities, creating conditions for social discord, crime, and violence. Lack of upward mobility and associated income inequality are costly to the economy. The U.S. health disadvantage puts the nation at a competitive disadvantage in the global marketplace, as U.S. companies compete with overseas companies that enjoy a healthier, more productive workforce and lower healthcare costs per capita. The rise in U.S. healthcare costs places unsustainable economic pressures on public payers (e.g., Medicare, Medicaid), employers, and patients who struggle with out-of-pocket expenses, while reductions in the health of the working-age population and reductions in participation in the labor force place economic pressures on businesses themselves. The U.S. health disadvantage has even raised national security concerns, as military leaders encounter a high prevalence of obesity and other health problems in active-duty personnel and future recruits.

## **Conclusion**

The U.S. health disadvantage began to emerge in the 1980s. Although this chapter focuses on the decline in life expectancy as a signal of that disadvantage, the contributors to that decline are powerfully important. Increases in disease (e.g., obesity and diabetes) and substance misuse, which exceed that of peer nations, and substantial disparities in the vital conditions of health (meaningful work, safe environment, quality education, and humane housing) constitute pathways to reduced participation in the labor force, poorer health, and early death. To improve the nation’s health, wealth, and well-being, Americans must transform the disadvantaged communities in which too many live, grow, learn, work, and raise families. As demonstrated in the next chapter, health happens in communities and is largely driven by conditions outside the healthcare system that compromise health, limit opportunity, and shorten life. Children pay a particularly high price for these poor conditions, and today’s children are tomorrow’s workers and national leaders. They are the next generation of teachers, doctors, business leaders, and military personnel. If the U.S. health disadvantage of today is not fixed, by strengthening communities and expanding

opportunities, then the future population—and workforce—will almost certainly be burdened with greater sickness, lower productivity, higher costs, and shorter lives. The U.S. health disadvantage is a threat to the business community and the national economy.

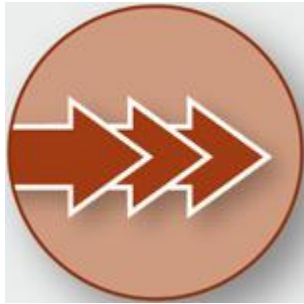
## APPENDIX A TOOLS AND RESOURCES

[Appendix A](#) identifies tools and resources addressing topics explored in [Chapter 1](#). The tools and resources were created by such businesses and organizations as John Hancock Insurance Company, Organisation of Economic Cooperation and Development, The Kresge Foundation, and others.

[Go to:](#)

### BELDEN INC.: Pathways to Employment

|                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|-------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|   | <p><b>Community Challenge  </b> The staggering levels of drug addiction in local communities across the United States has caused more than a health crisis. The economic impact of treating drug addiction is a burden on families and businesses. For those addicted, the ability to keep a job is difficult and gets harder over time, and those who manage to hold a job are less productive. For Belden, Inc. (Belden) something had to change.</p>                                                                                                                                                                                                                                                                                         |
|  | <p><b>Scenario  </b> Belden has been a member of the Richmond, Indiana, community since 1928. As the second largest employer in Wayne County and a global leader in specialty networking solutions, Belden is a respected American company and proud of its safety record and strong workforce. Belden requires all job applicants have a drug-free background and pass drug screening. If hired, employees must continue to be drug-free.</p> <p>Belden employed more than 500 people at its Richmond plant. Nearly one-third of these employees were set to retire within 5 years. At the same time, the labor pool for manufacturing workers was declining, just as customer demand was increasing. Where would the new hires come from?</p> |



**Action Taken |** Despite an influx of applications, many potential employees were turned away. “We found the pre-employment drug screen failure rate was steadily increasing—between 10 to 15%,” said Paul Mottershead, vice president Corporate Communications. According to Mottershead, when the data were presented to Belden’s Board of Directors, one member asked Chief Executive Officer John Stroup: “If you’re not going to do something about this, who is?”

With support from top leadership, Belden convened a team to work with community partners to address the drug use problem among its applicant pool. “We are not a healthcare expert and needed to rely on the expertise of [others] to develop, implement, and evolve [a] program,” Mottershead said. Partners included Centerstone Indiana, Meridian Health Services, Ivy Tech Community College, Manpower Richmond, and addiction specialist Dr. Mitch Rosenthal. Together, they built the Pathways to Employment Program, which launched as a pilot in February 2018 and provides 18 months of support to applicants who are hired by Belden.

Through the program, Belden offers rehabilitation *and* a job to applicants who fail the pre-employment drug test but agree to enter the program. In the program, a healthcare provider assesses employees and places them into one of two groups—low risk or high risk for substance use disorder. From there, employees receive personalized, evidence-based rehabilitation treatment, during which they work in such positions as cleaning, inventory, and other roles that do not pose a risk to their safety or the safety of others. Drug tests are conducted almost weekly for the first 8–16 weeks. Employees must remain drug-free to work in higher risk positions, like a machine operator. Employees who fail a drug test are released and provided with community resources to help them with substance misuse. However, if employees are forthright about a relapse before failing a test, they get a second chance.

By 2019, 34 employees had entered the program—12 were in machine operating roles, 12 left the program, and 10 were in lower risk roles. The program costs an average of \$6,000 per low-risk employee and as much as \$26,000 per high-risk employee. The program is also available to current employees who are seeking help with addiction problems. Based on the



|                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|-----------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                   | positive response, Belden developed a blueprint for other organizations to develop similar programs and began offering the program in 2020 at two other U.S. facilities.                                                                                                                                                                                                                                                                                              |
|  | <b>Key Takeaway  </b> Belden needed to hire people to produce products to meet business demands and the expectations of shareholders. All groups—business, government, and the healthcare system—worked together to address the need. Having a job is a critical part of maintaining a drug-free lifestyle; filling a job is critical to business success. Belden helped with both and is sharing its learnings with other companies, organizations, and communities. |

## Footnotes

1

A decrease in life expectancy of this duration has not occurred since the worldwide influenza pandemic of 1917–1918.

2

An estimated 62.5% of men and women combined participated in the labor force in 2020 ([Figure 1.4](#)). Actual monthly labor force participation reached a low of 60.2% in April 2020, due to the impact of the coronavirus pandemic, before rebounding slightly to 61.5% in June 2020.

3

Higher rates of smoking decades ago may also be contributing to currently high U.S. death rates from tobacco-related illnesses.

4

An increase in opioid prescribing has been observed in other countries (e.g., Australia, Canada, Denmark, Finland, Germany, Sweden, United Kingdom), but no country has experienced an increase in drug overdose deaths comparable to the United States.

## CHAPTER 2How Neighborhoods Shape Health and Opportunity

### OVERVIEW

The health of Americans is shaped in neighborhoods and communities outside the healthcare system. This chapter highlights the relationship between health and the communities where people live, grow, learn, work, and age. It presents examples of how public policies and vital conditions—like affordable housing, quality education, and

meaningful work—create thriving communities for children and families. Mobilizing resources and investments to create high-opportunity neighborhoods is a winning strategy to fix the U.S. health disadvantage.

## **KEY TAKEAWAYS**



Low-opportunity neighborhoods are plentiful across the United States and are often found in proximity to high-opportunity neighborhoods.



Low-opportunity neighborhoods lack the vital conditions necessary for health, wealth, and well-being, and they diminish the life chances of the people who live in them, particularly children.

- Compared with children in higher opportunity neighborhoods, children in lower opportunity neighborhoods attend preschool and graduate from high school at lower rates, have fewer green spaces, experience more days of extreme heat, and are more likely to lack health insurance and to live in homes with incomes below the federal poverty level.
- Across the United States, differences in life expectancy between high- and low-opportunity neighborhoods can be as high as 25 years.



Lack of educational opportunities (from early child development to higher education) and lack of economic opportunities (jobs, job skills, career pathways, and family-sustaining incomes) contribute to the U.S. health disadvantage.



The intertwined health and economic disadvantages are substantial for business and society.

## **A Tale of Two Communities**

Imagine a community where children have access to a high-quality preschool. When these young children get older, they attend excellent schools in their neighborhood.<sup>1</sup> Student achievement in reading and math is high in these schools, and superb high school graduation and college enrollment rates signal to youth that education is valued and attainable. The community is home to community centers, parks, and green spaces and offers easy access to healthy food retailers and other resources, such as banks and childcare. The community also enjoys an environment with low levels of pollution, high rates of employment and civic engagement, and low rates of poverty and crime. Parents of these children enjoy good jobs and short

commute times to work. Communities with these characteristics are known as high-opportunity neighborhoods.

Compared with families living in lower opportunity communities, families living in high-opportunity neighborhoods have more economic resources and reap significant, but often underappreciated, benefits, such as being able to spend more time raising children and less time commuting to work or working multiple jobs. An advantaged community is not defined only by the above features, but many would agree that such a community offers enhanced opportunities for children to grow and develop into healthy and productive adults. Many high-opportunity neighborhoods exist in the United States, and many children grow up and thrive in these types of communities.

However, many communities across the country look different. If preschools exist, they are poor quality. Student achievement in neighborhood schools is low, and norms and expectations about high school graduation and college attendance are weak. Green spaces and healthy food retailers may not exist or may be rare, and levels of environmental pollution are high. Employment options are few, transportation is unreliable, and the rates of crime and poverty are high. Communities with these characteristics are known as low-opportunity neighborhoods. Children who grow up in low-opportunity neighborhoods often face more challenges than their peers who grow up in high-opportunity neighborhoods. As a result, these children can grow into less healthy, less educated adults.

These descriptions match two actual neighborhoods that are adjacent to each other in a U.S. metropolitan area (see [Box 2.1](#)). The differences in the opportunities available to children in these two communities play out in many neighborhoods across the nation, and these differences have serious consequences for the abilities of children to achieve their full potential. Health and life expectancy differences between low-and high-opportunity neighborhoods—even those in close proximity to each other—are stark.

Healthy community environments are essential to support the development of human capital. Such environments contribute to a productive workforce and strong local markets.

Neighborhood, as an environment, provides a critical context in which children can develop in healthy ways, and it influences the life chances of children as they grow into adults. The family environment imparts another strong influence on the development of children, but families function in a context established by a community's ability (or not) to provide resources and conditions that shape health. Healthy community environments are essential to support the development of human capital. Such environments contribute to a productive workforce and strong local markets.

**BOX 2.1A TALE OF TWO REAL COMMUNITIES LESS THAN 3 MILES APART  
(REPRESENTATIVE OF MYRIAD SIMILAR COMMUNITIES ACROSS THE UNITED STATES)**

| Neighborhood A (high opportunity)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Neighborhood B (low opportunity)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
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| <p>With two high-quality early childhood education centers nearby, children in Neighborhood A get a jumpstart on the education ladder. Nearly two-thirds of 3- to 4-year-olds attend preschool. Math proficiency is almost universal (95%) among fourth graders. Four of every five adults 25 years of age and older have a college degree. A community rich in highly educated adults may increase expectations among children for their own education and work prospects and may positively influence their attitudes and actions about college attendance.</p> <p>With so many highly educated adults, the neighborhood's unemployment rate in 2019 (3.8%) is less than half that of the entire metropolitan area (9.8%). and the poverty rate (9.6%) falls considerably below the average (17.1%) for the metropolitan area.</p> <p>The neighborhood also hosts a variety of healthy resources. For example, several parks and green spaces offer areas in which children can engage in physical activities, which may reduce the chances of obesity and associated health problems. Most of the neighborhood's food establishments are considered healthy food retailers, which increases access to proper nutrition. Healthcare facilities are plentiful and close by. In fact, 178 healthcare facilities are located within 2 miles of Neighborhood A, making it closer in proximity to healthcare resources than 94% of all neighborhoods in the metropolitan area. This proximity to healthcare providers likely reduces travel times for people seeking healthcare, which</p> | <p>Children in Neighborhood B face a host of obstacles to opportunities and well-being. Only 9% of 3- to 4-year-olds attend preschool, and not one high-quality early childhood education center is nearby. By fourth grade, almost two-thirds of students are not proficient in math, limiting their future math achievement and their subsequent college attendance and labor wages. Among adults 25 years of age and older, only one in five have earned a college degree.</p> <p>Low levels of education are accompanied by high levels of unemployment and poverty. One-third of adults are unemployed, which may affect youth's expectations of their own employment prospects and result in weaker networks of employed adults who can help young people find jobs. Nearly 60% of residents live below the poverty line, and 92% of students are eligible for free or reduced-price lunch at school. Such concentrated poverty in neighborhoods and schools is associated with poor physical and mental health, as well as low student graduation rates and future earnings.</p> <p>The physical conditions and resources in Neighborhood B pose further challenges. A staggering 23% of housing units are vacant. High rates of housing vacancy are positively associated with increased crime, risk of fire, and drug use. Housing vacancy also increases property maintenance and decreases home values in nearby areas, thereby reducing household wealth overall.</p> <p>Food establishments in Neighborhood B are not considered healthy food retailers, which is a source of concern because lack</p> |

| Neighborhood A (high opportunity)                                                                               | Neighborhood B (low opportunity)                                                                                                                                                                                       |
|-----------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| in turn yields greater utilization of routine healthcare services and lower utilization of emergency room care. | of access to healthy food is associated with health problems and obesity in children. Further, the availability of nearby healthcare facilities ranks in the lowest 25% of all neighborhoods in the metropolitan area. |

### How Communities Affect Health

The striking contrast between the two communities described in [Box 2.1](#) is a powerful example of the large differences in conditions that promote health across the country, differences that sometimes exist between neighborhoods that are next to each other. Neighborhood features influence health and well-being through biologic and social mechanisms. For example, high levels of pollution may lead to a higher prevalence of childhood asthma, and high levels of crime or disrepair may increase the risk of physical injury and personal stress. On the other hand, the presence of healthy food retailers gives opportunities for residents to consume healthier foods, and green spaces provide opportunities for residents to engage in physical activities and to achieve a greater sense of well-being.

Social and environmental conditions in the neighborhoods in which children live and grow shape their health and affect their life chances. Although families certainly go beyond their neighborhoods to find resources and amenities, their immediate living environment is a powerful influence on children's prospects in adulthood. Children who grow up in high-opportunity neighborhoods, like Neighborhood A in [Box 2.1](#), have better chances of living long, healthy, and productive lives as a result of specific characteristics, such as better schools, positive social networks, safer environments, and less exposure to adverse behaviors. Supportive institutions, such as high-quality early education centers, positively influence child development and parents' abilities to work and their stress levels and parenting behaviors. Children's access to good schools can influence their decisions about the future, such as choosing to pursue higher education and working hard to attain that goal. Social networks, social cohesion, and social control affect health indirectly by influencing social factors that affect health. For instance, peer influences and role models affect youth development and outcomes later in life related to education, employment, and income. Absence of these features diminishes life chances for children who grow up in neighborhoods like Neighborhood B in [Box 2.1](#). Children, families, and neighborhoods win or lose depending on the resources and conditions around them in the community. Society at large and government and businesses also win or lose as access to nearby resources fosters or diminishes opportunities for human potential.

The community level is not immune from outside influences. For instance, economic forces (e.g., regional housing and labor markets) and federal, state, and local policies (e.g., land use zoning, public school funding) that operate above the community level ultimately shape the community's infrastructure and resources. The history of redlining illustrates the potent impact that decisions by public and private actors can have on community investment or disinvestment, and thus on community resources and characteristics ([Box 2.2](#)).

## **BOX 2.2 WHAT WAS REDLINING?**

Redlining was a broad and far-reaching legal discriminatory practice that led to negative and long-lasting decisions to underinvest in minority communities. Communities that were redlined experienced decades of disinvestment and neglect. In 1933, in order to avert housing foreclosures during the Great Depression, Congress created the Home Owners' Loan Corporation (HOLC) to refinance mortgages that were in default. In 1935, to develop a national mortgage lending market, which had previously been based entirely on local knowledge and relationships, the Federal Home Loan Bank Board asked HOLC to create "residential security maps" in 239 cities.

The maps indicated various levels of security for real-estate investments. These maps had a large influence on the level of investment in communities. Different colors on the maps reflected the estimated level of risk of making loans in those neighborhoods. Areas colored yellow were characterized by "obsolescence and infiltration of lower grade population," and areas colored red were considered "hazardous" and described by HOLC as "characterized by detrimental influences to a pronounced degree, undesirable population, or an infiltration of it." HOLC recommended lenders either not make loans in these areas or grant loans on a very conservative basis. Notably, the risk level of an area closely mirrored the racial composition of its residents, as neighborhoods with predominantly minority, immigrant, or mixed populations universally received higher risk scores. For example, the inhabitants of a "hazardous" D-rated neighborhood in Brooklyn, New York, (colored red in the map) were listed as clerks and laborers with 30% foreign-born of Jewish-Irish predominance. Clarifying remarks about the map stated, "Colored infiltration is a definitely adverse influence on neighborhood desirability although Negroes will buy properties at fair prices and usually rent rooms." As a result, these scores and descriptions strongly reinforced disinvestment in such communities.

Current geographic patterns of concentrated disadvantage and prevalence of health problems closely follow the redlining maps of the past. Communities that were redlined in the 1930s share many of the same traits as neighborhoods like Neighborhood B around the country today (and would benefit from investment attention).

Today, on average, formerly redlined areas are 28% Black, and 8% of African-Americans live in formerly redlined neighborhoods. Thus, addressing the needs of only the formerly redlined neighborhoods would likely miss many of the people who most

directly experienced the decades of disinvestment. Tackling place-based inequities is only one facet of tackling race-based inequities. Finally, many rural and smaller communities (including some that have grown tremendously since the 1930s) were not included in the HOLC maps. Although redlining—based on those HOLC maps—is an important part of the history of neighborhood disinvestment, it is not the whole story.

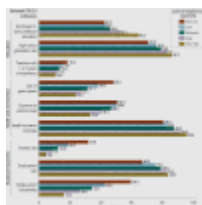
Redlining is just one example of the serious consequences that policy decisions have on the well-being of communities. Concentrating investments (by businesses and employers, community development corporations, large investment firms, and others) in low-opportunity neighborhoods can help to reverse the long-standing history of discrimination and disinvestment and the resulting economic and health disparities found in low-opportunity neighborhoods. Such investment, this report argues, will improve neighborhood conditions; increase opportunities; and strengthen health, wealth, and well-being for residents and communities.

### **How Health Differs Across Communities**

Neighborhood A and Neighborhood B, as detailed in [Box 2.1](#), represent two extremes of the considerable variability in resources and conditions available for healthy living in the United States. These extremes—as well as conditions in the middle—exist in virtually every U.S. city, metropolitan area, suburban area, and rural area. An examination of this variation provides insight into the experiences of people living in different communities and into the costs to society of community environments that do not support healthy living.

One approach to quantifying the enormous variation is the Child Opportunity Index (COI) 2.0, a composite measure of child neighborhood opportunity for virtually all U.S. census tracts including urban, suburban, and rural areas. COI 2.0 combines information on 29 indicators in three domains: Education, Health and Environment, and Social and Economic. The COI was created after ranking all 72,000 neighborhoods in the United States. The neighborhoods were divided into five levels of child neighborhood opportunity: very low, low, moderate, high, and very high.

[Figure 2.1](#) shows selected indicators for children by level of child neighborhood opportunity. The intertwined health and economic disadvantages facing children who grow up in neighborhoods like Neighborhood B across the country are indeed severe.

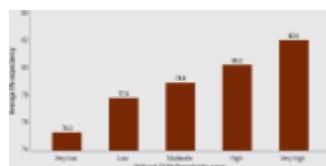


**[Figure 2.1](#)**



Features of neighborhood opportunity for the average child based on selected COI 2.0 indicators for the 100-largest U.S. metropolitan areas. *Note:* COI = Child Opportunity Index.

Health and life prospects also differ substantially between residents of very-low and very-high-opportunity neighborhoods. Across the 100-largest U.S. metropolitan areas, life expectancy differs by 7 years between residents in very-low- and very-high-opportunity neighborhoods (75 vs. 82 years life expectancy) ([Figure 2.2](#)). Throughout the United States, differences in life expectancy across census tracts, which in some cases are just a few miles apart, can be as high as 25 years ([Figure 2.3](#)).



**[Figure 2.2](#)**

Child neighborhood opportunity level and average life expectancy at birth in the 100-largest U.S. metropolitan areas. *Notes:* Life expectancy is the average number of years a person can expect to live at birth for individuals born in a given neighborhood ([more...](#))



**[Figure 2.3](#)**

Life expectancy at birth for U.S. Census Tracts, 2010–2015.

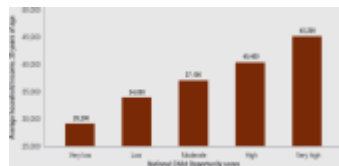
### **Implications of Health Inequities for Communities**

Where people live profoundly shapes their health, opportunities, and longevity. Nearly 10 million children live in very-low-opportunity neighborhoods within the 100-largest U.S. metropolitan areas. The majority of African American (66%) and Hispanic (59%) children live in very-low- or low-opportunity neighborhoods. Conversely, the majority of non-Hispanic White (66%) and Asian (62%) children live in high- or very-high-opportunity neighborhoods, reinforcing racial/ethnic differences in health outcomes and economic opportunities (calculations are based on data from the COI 2.0).

The costs of highly unequal access to neighborhood opportunity include reduced human capital, reduced economic productivity, lower educational achievement, less participation in the labor force, and lower potential for higher incomes as adults. Disparities in educational achievement are linked directly to levels of child neighborhood opportunity. Children with similar family structures, family incomes, and levels of parental education are more likely to drop out of high school and to have a teenage



pregnancy if they grow up in high- versus low-poverty neighborhoods. Access to neighborhood opportunity also affects a person's ability to climb the socioeconomic ladder. Socioeconomic mobility refers to the place in the household income distribution that people attain as adults compared with the place in the income distribution that their parents attained. A child growing up in a home at the 25th percentile of parent income in a low-opportunity neighborhood will likely have an annual income at 35 years of age that is \$17,000 less than the income of a child who grew up with similar family characteristics but in a high-opportunity neighborhood (\$29,000 vs. \$46,000 annual income, in 2019 dollars, representing a 37% reduction in annual earnings, with associated implications for consumption of goods and services) ([Figure 2.4](#)).



**[Figure 2.4](#)**

Child neighborhood opportunity level and socioeconomic mobility by adult household income (U.S. dollars) at 35 years of age among children growing up in households at the 25th percentile of the parent income distribution in the 100-largest U.S. metropolitan ([more...](#))

The costs of highly unequal access to neighborhood opportunity include reduced human capital, reduced economic productivity, lower educational achievement, less participation in the labor force, and lower potential for higher incomes as adults.

Socioeconomic mobility in the United States has declined steadily. The proportion of children earning more than their parents fell from 90% for children born around 1940 to 50% for children born around 1980. Restoring economic opportunity for more Americans would result in an increase in those with higher incomes and in higher standards of living, more consumption, and more social cohesion—all of which have enormous implications for economic prosperity. Improving neighborhood opportunity may be a promising strategy for promoting socioeconomic mobility.

## Summary

The health and social costs of living in a low-opportunity neighborhood radiate throughout the economy, reducing labor force productivity and availability and limiting consumption. Smart investments by leaders and decisionmakers at the federal, state, and local levels and by businesses and investors hold significant potential for enabling more children to thrive and become healthy and productive adults by both improving conditions in low-opportunity neighborhoods and creating real options for individuals and families who dream of moving to higher opportunity neighborhoods. ([Chapter 4](#) describes examples of such community investment and introduces the community actors who facilitate such investments.) The payoff of creating or improving access to

higher neighborhood opportunity accrues to children and can improve their life prospects as adults, and accrues to society as a whole in the form of improved health status, lower healthcare costs, higher productivity, and greater economic mobility.

Accomplishing these gains will require addressing vast inequities across neighborhoods and investing in the broader conditions of the everyday lives of Americans. [Chapter 3](#) argues why it is part of the purpose of business to do so, while [Chapter 4](#) sets out options for investing in communities for business leaders to consider.

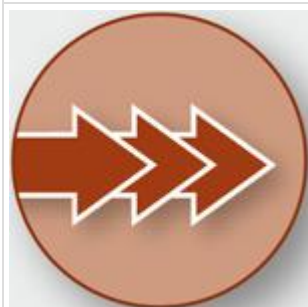
## APPENDIX A TOOLS AND RESOURCES

[Appendix A](#) identifies tools and resources addressing topics explored in [Chapter 2](#). The tools and resources were created by such businesses and organizations as Aspen Institute, Child Welfare Information Gateway, U.S. Economic Development Administration, and others.

### PARTNERSHIP FOR THE BAY’S FUTURE: A High-Impact Model for Investment



**Community Challenge** | Because of the success of the Bay Area of Northern California as a hub of technological innovation, land and housing costs have risen substantially in Silicon Valley. There, two breadwinners working full-time at \$15 an hour—or \$62,000 a year, which is close to the U.S. median household income—can afford to live in only 5% of Bay Area neighborhoods. This situation strains the health and well-being of lower- and middle-income families; major employers, including the “tech giants,” also feel the pressure. These employers recognize that their operations require a diverse labor market (e.g., maintenance technicians, administrative assistants, food-service workers) and that a community becomes unlivable for everyone when it cannot provide quality affordable housing for teachers, first responders, nursing assistants, transit operators, and others. Because the Bay Area expects nearly 1 million new jobs in the next 20 years, quality affordable housing for people from a variety of incomes is essential to continued growth.



**Action Taken** | Partnership for the Bay’s Future is a novel collaborative that addresses these concerns, beginning with the urgent need for housing. The partnership includes local tech companies Facebook and Genentech, the managed care organization Kaiser Permanente, financial services giant JPMorgan Chase, as well as the San Francisco Foundation, the Ford Foundation, Local Initiatives Support Corporation, and others. With a combination of equity and loans, the partners have capitalized a new investment fund of more than \$300

|                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                    | <p>million, which is attracting additional fund investors with competitive returns.</p> <p>The goal is to pool \$500 million and, through a variety of new financing products, invest those funds across five Bay Area counties to preserve existing and build new affordable homes, help middle-income workers with housing costs, and fast-track the process of providing safe and stable homes to those experiencing homelessness in the Bay Area.</p> <p>The fund offers small- and medium-sized community development corporations lines of longer term credit typically available only to large developers. The fund's first transaction offered a revolving line of credit that helped the East Bay Asian Local Development Corporation, a community development corporation with deep roots in the community, quickly buy property for six projects over 5 years.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|  | <p><b>Key Takeaway</b>   The Partnership for the Bay's Future illustrates the enormous promise of investment partnerships among public, private, and nonprofit stakeholders. Investment partners need not become developers or housing finance experts. Instead, community development financial institutions bring the infrastructure and know-how to manage the complex investment fund and connect with longtime Bay Area partners to ensure projects reflect the priorities of residents and community leaders. The Partnership also includes a regional policy component where interested businesses bring their power to advocate and to convene stakeholders in the public, private, and nonprofit sectors across municipal boundaries. Their common cause: The need for tens of thousands of preserved, expanded, and newly built affordable homes—the very foundation of health and economic vitality for individuals, families, and communities. While this progress represents only a tiny fraction of the Bay Area's housing need, the Partnership for the Bay's Future is a potential model for corporations and organizations nationwide to preserve and expand affordable housing. Wherever the availability of quality affordable housing is limited, such partnerships can address that lack of availability and be a first, critical step toward enhancing community health and economic prosperity.</p> <p>Investments to create a robust business environment can powerfully improve the health and well-being of communities and</p> |

|  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|  | strengthen business opportunities. Likewise, initiatives aiming to improve health can meaningfully contribute to a vibrant local business ecosystem. However, this synergy exposes a lesson and aspiration: Investors, philanthropists, public sector leaders, and communities must work together to realize the greatest return from their investments. Time spent stewarding these collaborations—including aligning goals and establishing mechanisms for coordination and accountability—will yield dividends in the form of stronger and more resilient businesses and communities. |
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**Footnotes**

1

The terms *neighborhood* and *community* are used interchangeably in this report.

**CHAPTER 3The Meaning, Purpose, and Opportunity of Business in 21st Century America**

**OVERVIEW**

Perceptions and expectations of businesses in America constantly evolve. This chapter explores new opportunities for engagement by business in society. Theories of management that address societal issues are examined throughout the chapter, which lists five actions that businesses can take to begin to support healthier communities.

**KEY TAKEAWAYS**



Business is a force for good in American society and around the world. Business and society are mutually dependent and best thrive together.



The growth in transparency, the increase in interdependence and mutuality, and the public’s attention to values pose potential threats and opportunities to a business’s reputation, brand, and long-term success.



Businesses are looking harder at these threats and opportunities and increasingly choosing to align business values, policies, investments, and actions with the expectations of consumers and the public.



Stakeholder theory provides a framework for this alignment. According to stakeholder theory, businesses exist to create value for the groups who make the business “a going concern”—that is, groups that are part of the cooperative scheme that allows a firm to come into being and to be successful over time.



Stakeholder firms are those that have implemented the principles of stakeholder theory. These firms tend to achieve better business outcomes, including greater innovation and higher profits.

## Introduction

Business has been, on balance, a force for good in American society and around the world. Business produces wealth, creates value, provides jobs, pays taxes, offers goods and services, and brings innovation to the marketplace. Business in the United States also reflects American values. To succeed, business depends on the rule of law; respect for individual and property rights; and a government that enforces the law, builds and maintains infrastructure, and strengthens and defends the common good. Of particular importance for business are property rights, the freedom of individuals to negotiate the terms of doing business, and the understanding that a government’s regulation of commerce is limited and fair. Business also encapsulates a uniquely American idea of the “self-made” individual in a “land of opportunity” who rises from humble beginnings through hard work, new ideas, and good business sense to become a prosperous and generous citizen. In short, the story of business in the United States is about more than just wealth—it embodies and perpetuates values that form the core of the American identity.

*“[W]hat improves the circumstances of the greater part can never be regarded as an inconveniency to the whole. No society can surely be flourishing and happy, of which the far greater part of the members are poor and miserable.”*

—Adam Smith

The story of business in the United States is about more than just wealth—it embodies and perpetuates values that form the core of the American identity.

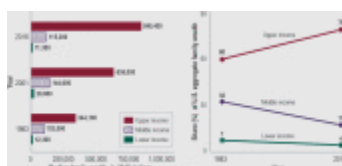
At the same time, the role of business in society can be contentious. Some business practices have caused (and continue to cause) harm to both business and society, as harmful products are brought to market, and damaging production processes contaminate air, land, and water and harm the environment. The interdependence between business and society has not been fully recognized or embraced. Today, the United States is emerging from several decades during which, for some business leaders, the priority principle for corporations was “shareholder primacy.” This principle asserts that the core—and perhaps sole—responsibility of business is to maximize profits for shareholders.

Increases in returns to shareholders have not been the rising tide to lift all boats, as once expected. From the 1970s to the early 21st century, income inequality increased in the United States as real incomes for employees stagnated. Some of these trends were facilitated by (or occurred despite) government regulation or deregulation. For example, Fortin and Lemieux analyzed the role of three systemic changes—the decline in the real value of the minimum wage, deunionization, and economic deregulation—on the rise in wage inequality in the United States during the 1980s. They found that about one-third of the increase in wage inequality (for both men and women) can be traced to these system-level changes. These kinds of developments in the United States, along with the widening gap in pay between company leaders and managers and lower-level workers, have caused people to question business-as-usual. In turn, corporations have begun to respond to inside questions and outside pressures and to recognize that their success also depends on engaging all those upon whom the company’s success depends, measuring their quarterly earnings and financial risk and also their impact on society.

*“[T]here is one and only one social responsibility of business—to use its resources and engage in activities designed to increase its profits so long as it stays within the rules of the game, which is to say, engages in open and free competition without deception or fraud”*

—Milton Friedman

A “reversal of fortune” among working Americans is one of many factors at play in the current shift of attitudes and expectations toward corporations in society. The reversal of fortune refers to the adversities—such as a diminished quality of life, environmental impact, and poor health—that are changing the way people think about business and companies think about conducting business in the 21st century. Many businesses have begun to reevaluate their role in society and see opportunities in becoming partners in creating healthy, inclusive, and prosperous communities. Many U.S. communities are facing threats to their health (as described in [Chapters 1](#) and [2](#)) and future from addiction, loneliness, chronic illness, incarceration, gun violence, and more. In public health terms, these issues stem from the fact that for many people living in America today, vital conditions—like housing, education, income, and transportation—are not being met ([Box 1.1a](#), [Box 1.1b](#), and [Box 3.1](#)), for example, in low-opportunity neighborhoods (as described in [Chapter 2](#)). While some Americans have never been wealthier and healthier, others live in distressed communities with little opportunity and feel a loss of hope when they look toward the future. As depicted in [Figure 3.1](#), the gap in wealth between high-, middle-, and low-income families has increased substantially since the 1980s.



### **Figure 3.1**

Gaps in wealth among upper, middle, and lower income families. *Note:* Families were assigned to income tiers based on their size-adjusted incomes.

Many businesses have begun to reevaluate their role in society and see opportunities in becoming partners in creating healthy, inclusive, and prosperous communities.

#### **BOX 3.1 THE SEVEN VITAL CONDITIONS**

1. Basic requirements for health and safety
2. Continuous learning, education, and literacy
3. Rewarding work, careers, and standards of living
4. Humane, consistent housing
5. Thriving environment
6. Reliable, safe, and accessible transportation
7. Belonging and civic muscle (also see [Chapter 1](#), [Box 1.1](#))

More recently, the recognition that business and society are mutually dependent and best thrive together has generated new ideas about the meaning, purpose, and responsibility of business. Ideas such as conscious capitalism, creative capitalism, stakeholder capitalism, capitalism 2.0, corporate social responsibility, shared value, community investing, and social entrepreneurship have increased expectations—on the part of businesses, investors, consumers, and employees, among others—that businesses will “do well by doing good.” Both scholarly and practical voices have encouraged mutualism between businesses and the communities in which they operate.

In addition, businesses are being asked to take responsibility for the consequences of their actions and to engage valuable stakeholders in their communities, all while maximizing value for the various stakeholders they serve. These multiple stakeholders include customers and consumers, employees and contractors, vendors and suppliers, neighborhoods and communities, and shareholders and investors. The new expectations have grown out of the recognition of the interdependence between business and society, and a greater availability of information on how businesses operate in the United States and abroad. Consumers and the public have unprecedented access to information about working conditions, hiring practices, environmental impacts, salary and wage structures, and much more. Especially after the global financial crisis of 2008, and particularly among younger consumers and employees, there is a growing focus on values and purpose in business. Business has almost always been about purpose, but consumers, employees, and the public now are more likely to demand that the values of business align with their own values, and based on that alignment will make decisions about the companies they buy from, work

for, and invest in. Employees, consumers, and the public are asking businesses to take into account the best interests of a variety of stakeholders and to create value for society as well as for business.

*“Companies that fulfill their purpose and responsibilities to stakeholders reap rewards over the long-term. Companies that ignore them stumble and fail. This dynamic is becoming increasingly apparent as the public holds companies to more exacting standards. And it will continue to accelerate as millennials—who today represent 35 percent of the workforce—express new expectations of the companies they work for, buy from, and invest in.”*

—Larry Fink

### **The American Narrative on Business**

Americans have a complex relationship with business and offer several critiques. First, they have long accused businesses of practicing greed. As the narrative goes, some business leaders think only about how their choices benefit themselves (i.e., their financial self-interest) and disregard any harm passed on to others or society. These businesses fail to recognize their dependence on society and its goods and services (such as educated employees, consumers with disposable incomes, and legal systems and protections). Americans have deep reservations about the size, scope, and influence of large, multi-unit firms. For example, a Gallup poll found a majority (63%) of U.S. adults is dissatisfied with the size and influence of major corporations, consistent with other Gallup findings in recent decades. A different Gallup poll showed that 70% of Americans have “a great deal” or “quite a lot” of confidence in small businesses, compared with 21% having confidence in large businesses. These differences are driven by a sense that leaders of large corporations have outsize influence over political processes, are accumulating greater wealth at the expense of wages, are relatively less accountable to the communities in which they operate, and are less likely to create local jobs.

Business operations are often tied to an array of negative externalities, for example, excessive consumption of resources, pollution, deskilled workers, and the creation of unhealthy levels of dependence on particular products and resources. In places where regulations are weak (e.g., minimal environmental protections), businesses may easily reap rewards while leaving significant harms or costs for communities to bear (e.g., contaminated water or soil) with little or no compensation for the externalities. For some stakeholders, the harms created by a given firm may well outweigh the benefits.

In addition to greed and negative externalities, critiques of business also focus on income inequality and lack of economic opportunity, which have been linked to unencumbered markets and government policies that favor business. Those who have power and resources, according to this critique, are more likely to benefit from successful (and even unsuccessful) businesses, while workers, mid-level managers,



and even consumers, the public, and communities benefit less. These troubling trends have prompted many leaders—even strong pro-market leaders, including Jamie Dimon, Warren Buffett, and Larry Fink—to question the sustainability of capitalism, if a more equitable distribution of benefits cannot be implemented. Even those who consider capitalism in the early 21st century to be stronger than ever recognize that the perception (if not the reality) of capitalism in crisis is due to, among other factors, an uneven distribution of gains, with many of the benefits of a thriving capitalism going to the wealthiest individuals.

Equality of economic opportunity is a deeper challenge. Independent of the amount of benefit (or value) produced, a big part of the story of capitalism in the United States is the idea of opportunity—that is, the ability of people to “have a shot,” to improve their lot in life through hard work and creativity, and to become successful regardless of who they are or who they know or where they come from. The core of the American identity is based on social mobility (described in [Chapter 2](#)) and economic opportunity. Both are central to the notion of *the American dream*—that is, the notion that a person does not need to be well-born to have a chance to achieve or get ahead in this country. Although the values that support these sentiments are still alive and well and fueled by real-life success stories, the data increasingly suggest that the American dream is becoming harder to obtain for many Americans. In other wealthy nations, meanwhile, opportunities for economic advancement are greater than they are in the United States.

## **Reinventing Business**

Amid this shifting context of American society, some businesses are striving to reinvent themselves and redefine their roles in society. The operations of today’s firms, industries, and entire economies differ notably from those of the past. Three emerging dynamics are largely responsible for changes in the way companies operate their businesses: the growth of transparency, the increase in interdependence, and the focus on values.

First, people in today’s world have unprecedented and instant access to information from around the globe. Online rating systems, consumer-produced videos, and anonymous blog posts have helped to create an environment that makes it difficult for firms to shield activities from consumers, employees, competitors, and the public—even in widely dispersed operations. Access extends to the practices in which businesses engage and the partners that they choose—even in operations conducted in remote parts of the world (e.g., use of child labor, corrupt practices, or environmental damage). In past decades, such practices would become public knowledge mainly through investigations by the media. But with the high-level of transparency in today’s environment, these practices are being reported by people with firsthand knowledge. The rise of transparency has forced companies to be ready to face scrutiny—both at home and worldwide—for their practices and to feel the pressure of accountability.

Second, the recognition of interdependence and mutuality between business and society has increased with increasing healthcare costs, rising rates of obesity and addiction, and most graphically, with the coronavirus pandemic of 2020 that kept workers and customers at home and shuttered many businesses. Two similar themes are emerging in this context: (a) the recognition that the success of a business depends on the success of its stakeholders; and (b) the understanding that when the rewards of an enterprise are distributed among its participants, the enterprise is more likely to be compelling to those participants. This positive reciprocity increases the likelihood that the firm will be successful over time. Interdependence may be a simple relationship—a business creates a job, an employee produces value, and a consumer pays for that value. The recognition of the interdependence leads the company to share the profit when the employee produces exemplary value that consumers reward with purchases and loyalty. Mutuality is more purposeful and intentional and includes the creation of shared value and lasting benefits for those engaged. For example, a company chooses to locate in a particular community and create value for local residents (such as jobs, quality childcare, apprenticeships, and employment pathway programs). Local residents then reward the company with productivity and loyalty, allowing the company to efficiently produce a quality product and earn a robust profit (see Exemplar about Greyston Bakery). Interdependence and mutuality emphasize the relationship between business and society and encourage that relationship to be deeper and richer for the benefit of both society and business.

Third, consumers (and employees) are attentive to the values of a business, as discussed previously. Although ethics have always been integral to the operation of markets, people are becoming more concerned with how a company's values align with their own values. Based on current estimates, \$1 of every \$5 invested in equity markets undergoes some kind of values vetting, and interest in this kind of vetting is growing rapidly. Businesses have always been concerned about reputation and protective of their brands. Transparency, interdependence and mutuality, and values each pose potential threats and opportunities to a business's reputation and brand. Businesses are looking harder at these threats and opportunities and increasingly choosing to align values, policies, investments, and actions with the expectations of consumers and the public, while also solving business problems and meeting the needs of multiple stakeholders. Stakeholder theory provides a framework for understanding and implementing business strategies to effectively serve these needs.

### **Stakeholder Theory and Practice**

New models of capitalism, particularly stakeholder theory, are taking hold that better fit today's trends and expectations of workers, consumers, and members of the public. These approaches support a richer notion of how business relates to stakeholders, including communities.

The concept of *stakeholders* in business emerged in the 1960s and 1970s and gained prominence in the 1980s and 1990s following initial publication in 1984 of *Strategic Management: A Stakeholder Approach* by R. Edward Freeman. Stakeholder theory argues that businesses will be in a stronger position to succeed if they take into account the needs and perspectives of *all* stakeholders, not *only* shareholders (who are one of several stakeholders). Just how many businesses and corporations adhere to a stakeholder approach is unknown. But extensive scholarship has been dedicated to understanding the business impact of engaging multiple stakeholders, and countless tools and resources have been developed to help businesses identify stakeholders and implement stakeholder engagement strategies. Even state legislatures took notice of stakeholder theory in the mid-1980s. Thirty-four states have enacted so-called “constituency” laws that explicitly give standing to core stakeholders (beyond shareholders) in important board-level business governance decisions.

Stakeholder theory begins with a simple premise: Businesses exist to create value for the groups who make the firm a “going concern”—that is, groups that are part of the cooperative scheme that allows a firm to come into being and be successful over time. In this view, core stakeholders include customers, suppliers, employees, the local community, and shareholders. Without the support and involvement of these stakeholders, the firm would not exist, and unless these stakeholders cooperate consistently and well, chances are the firm will not perform optimally. In return for their choice to engage with the firm, the company actively works to create value for each stakeholder, while simultaneously making all stakeholders better off.

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Profits (and shareholder returns for publicly traded companies) are vital to business success, and most businesses begin with a purpose beyond just making money. Stakeholder firms also have an animating purpose, something noble and inspiring that is essential to the form of value they create. This commitment to a purpose and to creating value for each stakeholder, the theory holds, makes stakeholder firms more successful and sustainable over time. A small but growing number of studies has demonstrated that firms that consistently implement a stakeholder approach tend to achieve better outcomes, including greater innovation and higher profits over time.

*“The 18 publicly traded companies out of the 28 [identified as the “most conscious” based on stated purpose, generosity of compensation, quality of customer service, investment in their communities, and impact on the environment] outperformed the S&P 500 index by a factor of 10.5 over the years 1996–2011. And why ... should that be a surprise? Conscious companies treat their stakeholders better. As a consequence, their suppliers are happier to do business with them. Employees are more engaged, productive, and likely to stay. These companies are more welcome in their communities and their customers are more satisfied and loyal. The most conscious companies give more, and they get more in return. The inescapable conclusion: it pays to care, widely and deeply.”*

—Tony Schwartz

In addition to financial rewards and stronger relationships with stakeholders, adopting a stakeholder approach offers potential benefits in the realm of trust, reciprocity, and understanding. For example, moral psychology research suggests that the logic of stakeholder theory helps to avoid many of the traps that are common to an exclusive focus on profits. For instance, although many people would like more money and more goods, most people care about fairness. Stakeholders who are treated fairly by a business are more likely to reciprocate. This dynamic is known as *positive reciprocity*, and when this dynamic is created across a firm and within stakeholder groups, it can create a virtuous cycle of benefits for business and society. Stakeholders can stop worrying about being taken advantage of and instead act in ways that make the firm and fellow stakeholders better off. On the other hand, the dynamic of *negative reciprocity* can deeply strain and erode the relationship between stakeholders and a firm. It can turn customers and suppliers away, for example, and prompt employees to underperform. A stakeholder approach helps firms to foster positive reciprocity and avoid negative reciprocity.

Firms are increasingly practicing stakeholder theory. They are

- Recognizing primary stakeholder interests as joint and (mostly) aligned with business interests;
- Emphasizing a purpose beyond (only) profits, while still caring about financial returns, and
- Investing in stakeholder relationships (e.g., with suppliers, employees, customers, and the local community) with an eye toward strengthening business returns.

A few firms that have embraced this approach (or at least adopted the language and logic of stakeholder theory) include Costco, Eastman Chemical, Google, Salesforce, Starbucks, Unilever, Vanguard, and others. Each of these companies has implemented specific management strategies and practices aligned with the practice of stakeholder theory.

Stakeholders who are treated fairly by a business are more likely to reciprocate.

Stakeholder theory offers a constructive view of business, a way of understanding and operating a business as an institution that exists to serve multiple groups in society and to create value for people and communities. Stakeholders are interdependent, and firms create value through dynamic cooperation with and among these groups. To be successful over time, businesses must nurture these relationships and find ways to create new forms of value so that all stakeholders in the value chain are better off. If this happens, stakeholders will choose to engage with the firm and work to see it succeed. Thus, the theory holds, while firms must care about profits and shareholders to succeed and thrive, they also should serve a larger purpose and recognize that the very foundation of their profits is the stakeholder relationships that enable businesses to generate value for society *and* for themselves.

In practice, the many stakeholders of a business, including shareholders, may not have the same interests (shareholders are stakeholders but not all stakeholders are shareholders; many companies have no shareholders).<sup>1</sup> Depending on the business, some interests of employees, customers, suppliers, and communities may align and some other interests may compete. The challenge for the business is to avoid tradeoffs among stakeholders and deploy strategies that keep all stakeholders engaged. While employees and suppliers (and sometime customers) may be tied to particular communities, shareholders tend to be physically, geographically, and socially separated from the needs and challenges of particular communities where businesses operate. Part of the challenge in getting those two entities to cooperate is being able to explain to shareholders how investments in communities are critical for making sure that the business can operate and thrive in the long term, even if the investment may not yield the best return on a stock price in the short term. More and more companies are taking this long-term view ([Box 3.2](#)), which was also encouraged in Business Roundtable's revised statement on the purpose of a corporation.

### **BOX 3.2 SODEXO'S STAKEHOLDER APPROACH**

Since its founding in 1966, Sodexo has sought to create value for its multiple stakeholders, including customers, clients, employees, suppliers, communities, and shareholders. From its food services operations that serve private corporations, hospitals, healthcare facilities, schools, colleges and universities, senior living communities, sports and leisure venues, and government agencies to its facilities management, benefit and rewards, and home care operations, Sodexo strives to create value for all of its stakeholders and integrate actions that support health and wellbeing into the core of its business operations.

With its Better Tomorrow 2025 initiative, Sodexo considers environmental, social, and economic impacts as it establishes and implements its business goals, ensuring that Sodexo's growth benefits:

- Employees who work hard every day,
- Clients and suppliers who seek relationships based on shared value,
- Shareholders who want sustained long-term growth, and
- Tens of millions of people served by Sodexo everyday—that is, people who hold the business accountable for having a positive impact on the community.

Sodexo uses data to determine where to focus its efforts and to measure results. Sodexo has had public, measurable, and audited corporate responsibility goals since 2009.

Here are two examples of how Sodexo strives to offer healthy and nourishing lifestyle choices to every one of its consumers every day:

- In collaboration with the Partnership for a Healthier America, Sodexo implements Mindful by Sodexo, a healthy dining program, in 95% of its food service accounts, expanding healthier food choices in at least 25% of its hospitals, offering 17 million more free breakfast meals in primary and secondary schools, and increasing the selection of healthier, more nutritious options in its vending and K–12 lunch programs.
- Sodexo offers healthier children’s meals at 40% of its food service accounts with American cultural destinations, such as aquariums, museums, ballparks, and other recreational facilities.

Sodexo also aims to source responsibly and provide management solutions that reduce its carbon emissions. The company focuses on four environmental actions: preventing food waste, promoting plant-based meal options, sourcing responsibly through local and short supply chains; and helping clients to reduce their emissions through better energy and waste management, for example:

- Nearly all Sodexo site managers, chefs, and kitchen staff implement initiatives to cut food waste. Sodexo’s WasteWatch powered by Leanpath Program tracks food waste, monitors performance, and takes actions to drive reductions. The program captures data on daily food waste and measures pre- and post-consumer waste. In 2019, Sodexo avoided 584 tons of food waste at its sites, the equivalent of 3,689 metric tons of carbon dioxide.
- Sodexo is committed to increasing food purchased in its clients’ communities from local producers and small businesses, contractually requiring its produce vendor partners to source local and seasonal foods whenever possible. Sodexo purchases more than 4 million gallons of locally sourced milk each year. In 2019, Sodexo spent \$1 billion with small- and medium-sized enterprises in the United States.

For Sodexo, growing responsibly is about pursuing and tracking what it can do better, safer, healthier, and more sustainably for people and planet. It's about how Sodexo can improve as a corporate citizen, meeting the needs of and creating value for all its stakeholders.

## **Ties to Community Health, Wealth, and Well-Being**

Challenging a simplistic, shareholder-centric view of business and adopting a stakeholder approach has important implications for community health, wealth, and well-being. Two themes make the connection: (1) creating value for stakeholders and (2) the interdependence and mutuality between business and society, including the interdependence among various stakeholders (including shareholders) and between each stakeholder and the business.

Stakeholders are people with a variety of needs, including access to clean air and water, nutritious food, safe work places and communities, green spaces, family-sustaining careers, education, and economic opportunity—all vital conditions (described in [Chapter 1](#)) that shape health, wealth, and well-being. Businesses investing in their employees, suppliers, and communities are already adding value in the form of jobs, income, health insurance (often), and goods and services of use to community members. Stakeholder firms demonstrate that businesses can go further (and get even more in return). Subsequent chapters in this report ([Chapters 4](#) and [5](#)) describe a variety of investments and strategies that businesses can deploy and of ways to partner to help solve some of the pressing community challenges that detract from health, wealth, and well-being—such as poverty, lack of education, lack of affordable housing, income inequality, and lack of economic opportunity. As businesses partner to raise the level of well-being in a community, they create greater business opportunities for themselves and more stakeholders to bring value to the business.

As businesses partner to raise the level of well-being in a community, they create greater business opportunities for themselves and more stakeholders to bring value to the business.

Moreover, stakeholders and businesses are interdependent and linked together in a larger ecosystem. Where people are healthy and the vital conditions for health are present, businesses have an easier time finding employees who will be productive, miss fewer days of work due to illness, and do more to contribute to the firm. Businesses in this environment also tend to find customers who are more likely to buy their products and investors who are more likely to want to buy their stock.

## **The Role of Business in Well-Being**

Opportunities for businesses to join in creating thriving communities can be divided into three areas: (1) the well-being of people (employee and dependent benefits, workplace policies and environment, customer well-being), (2) the well-being of places (vital conditions of a community, access to opportunity, broader community systems), and (3)

equity, ensuring resources are focused on those most in need and everyone has the opportunity to thrive.

Investing in the well-being of employees has long been the purview of business. From providing safe working conditions, health insurance coverage, and paid sick leave to offering workplace health promotion, wellness or well-being programs, family-sustaining compensation, paid maternity leave, and profit sharing, companies that offer these conditions and benefits have seen the value of investing in employees and their dependents. Businesses can continue to strive to ensure these conditions and benefits are met for all employees and dependents.

Companies investing in *place* is less common and occurs most often in communities in which company headquarters are located (see Perspectives From Business Leaders). Companies may establish partnerships to create pathways to employment; build physical infrastructure, including green spaces and grocery stores; and invest in quality education. Companies can continue to make these kinds of improvements and expand opportunities in the communities they serve.

The most advanced businesses invest in people and place with an eye toward improving the lives of those who are not thriving and creating conditions for all people to prosper by adding customized supports for those who are least likely to thrive. Such investments have the potential to improve the health, wealth, and well-being of employees, families and consumers, and future employees and consumers. Some companies are tackling health, wealth, and well-being more broadly—in the context of (a) people in the wider community they may not directly touch and (b) the vital conditions required for all people to thrive in the places in which businesses operate or serve (see, for example, the Exemplar about Reinvestment Fund’s Gem City Market).

These roles are aligned with the purpose and meaning of business. Businesses exist to

- Create sustained, long-term value for all stakeholders;
- Fulfill a larger purpose as a means of making money;
- Recognize the interdependencies between themselves and stakeholders; and
- Seek ways to contribute positively to communities and stakeholders.

Firms take these actions because they help the business succeed, consumers expect them to, and it is the right thing to do. Stakeholder firms see the connection between community health, wealth, and well-being and their own prosperity over time. They also seek ways to improve community health, especially where it is most clearly linked to their stakeholders and the prosperity of the firm.

## **APPENDIX A TOOLS AND RESOURCES**

[Appendix A](#) identifies tools and resources addressing topics explored in [Chapter 3](#). The tools and resources were created by such businesses and organizations as DePaul



University, Fisher Investments, U.S. Department of Housing and Urban Development, and others.

## HYATT HOTELS CORPORATION: An Opportunity Partnership

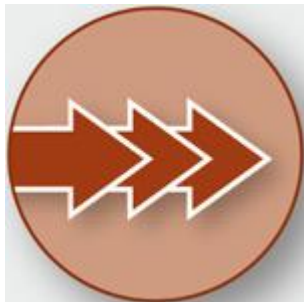


**Community Challenge** | Even before the coronavirus pandemic devastated the global economy in 2020, a high percentage of young adults (18- to 24-years of age) who were not in school were jobless. Being jobless at such a young age can set the stage for long-term unemployment or for taking fringe jobs that lack benefits or social security. Some young adults can become economically marginalized for the rest of their lives.



**Scenario** | It started at the top. Mark Hoplamazian, president and chief executive officer of Hyatt Hotels Corporation (Hyatt), saw the issue of young people being left out of the workforce and the economy as a primary driver of the widening skills, income, and wealth gaps. He believes that companies have a responsibility to help address such issues in the communities in which they operate.

Hyatt is a hospitality company that manages hotels and resorts. The company has a clear purpose—to care for people so they can be their best. “Our purpose of care applies to our colleagues, our guests, and our communities,” said Audrey Williams-Lee, senior vice president of Human Resources and Philanthropy. “There is a growing wealth and skills gap, and our [chief executive officer] wanted us to focus on a signature philanthropic cause that both aligned with our values and supported our communities.” Hyatt concluded that addressing the issue of unemployment among young adults who are not in school and not in the workforce (often called “Opportunity Youth”) would accomplish that goal, providing a diverse employment pipeline to spur future growth at Hyatt and to support communities in which Hyatt is located.



**Action Taken |** Williams-Lee and her team conducted research and interviewed community organizations that worked with youth globally. Hyatt worked with Grads of Life to design the RiseHY program. Launched in 2018, the RiseHY program seeks to hire 10,000 young adults by 2025. In its first year, Hyatt and its hotels had hired more than 16% of its 10,000-hirings goal.

To facilitate the RiseHY program, Hyatt focuses on four areas:

- **Use a majority of the Hyatt Hotels Foundation’s philanthropic giving to fund RiseHY.** “We were able to articulate very clearly who we were giving to,” Williams-Lee said. “And why we were supporting certain organizations.”
- **Develop a network of community organizations focused on training and supporting opportunity youth for job readiness.** The hospitality industry has an abundance of entry-level jobs. With such a network in place, Hyatt began to fill those positions with opportunity youth. Hyatt fosters a workplace where young people without prior experience can create a foundation for a life-long career, gain new skills, and advance in the organization.
- **Use technology to help with hiring.** For example, Hyatt uses a gamified tool (in 18 languages) to match the skills of young workers with the skills needed for potential hospitality roles. Hyatt also uses a virtual reality simulation to capture what life is like in a hotel. “This increases the quality of hires we bring into the program,” Williams-Lee said. “And it helps young people who have never been in a hotel understand what it’s like.” To help applicants decide which job to apply for, the simulation describes the different roles and helps candidates understand the responsibilities of each role.
- **Work with community organizations to identify wraparound services.** Such services can support young people when they are placed in a role in the company, and help managers at Hyatt Hotels understand how to help opportunity youth succeed.



**Key Takeaway** | Without a job, and with little hope of finding one, the self-worth of out-of-school teenagers and young adults plummets. A lack of confidence quickly translates to being less employable. In the end, unemployed young adults hurt all communities. But opportunity abounds as businesses (a) become more aware of young adults as a potential talent pipeline and (b) foster roles in their organizations for these workers. Several factors are critical to the success of Hyatt's RiseHY program, including embracing a cause aligned with its purpose, the nature of the hospitality business, and locating its corporate philanthropy within the human resources department. This critical move ensures that corporate philanthropy and business success are aligned and reinforce each other. Together, these factors create opportunities for synergy between doing well and doing good.

## Footnotes

1

Stakeholder theory applies primarily to publicly traded corporations, as a management strategy. But the theory also applies to any type of business or other organization, including government.

## CHAPTER 4 Bringing Opportunity to Communities Through Partnerships With Community Development and Community Finance

### OVERVIEW

No single business or sector can create lasting change on its own. This chapter tells the story of community development and how it brings public, private, and nonprofit resources together to fight poverty and advance health. Numerous agencies and approaches that create opportunities and improve quality of life are explored, finding common ground and financial alignments that benefit everyone. Access to capital is the lifeblood of the U.S. economy, and financial resources are essential to the health of communities and the livelihood of families. This chapter gives special attention to community development financial institutions (CDFIs)—which are well positioned to address the lack of available capital, credit, and financing expertise in many communities—and describes “win-win” ventures, such as business investments in affordable housing and creatively financed projects that improve the health of employees and communities.

## KEY TAKEAWAYS



The need for a healthy, skilled labor force remains a top priority for individual businesses and the broader economy. People are more likely to be healthy and skilled and participate in the labor force when they grow up and live in thriving neighborhoods where the vital conditions are met.



The human capital potential that could be unleashed if *every person* had access to thriving neighborhoods would be transformational for America's communities, businesses, and economy.



Resource alignment for this transformational work is already underway in the field of community development, a mission-driven enterprise that fosters vibrant economic, social, and health conditions to increase opportunities for people with low incomes.



### Community development

- Requires investments and partnerships across the public, private, and nonprofit sectors; and
- Leverages public, private, and philanthropic investments to develop real estate, promote small businesses and entrepreneurs, and strengthen human capital.



Businesses and other investors seeking careful, knowledgeable investors in underserved areas can partner with community development financial institutions to raise capital for specific community investments.



The community assets that comprise the vital conditions for health, wealth, and well-being create an excellent environment for private enterprise. Strengthening these assets through community development enables employees to come to work prepared and engaged and promotes a thriving local network of businesses, suppliers, employees, colleagues, customers, and clients.



Despite sizeable investments, the current scale of community development is not sufficient to address the many complex causes of poverty and the negative impacts of poverty on health, wealth, and well-being.



New business models are needed to align the financial interests of those who benefit from a healthier, more productive population with those who create the conditions that promote human flourishing.

## **Introduction**

Like any complex system, the U.S. economy evolves in unpredictable ways. Despite these ongoing shifts, the need for a healthy, skilled labor force remains a top priority for individual firms and the broader economy. [Chapters 1](#) and [2](#) noted the magnitude of the U.S. health disadvantage; the vital conditions that shape the health of Americans (and harm their health, when unmet); and the ways in which neighborhoods and communities expand or limit opportunities for health, wealth, and well-being. People are more likely to be healthy and to prosper when they live in thriving neighborhoods that include high levels of social capital and community cohesion, high-quality and affordable housing, regional connectivity through transit, vibrant educational and workforce opportunities, and access to healthy food and recreation.

The human capital potential that could be unleashed if *every person* had access to this kind of opportunity—regardless of his or her race/ethnicity, disability, or income—would be remarkable: Such access would be transformational for our communities, businesses, and the economy. Because no single sector can realize this vision in isolation, the transformation requires investments and partnerships across the public, private, and nonprofit sectors. Nationwide, this transformative work of aligning financial resources from across organizations to address unmet vital conditions is already underway through the field of “community development.” Actors working in this field are essential partners for businesses seeking to engage with and invest in communities.

## **What Is Community Development in the United States?**

Community development in the United States is a mission-driven enterprise that fosters vibrant economic, social, and health conditions to increase opportunity for people with low incomes. The approach recognizes the inseparable connection between people’s economic (and increasingly, health) outcomes and the opportunities available in the places where they live. Community development leverages public, private, and philanthropic investments to support a variety of activities that strengthen historically marginalized and disinvested communities and expand opportunities at the individual, family, and neighborhood levels, including

- Promoting and bolstering community engagement to identify and address local barriers to opportunity;

- Developing real estate, such as quality, affordable, and accessible housing and community facilities;
- Promoting small business and entrepreneurship;
- Strengthening human capital, from early childhood education to workforce training; and
- Supporting neighborhood residents in the areas of financial health and asset development, such as personal savings and credit repair.

Community development comprises organizations that specialize in real estate, city planning, law, social work, public policy, public health, affordable housing, and finance. The work is inherently interdisciplinary; requires diverse resources and skills; and needs to be deeply informed by local residents and community voices. As a result, successful community development entails strong and collaborative partnerships across multiple stakeholders—from the public, private, and nonprofit sectors to neighborhood residents and local leaders. [Box 4.1](#) presents more information about the history of community development in the United States.

#### **BOX 4.1 THE ORIGINS AND EVOLUTION OF COMMUNITY DEVELOPMENT IN THE UNITED STATES**

The modern field of community development in the United States has its historical origins in the *War on Poverty* programs of the 1960s, which introduced a constellation of federal programs designed to provide education and job training to expand employment opportunities, as well as government support for community planning and organizing. In 1966, Senator Robert F. Kennedy and his aides worked with local residents to create the first “community development corporation” (CDC) in the Bedford-Stuyvesant neighborhood in Brooklyn, New York, which combined locally driven community action with the market-based principles of private enterprise.

This first CDC, founded in 1967 as the Bedford Stuyvesant Restoration Corporation, coordinated programs focused on the creation of housing, jobs, health facilities, recreation, and more in the defined geography of the neighborhood, fulfilling Kennedy’s vision for holistic and locally driven approaches for alleviating poverty. “An effort in one problem area is almost worthless,” Kennedy said in a speech announcing the first community development project. “A program for housing, without simultaneous programs for jobs, education, welfare reform, health, and economic development cannot succeed.” This movement spread nationwide, with low-income communities creating the thousands of CDCs that exist nationwide today.

During subsequent decades, major cutbacks in federal funding for housing and other neighborhood investments spurred more innovation at the state and local levels and led to the establishment of new nonprofit entities dedicated to antipoverty work, such as Local Initiatives Support Corporation (LISC) and Enterprise Community Partners, two of

the largest community development intermediaries in the United States. Eventually, these networks skillfully organized, became politically active, and lobbied successfully for more federal resources to sustain antipoverty efforts. Today, as an established field with significant technical expertise in a variety of functions, community development serves as critical infrastructure for deploying public and private resources into actions that improve the health and prosperity of low-income communities.

### **Critical Actors in the Community Development Field**

As Robert F. Kennedy suggested in 1966 ([Box 4.1](#)), successful community development requires simultaneously addressing the complex web of social and economic factors that underlie poverty. Consequently, a variety of partners have engaged in a range of community development activities. The following sections describe some of the field's essential actors who implement community development activities.

#### **Community Development Corporations**

The National Alliance of Community Economic Development Associations describes community development corporations (CDCs) as nonprofit organizations that are typically based in low-income communities and work to improve the future of the neighborhood for the benefit of the people who live there, through such activities as real estate development, economic development, and community organizing. Approximately 4,600 CDCs exist in the United States. The East Bay Asian Local Development Corporation (EBALDC) in Oakland, California, is an example of a CDC that has adopted a “healthy neighborhood approach” to address the interconnected social, economic, and environmental factors that shape neighborhood health and well-being, specifically working to ensure that people of all classes and incomes can live where they work in the Bay Area.

#### **Affordable Housing Developers**

Although many CDCs develop affordable housing as part of their suite of local activities, larger regional and national organizations also dedicate their work solely to the development of affordable housing. For example, Stewards of Affordable Housing for the Future (SAHF) is a national network of the 13 largest nonprofit affordable-housing developers, including BRIDGE Housing, Homes for America, Mercy Housing, National Housing Trust, and National Church Residences. SAHF members collectively provide more than 140,000 affordable rental homes nationwide.

#### **Community Development Financial Institutions**

Community development financial institutions (CDFIs) are mission-driven financial institutions that provide access to affordable capital and financial services for low-income communities. CDFIs leverage federal resources, awarded through the U.S. Department of the Treasury's Community Development Financial Institutions Fund (CDFI Fund), to attract private sector investment, which they use to provide flexible



financing for projects like affordable housing development, small business creation, and community facilities. The CDFI industry manages more than \$150 billion among the more than 1,100 certified CDFIs nationwide ([Box 4.2](#)); CDFIs are headquartered in all 50 states, the District of Columbia, Puerto Rico, and Guam ([Figure 4.1](#)). Industry performance is strong. In 2017, CDFIs had a net charge-off rate of 0.4%, which was lower than the net charge-off rate of 0.5% among banks insured by the Federal Deposit Insurance Corporation.



**[Figure 4.1](#)**

Locations of certified CDFIs.

### **BOX 4.2 OVERVIEW OF CDFI CERTIFICATION**

CDFI certification ensures that a CDFI:

- “Is a legal entity at the time of Certification application;
- Has a primary mission of promoting community development;
- Is a financing entity;
- Primarily serves one or more target markets;
- Provides development services in conjunction with its financing activities;
- Maintains accountability to its defined target market; and
- Is a nongovernment entity and not under the control of any government entity (Tribal governments excluded).”

This combination of solid financial performance and deep commitment to mission enables CDFIs to serve as trusted conduits between traditionally risk-averse sources of capital and impactful projects in low-income communities.

### **Nonprofit Service Providers**

Besides revitalizing low-income neighborhoods through real estate development, the community development field also works to develop human capital. Nonprofit service providers play a critical role in the field by building relationships with and offering direct services to low-income clients, from young children to older adults. These services can be grouped loosely into two types of service activities: (1) providing support to address immediate needs, such as a food bank or homeless shelter, and (2) focusing on longer term development that contributes to economic stability and wealth creation, for example, through activities that target educational readiness, workforce skills, or



financial capability. Together, nonprofit service providers across the community development field address the wide range of complex barriers that people with low incomes face in achieving financial well-being.

### **Community Members**

Despite its early origins as a community-based, resident-driven movement, the increasing technical complexity and professionalization of the community development field has made it less accessible to community members and residents. Nonetheless, many community development projects have successfully engaged community members in a variety of ways, including as board members of involved organizations, as members of advisory committees, and through community meetings. Importantly, many CDCs rose from and represent communities through their history and leadership “rooted in and rooting for struggling communities.” Indeed, creating lasting change will require more intentional and meaningful partnerships with community members.

For example, Building Healthy Communities (BHC) is a comprehensive community initiative of The California Endowment, which is one of the country’s largest health-focused philanthropies. BHC is designed to transform communities facing major health inequities into places where all people and neighborhoods thrive. It focuses on decreasing violence, increasing healthcare coverage among children, and improving transportation, among others. BHC takes an inclusive engagement approach that “[strengthens] the fabric of our democracy by investing in the social, economic, and political power of the very residents who have been the targets of exclusion, stigma, and discrimination.” This movement across the field emphasizes the longer term need to build relationships and support the lasting power in the community as a means of transformative change.

### **Working With Community Development Financial Institutions**

CDFIs are financial institutions concerned with creating an inclusive economy, in which opportunity is widely accessible and prosperity is broadly shared. Because CDFIs recognize that access to capital is the lifeblood of our economy and essential to the economic health of families and communities, their shared mission is investing in people and places that otherwise lack access to safe, affordable financial products and services.

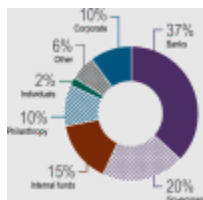
More than 38 million Americans (11.8%) lived below the federal poverty line in 2018. About 6% of Americans—21 million people—lived in counties characterized by persistent poverty, with poverty rates at least 20% for 30 years or more and as high as 32% for minority populations. Although median household income has increased nationally over the past several years, the net worth of the median household is still about 7% lower than it was in 2000. Given the well-documented link between economic distress, especially geographically concentrated poverty, and poorer health, investing in

the most under-resourced American communities may help achieve better outcomes overall. CDFIs are experienced in such investments.

In a market economy, investors of capital channel money to where it can secure the highest rate of return for commensurate risks. Communities that are deemed too risky, or not profitable enough, are often bypassed by traditional financial institutions and as a result do not have access to the credit and capital they need to thrive. CDFIs focus on communities that have suffered the long-term effects of chronic and systemic disinvestment, such as urban areas where discriminatory “redlining” was once practiced and still casts a shadow, rural areas experiencing persistent poverty, and tribal communities that are often isolated from local and regional economies. CDFIs also focus on communities experiencing more recent economic stress, such as towns that have lost manufacturing businesses.

CDFIs finance entrepreneurs to develop small businesses; homeownership for first-time buyers; affordable housing for cost-burdened families and individuals; community facilities, such as schools, daycare centers, and health centers; and commercial enterprises, such as healthy food retail and small manufacturing companies. They offer bank accounts to the unbanked and under-banked and technical assistance that boosts families’ financial capability.

The public and private sectors have come to recognize CDFIs as effective and vital intermediaries that function in the spaces between public policy and market forces. In 1994, with bipartisan support, the United States Congress created the CDFI Fund and placed it within the U.S. Department of the Treasury. CDFIs use public resources from federal tax credits (described below) and the CDFI Fund to leverage investments from a variety of private sources, including corporations. [Figure 4.2](#) shows the composition of a balance sheet for a typical community development loan fund organized by a CDFI.



**[Figure 4.2](#)**

Fictional example of typical sources of capital for a CDFI loan fund.

## **What Businesses Should Know About CDFIs**

### **CDFIs Are Diverse**

CDFIs come in many forms, including regulated banks and credit unions as well as unregulated loan funds, microlenders, venture capital funds, and socially responsible financial service firms ([Figure 4.3](#)). Some are for-profit, and others are nonprofit.

Regardless of their business model, CDFIs share a common mission of reaching the people and places underserved by traditional financial institutions.



**Figure 4.3**

Types of certified CDFIs (among 1,112 certified CDFIs as of September 30, 2018).

CDFIs come in many sizes. The largest CDFIs manage several billion dollars in capital; the assets of small CDFIs may be only a few million dollars. Larger CDFIs tend to have better access to resources and bigger footprints; smaller CDFIs may have deeper local roots and a better understanding of local markets.

### **CDFIs Are Businesses**

Though CDFIs are mission driven, they must attend to the bottom line. CDFIs manage the tension between earning enough income to cover costs and support growth and innovation while also achieving their mission of providing affordable financial products and services to underserved communities. CDFIs earn income from the fees and interest they charge borrowers. Some earn income from advisory services and contracts. CDFIs also raise grants from a variety of sources, including the CDFI Fund and other government programs, banks, and foundations. For many firms, a CDFI can be a partner with operations in communities and in specific areas, such as health clinics, with which interested businesses may be less familiar.

Businesses and other investors seeking careful, knowledgeable investors in underserved areas can partner with CDFIs to raise capital for a particular community investment.

CDFIs make their business models feasible by raising investment capital from a variety of sources—some at market rates of return and others below market—and blending them together to make their financial products and services affordable. Businesses and other investors seeking careful, knowledgeable investors in underserved areas can partner with CDFIs to raise capital for a particular community investment.

### **The Impact and Performance of CDFIs**

CDFIs have stood the test of time. At the end of 1997, there were 196 certified CDFIs with total assets of \$4 billion. Today, more than 1,100 certified CDFIs hold total assets of over \$150 billion.<sup>1</sup> Since its establishment, the CDFI Fund has awarded over \$3.3 billion to CDFIs, community development organizations, and financial institutions through its funding programs. In addition, it has allocated \$57.5 billion in tax credits through the New Markets Tax Credit (NMTC, described below) Program and issued

guarantees on \$1.51 billion in bonds through the CDFI Bond Guarantee Program. Both programs are public initiatives that incentivize private investment in businesses and large-scale development projects to revitalize distressed communities. Finally, the Healthy Food Financing Initiative (HFFI), administered by the U.S. Department of Agriculture with support from the U.S. Departments of Treasury and Health and Human Services, provides grants and loans to improve access to healthy foods in urban and rural areas of need by financing grocery stores, farmers' markets, co-ops, and other food access businesses. With CDFIs as an intermediary, HFFI has provided more than \$220 million in grants and leveraged an additional \$1 billion in private financing to nearly 1,000 groceries and healthy food retailers in 35 states (see Exemplar about Reinvestment Fund).

The CDFI Fund's investments are leveraged many times over. The leverage ratio varies from program to program, but most, like the NMTC, attract about \$8 of private capital for every \$1 of federal spending. This creates a win-win for investors: CDFIs use public resources to mitigate risk for private investors, and the public benefits by achieving social outcomes that exceed the value of its investment. For example, the public may receive a new grocery store that offers food and employment opportunities; or it could get help with affordable housing that allows people to stay close to jobs. By serving as financial intermediaries, CDFIs can connect investors with needs and help improve the conditions that shape health in a community.

CDFIs have a positive impact on communities. For instance, under the Fund's CDFI Program, which gives financial and technical assistance directly to qualifying CDFIs to sustain and expand their work, "award recipients reported originating loans or investments in FY 2018 totaling over \$11 billion, including

- \$2 billion for 19,000 home improvement and purchase loans,
- \$2 billion for 17,963 business and microenterprise loans,
- \$3.4 billion for over 207,000 consumer loans, and
- \$1.3 billion for 2,800 residential real estate transactions."

CDFI Fund award recipients also financed over 33,600 affordable housing units and served more than 343,000 individuals with financial literacy and other training. These products and services are delivered to underserved people and communities and allow struggling individuals and families to afford rent; own or upgrade a home; start a business, grow a business, or gain a job at a local business; establish a credit score; finance a car or an education; and live near employment opportunities, thus contributing to the strengthening of individuals, families, and communities and contributing to health, wealth, and well-being.

CDFIs are reaching hard-to-serve places. CDFI Program award recipients invested over 80% of their assets in low-income communities in 2018. Indeed, CDFIs receiving

awards outperform the baseline certification guidelines, which require 60% or more of assets be invested in low-income communities. In the NMTC Program, allocatees (i.e., people and programs that receive funds) exceed the baseline requirement of serving low-income census tracts by driving 75% of transactions to *highly* distressed communities. Another CDFI Fund program, the Bank Enterprise Award, gives monetary awards to banks and thrifts that increase lending and services to communities that need them most. In this program, all transactions are in communities with poverty rates of 30% or higher and unemployment rates 1.5 times higher than the national average. In communities with these characteristics, the additional support—whether for small business expansion, construction of a federally qualified health center, or investment in job training and skills—can have a lasting impact on quality of life and community health outcomes. [Box 4.3](#) offers examples of the reach of CDFIs.

#### **BOX 4.3EXAMPLES OF THE REACH OF COMMUNITY DEVELOPMENT FINANCIAL INSTITUTIONS**

- **“Former manufacturing communities.** More than 400 counties are affected by manufacturing job losses, and these counties have simultaneously experienced economic decline and population loss. CDFIs have lent and invested \$2.7 billion through more than 49,000 individual transactions. In addition, over \$5 billion in NMTCs have been invested in these counties.
- **Coal-impacted communities.** CDFIs are working in areas experiencing economic challenges due to contractions in the coal industry. [CDFIs] are supporting economic diversification and community revitalization initiatives. Sixty CDFIs across 14 states have lent or invested more than \$100 million, and 24 community development entities [which are organizations certified by the CDFI Fund] have deployed nearly \$230 million in NMTC investments in nine states.
- **Areas of persistent poverty.** While over 6% of the U.S. population lives in areas of persistent poverty, nearly one-fifth of CDFI investments and transactions and 18% of CDFI headquarters are located in these areas. CDFIs have invested more than \$640 million in persistent poverty counties.
- **Small towns, rural communities, and Native communities.** CDFIs have provided \$6.1 billion in loans and investments in small towns and rural communities and over \$757 million in investments in Native communities.
- **Small business finance.** Financing entrepreneurs and small business owners remains a challenge in America, but CDFIs are making inroads. [In 2018], CDFI Program awardees provided financing to nearly 16,000 businesses nationwide.”

Overall, CDFIs have tremendous impact in some of the hardest to serve places across the country, have lower rates of loan losses, and are more efficient than traditional lenders. According to the Opportunity Finance Network, although CDFI loans have higher delinquency rates than loans by traditional banks, their loss rates are in fact

lower (0.65% versus 1.05% in 2001 through 2015). Since lending in distressed communities is their core business, CDFIs are experienced at managing risk by offering technical and other assistance to borrowers, including individuals and their communities, entrepreneurs and small businesses, and even large institutional actors. An analysis by Fairchild and Jia found that CDFIs perform on par with mainstream banks when it comes to operational efficiency and are at no greater risk of institutional failure.

### **Options for Working With CDFIs**

Businesses can invest in CDFIs in a variety of ways based on the outcomes they are seeking to achieve, such as improving the health, wealth, and well-being of the labor force or ensuring availability of affordable housing in their communities. The following section describes three options frequently used by CDFI investors.

#### **“On Balance Sheet” Investments**

Many investors choose to invest in the CDFI rather than directly into a project the CDFI will eventually finance, like affordable housing, a community facility, or a small business. These are referred to as “on balance sheet” investments and can be an effective option for an investor interested in the entire range of activities undertaken by a given CDFI. The investment can be spread across many transactions over a period of time, giving the CDFI maximum flexibility.

#### **Structured Funds**

CDFIs often structure special funds for an investor, or investors, interested in more targeted outcomes; for example, making healthy food more accessible in low-income, low-access areas. Structured funds can also be designed to target specific geographic areas. Structured funds are usually set up “off balance sheet,” meaning that investments are made into a separate legal entity created solely for the purpose determined by the investor(s). The CDFI typically plays the role of the fund manager and often invests its own capital as well. A business interested in potentially contributing to community investments can (a) leverage their capital by pooling with other investors and (b) lower their risks by working with institutions that have experience in these types of investments and communities (see, for example, *Funds for kickstarting affordable housing preservation and production: Lessons for new investors* by Elizabeth Mattiuzzi).

#### **Transaction Level**

CDFIs are skilled at facilitating project-level investments from investors. If an investor has an interest in a single project, they can invest in that project through the CDFI or together with the CDFI. If a company is planning to invest in or contribute to a project, it should consider working with a CDFI that can potentially lower risk and attract other market-rate or below-market-rate investments into the project.

Communities that meet the needs of families—safe neighborhoods, childcare, affordable housing, and good schools—ultimately produce healthier and more productive workers, now and into the future, with attendant returns of value to the business. Partnering with CDFIs to invest in communities is a well-developed strategy for realizing this vision.

CDFIs are working to close wealth gaps across America by investing in the engines that create mobility from poverty, such as good schools, safe and affordable housing, access to healthy food, and quality healthcare. By reducing or closing gaps in wealth and increasing economic opportunity, improvements in health and well-being will be more attainable. Examples in other sections of this report demonstrate tangible ways that the business community is already advancing this work. But more is needed. Businesses can contribute in even greater ways to creating a society in which health and prosperity are more broadly shared. Communities that meet the needs of families—safe neighborhoods, childcare, affordable housing, and good schools—ultimately produce healthier and more productive workers, now and into the future, with attendant returns of value to the business. Partnering with CDFIs to invest in communities is a well-developed strategy for realizing this vision.

### **Main Sources of Community Development Funding**

Because of the overall insufficiency of any single funding source dedicated to low-income communities, the practice of community development requires a combination of multiple funding streams from across the public, private, and philanthropic sectors. These varied sources have different motivations for investing in community development efforts. The most common types of funding are described below, but the field is constantly evolving in its ability to connect new sources of capital to efforts that strengthen low-income communities.

### ***The Community Reinvestment Act***

The *Community Reinvestment Act* (CRA) is a regulatory statute that helps ensure depository banking institutions provide capital and financial services to the low-income communities in which they operate, consistent with safe and sound practices. CRA was enacted in 1977 in response to decades of disinvestment in low-income communities and, most notably, to lend and invest in the communities in which they are chartered. Estimates indicate that CRA-motivated banks made aggregate loans of more than \$400 billion in 2016 to support housing, small businesses and farms, and community development efforts in lower income communities. Of the multiple sources of community development funding, CRA-motivated bank lending and investment represent the largest share.

### **Low-Income Housing Tax Credit and New Markets Tax Credit**

To incentivize additional private sector actors to invest in low-income communities, the federal government allocates tax credits that can be purchased by private entities to

offset their tax liabilities. The largest such program is the Low-Income Housing Tax Credit (LIHTC), which was created in 1986 to encourage private investment in affordable housing. Under the terms of the LIHTC program, states receive an annual allocation of federal tax credits based on population size (nearly \$9 billion in 2017), which are then awarded through a highly competitive process to developers that construct, rehabilitate, or preserve affordable housing. The developer then sells the credits to a corporation that can apply them toward future tax liability, and the proceeds of the sale generate equity for the housing endeavor. Since its inception, LIHTC has financed more than 3 million units and served more than 7 million households, supporting 3.4 million jobs while generating \$323 billion in local income. Congress enacted a related program, NMTC, in 2000 to attract private capital for small businesses and community facilities that operate in low-income communities. Since 2001, the NMTC program has provided \$49 billion in incentives (\$3.5 billion in 2018), creating or retaining nearly 750,000 jobs and supporting the construction of 190 million square feet of manufacturing, office, and retail space.

### **Public Sector Investments**

The public sector also provides significant funding in the form of loans or grants from sources, such as tax revenue and municipal bonds, across all scales of government. At the federal level, the U.S. Department of Housing and Urban Development (HUD) administers multiple grant programs, such as the Community Development Block Grants, from which funds are then allocated at the state and local levels. State and local governments also administer their own funding programs, such as California's Affordable Housing and Sustainable Communities Program, which uses revenue from the proceeds of the state's cap-and-trade program (\$402 million in 2019, more than \$1 billion since 2016) to fund housing, transportation, and land-use projects that reduce greenhouse gas emissions. In addition, multicounty or regional bodies, such as metropolitan planning organizations, also can provide funds to support community development efforts at the regional level. Businesses can tap into some of these resources or join with public-sector partners to lower the costs of their community investments.

### **Foundations**

Charitable foundations are known most widely for their grant-making efforts, which have no expectation of repayment or investment return. Many foundations, however, also make investments from their asset portfolio through "program-related investments" and "mission-related investments" that are designed to further the organization's social mission while earning some level of financial return. These philanthropic investments can take multiple forms, such as below-market-rate loans, loan guarantees, or equity investments. Philanthropic investment complements grant funding and often provides the flexibility needed to pursue innovative new projects and financial structures. [Chapter 5](#) presents more information about partnering with philanthropy.



## **Direct Private Sector Investment**

Private firms have begun to invest directly in community development efforts, separate from any regulatory requirements or tax credit incentives. For example, technology companies—such as Microsoft, Google, and Facebook—have made commitments to fund affordable housing in the regions in which their offices are located, in response to the growing pressure their presence has created on local housing markets. In addition, health systems—such as UnitedHealthcare, ProMedica, Bon Secours Mercy Health, Nationwide Children’s Hospital, and Kaiser Permanente—have also invested directly in community development efforts, recognizing that such issues as housing stability and access to healthy foods improve health outcomes.

## **Putting It All Together: The Practice of Community Development**

The same community assets that boost population health also create an excellent environment for private enterprise. The combination of these assets and their ongoing development and enhancement in the community through the practice of community development (a) helps employees across a variety of skill levels; (b) enables employees to come to work prepared and engaged; and (c) promotes a thriving local network of businesses, suppliers, colleagues, customers, and clients. The assets of a healthy community ecosystem help underserved and disadvantaged populations realize economic prosperity, which in turn promotes their engagement as consumers. Indeed, communities enriched with the vital conditions for health, wealth, and well-being are economically resilient—that is, they are better able to withstand the blow of a recession without spiraling into depopulation, blight, and crime and to build wealth broadly in times of plenty.

A “one-size-fits all” approach to the practice of community development does not exist, and the range of actors, activities, and funding sources varies depending on the local context. Community development approaches, however, traditionally have fallen into two categories—“people” and “place”—defined by the scale of the intervention. Effective community development addresses people and place simultaneously; the work must be grounded in the lived experience of people with low incomes, which cannot be separated from the places in which they live. Thus, community development is not a singular exercise carried out by any one organization. Instead, community development is a collective effort to harness resources and strengths across multiple organizations and sectors, including the private sector.

## **People: Improving Economic Outcomes for People With Low Incomes**

Improving economic outcomes for people with low incomes involves the expansion of skills and assets at the “person level,” such as job training, savings programs, and youth development. These approaches are designed to improve household financial health, which in turn positively affects physical and mental health, labor force attachment, and educational attainment. For example, children’s savings accounts—often implemented

through partnerships involving the public, private, and nonprofit sectors—are long-term savings accounts that help families with low incomes build savings for postsecondary education. Even small amounts of savings can affect a child’s life trajectory. Children who live in families with low- and moderate-level incomes and have savings designated for college (even less than \$500) are three times more likely to enroll in and four times more likely to graduate from postsecondary school or from a certificate program than children with no savings account. Another approach is the bundling of multiple services into a single program, such as Financial Opportunity Centers (FOCs), which integrate job training for workers with low incomes with financial coaching and connections to income supports. FOCs provide employment counseling, one-on-one financial coaching, and low-cost financial products that help build credit, savings, and assets. FOCs also connect clients to food assistance, utilities assistance, and affordable health insurance. Compared with people in programs offering employment assistance alone, members of FOCs are more likely to be employed year-round, reduce consumer debt, and build positive credit histories.

Children’s savings accounts, FOCs, and other services are not structured to provide financial returns to investors, and thus rely heavily on grant funding. One exception is “social enterprise,” which is a business model that generates revenue while fulfilling a social mission. (Social enterprise is described fully in [Chapter 5](#).) A growing movement in the community development field seeks to expand the availability of capital beyond grant funding for strategies that improve person-based outcomes. This shift toward “outcomes-based financing” aims to help coordinate the financial interests of multiple stakeholders into integrated interventions that focus on the whole person, recognizing that “[o]utcomes arise from complex interactions that can never be under the control of any one organization.” Businesses can participate in these efforts by providing grants and capital for loans that generate a return while producing an outcome.

### **Place: Fostering Investment in Low-Income Neighborhoods**

Increasing investment and resources in a specific neighborhood generally includes improvements to the built environment or the physical structures and amenities present within a community, and involves real estate development projects—such as affordable housing, health clinics, charter schools, or community centers—that are designed to serve people with low incomes. Funding for these projects is scarce and requires community developers to form diverse partnerships across the public, private, and nonprofit sectors. The project developer, often a nonprofit CDC, works with a financial institution, typically a CDFI, to layer multiple sources of debt and equity financing into a single structure known as the “capital stack” ([Figure 4.4](#)). Each layer in the stack reflects a different type of capital that assumes a different level of risk and return. As a helpful conceptual framework, the capital stack lays out how different partners with different incentives and levels of risk tolerance can be brought into a shared purpose, ultimately for the benefit of low-income communities. CDFIs often pool capital from a range of partners into a single loan fund that invests in multiple projects, “providing the nimble,

patient [i.e., long-term] financing” that is especially crucial in the early stages of development ([Box 4.4](#)).

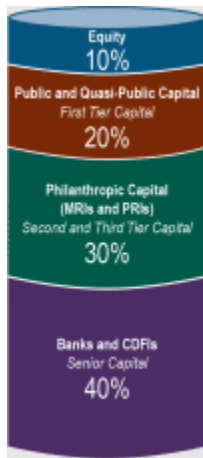


**Figure 4.4**

Example of a capital stack. *Notes:* This example of a capital stack depicts the totality of capital invested in a project. The most risk is at the top, and the least risk is at the bottom, with higher positions in the stack expecting higher returns. *CDFIs* ([more...](#))

Investing to ensure an adequate supply of quality affordable homes in residential neighborhoods with access to businesses and employment is critical to building healthy and well employees, families, and communities. Historically, businesses and residential neighborhoods have developed in tandem, simply because employers need access to a stable labor pool, and workers need access to their jobsites. When the local housing market changes and employees can no longer afford to live near employers, both the community and the businesses suffer ([Box 4.5](#)).

#### **BOX 4.4EXAMPLES OF CAPITAL POOLING**

- **Local Initiatives Support Corporation (LISC)** partnered with Morgan Stanley and The Kresge Foundation to create the \$200-million Healthy Futures Fund (HFF). The Fund supports financing of community health centers and affordable housing in underserved areas. HFF combines tax credit equity, loan guarantees, debt, and grants into a single fund that finances a variety of projects. So Others Might Eat (SOME), a nonprofit community development corporation, accessed funds from HFF to develop the Conway Center in Washington, DC, which serves formerly homeless families with affordable housing, a health center, and job training—all adjacent to a transit station.
- **Enterprise Community Partners** worked with a range of public, private, and philanthropic partners to launch the Denver Regional Transit-Oriented Development Fund. The fund provides financing to create and preserve affordable housing along transit corridors in the Denver area, helping to ensure

that residents with lower incomes have access to transit for employment opportunities across the region. To date, the fund has made 16 loans, which have created or preserved more than 1,300 affordable apartments, a new public library, and more than 100,000 square feet of commercial and nonprofit space—all near public transit.

- **Public transit and family-friendly communal spaces**, such as libraries, are essential ingredients of thriving, high-opportunity neighborhoods that foster economic mobility.
- **Partnership for the Bay's Future: A High-Impact Model for Investment** (see Exemplar).

#### **BOX 4.5 IMPACT OF HIGH COST OF HOUSING ON BUSINESSES AND EMPLOYEES**

In a survey of employers in the Greater Boston area, nearly half of the respondents said they had failed to recruit or retain employees because of the high cost of local housing. About 40% said they had to increase salaries or benefits to account for rising housing costs.

In another survey of employers, nearly three-quarters of 14 major employers representing 200,000 jobs in Los Angeles affirmed that they face challenges retaining workers because of high housing costs, and most employers said that more than one-quarter of their workers faced one-way commutes of at least 45 minutes. These employers cited certain categories of employees—including single-earner families, part-time and lower wage workers, and those planning to buy a home—as being particularly vulnerable to the lack of quality affordable homes in the local housing market.

This presents an opportunity for local companies. A variety of businesses can step into this breach by investing in their own neighborhoods to tackle specific housing and health priorities that affect their communities. To facilitate these investments, emerging creative funding models layer public and philanthropic dollars with for-profit and mission-driven investments at various rates of return. Fine-tuning a fund's capital stack ([Figure 4.4](#)) enables local companies to attract more capital and to deploy those resources in ways that adjust flexibly to current needs.

#### **A Caution: Improving Neighborhoods While Preserving Affordability**

Investing in or adding amenities to historically disinvested neighborhoods can offer valuable benefits to residents. Improvements, however, raise the risk of gentrification, a process of neighborhood change that includes economic shifts, such as real estate investment and new residents with higher incomes moving in, as well as demographic shifts, such as changes in the racial composition and education level of residents. Gentrification results in the involuntary displacement of long-time residents, particularly people with low incomes and people of color, who cannot afford to stay and do not

benefit from new investments into the area. The newly developed “606” recreational trail in Chicago is an example. Here, a historically low-income neighborhood sits on the west side of the trail, but within 3 years of breaking ground on the linear park, home prices in the neighborhood increased 48%, more than double the rate for the entire city. Local community development groups, such as Latin United Community Housing Association, are responding to the housing market pressures by working with partners to add to the stock of new affordable housing units and advocating for city ordinances to increase funding for affordable housing.

The availability of affordable housing is critical to preventing displacement. The community development field is deeply engaged in affordable housing strategies to address displacement through an approach widely referred to as the “Three P’s”:

- **Protection** for current tenants, such as policies related to rent control and evictions;
- **Preservation** of existing affordable units (e.g., a nonprofit could acquire and rehabilitate an older apartment building to take it off the speculative market and keep rents permanently affordable); and
- **Production** of new affordable units, such as a new LIHTC development that would add rent-restricted affordable units to the existing stock of housing.

Preventing displacement due to gentrification requires proactive policies, innovative development practices, and deep community engagement and empowerment. Community partners need to plan and take preventive measures to preserve affordability well before gentrification begins.

Early strategies for promoting affordability can include coalition building, community land trusts, and inclusionary zoning policies. Such strategies as employer-assisted housing programs and affordable housing trust funds can also help communities in later stages of gentrification. Groups like EBALDC also provide a model for community development that aims to ensure affordable housing while preventing displacement.

## Looking to the Future

From its origins in the federal *War on Poverty* in the 1960s, to its modern multisector networked approach, the community development field has evolved as a mature industry that is highly skilled in connecting low-income communities to the capital and resources necessary for expanding economic opportunities. However, despite the sizeable investments that flow through public and private channels, the current scale of the field is not sufficient to address the many complex causes of poverty and the negative impacts on health, wealth, and well-being.

Addressing poverty is in the direct interest of many more stakeholders beyond community development, including government, businesses and business owners, educators, and healthcare providers and payers. The challenges ahead require

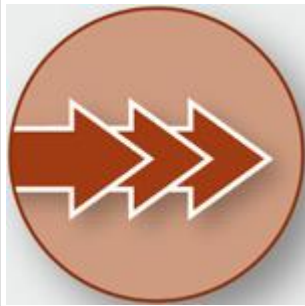
rigorously pursuing a new business model that more closely aligns the financial interests of those who stand to benefit from a healthier, more productive population with the capacities of those who create the conditions that promote human flourishing. A wide range of actors across all sectors must be committed to increasing the productive capacity of every person in the United States—that begins with robust and strategic investments in community health and economic prosperity. Our shared future as a nation depends on it.

## APPENDIX A TOOLS AND RESOURCES

[Appendix A](#) identifies tools and resources addressing topics explored in [Chapter 4](#). The tools and resources were created by such businesses and organizations as Bank of America, The Brookings Institution, Opportunity Finance Network, U.S. Department of the Treasury, and others.

### REINVESTMENT FUND: A CDFI Uses Data to Expand Food Retail in Ohio

|                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|-------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|   | <p><b>Community Challenge</b>   Despite gains over the past decade, limited access to healthy food continues to affect residents of urban and rural communities across the United States. Reinvestment Fund’s Limited Supermarket Access (LSA) analysis estimates that 17.6 million people live in communities without easy access to healthy, nutritious food options. This analysis goes beyond simply identifying areas with limited access; it also measures the extent to which LSA areas can support new or expanded food retail.</p>                                                                                                                                                                                                                                                                                               |
|  | <p><b>Scenario</b>   Dayton, Ohio, ranks in the worst quartile of cities in the nation for rates of food hardship in households with children. The Salem Avenue corridor in Dayton is an LSA area with limited healthy food access. Approximately one-third of households in this area receive benefits from the Supplemental Nutrition Assistance Program. The neighborhood has several dollar stores and only two grocery stores—neither of which serves the community adequately. Market analysis reveals that the area is “understored” with less grocery square footage than the Ohio and national averages. As a result, residents spend their grocery dollars in pharmacies, convenience stores, and dollar stores in the local area, or they are travelling to suburban areas to shop at larger stores, like Aldi and Meijer.</p> |



**Action Taken** | Since 2015, members of the Dayton community have worked to improve local access to food. They started with a community needs assessment, which resulted in a steering committee led by community residents. Thanks to their work, the community is opening a worker- and member-owned grocery store. The Gem City Market will be a full-service store focusing on affordable products and will also include a teaching kitchen, space for nutrition classes and wellness programming, a mini-clinic, cafe, and community room. The project brings together Greater Dayton Union Cooperative Initiative; Miami Valley Community Action Partnership, a long-standing nonprofit in the region; and Greater Dayton Premier Management, an arm of the Dayton city government. Reinvestment Fund, along with Dayton Regional New Markets Tax Credit Fund and PNC Bank, are providing financing for the project.

The store will be open to everyone; shoppers do not need to have a membership. The cooperative is designed to serve its community with traditional grocery products; discounted pricing for consumer-owners with lower incomes; and an employee equity program. Residents with low incomes can become consumer-owners at discounted rates. More than 2,400 Daytonians have already purchased memberships. Gem City Market will also be owned by its employees, improving the (a) quality of the work above industry standards and (b) outcomes for the store by educating employees in business finance and operations and giving them an equity stake.



**Key Takeaway** | Aside from data, community need and support are critical to driving investment and developing viable solutions. Although business engagement can be critical to success, sometimes the solution is just creating a business.

## Footnotes

1

Except where otherwise noted, figures on CDFI Fund activities are based on CDFI Fund's 2018 annual report and on financial audits for fiscal years 2017 and 2018, using internal data from the Office of Inspector General.

## **CHAPTER 5Working With Community Changemakers**

### **OVERVIEW**

This chapter introduces four community changemakers with which businesses can partner to improve community health, wealth, and well-being. Stories describe effective partnerships and unique ways that businesses can create healthier, stronger communities. Examples in this chapter show how partnerships with businesses can solve both business and community problems and create opportunities for business in communities.

### **KEY TAKEAWAYS**



In addition to community development actors, businesses that would like to invest in or engage with their communities might also collaborate with social enterprises, public health departments, foundations and philanthropies, and anchor institutions.



Social enterprises are in the business of knowing communities and effecting change to make them stable and help them thrive, all while operating a successful company.



Public health departments collaborate with a variety of organizations to meet shared goals and address the vital conditions that shape health. These departments can be creative, dependable, and effective partners of businesses.



Foundations and philanthropies are critical partners at the local, regional, and national levels. These entities bring rich community knowledge, long-standing relationships, and a range of resources, including investment resources, to achieve shared goals.



Anchor institutions are place-based economic engines with an embedded social mission inextricably linked to the long-term, well-being of the surrounding communities. Businesses can join with—or become—anchor institutions as they work to increase local hiring and procurement and support equitable economic development.

### **Introduction**



Businesses seeking to invest in or engage with their communities may join with many partner organizations that are already working to improve community health and increase economic prosperity. As described previously, actors within the community development field, including community development financial institutions (CDFIs) and community development corporations, are proven partners for capital and service investments to improve the vital conditions that shape health, wealth, and well-being. This chapter briefly introduces four additional partners, with complementary strengths and skills.

- **Social enterprises** are companies with socially driven missions that have discovered ways to align their profits with improving health, wealth, and well-being. These businesses meet a need in the community, such as preventing evictions and providing jobs, and meet the business imperative of being profitable.
- **Public health agencies** provide critical services and infrastructure to protect and improve the health of people in communities. Partnerships between public health departments and local businesses address such issues as healthy behaviors, worker safety, food and nutrition, neighborhood livability, and criminal justice reform. Public health departments can serve as chief health strategists in their communities.
- **Foundations and philanthropies** harness the power of wealth to tackle entrenched health and social problems. Business and foundation/philanthropic partnerships can spread prosperity and opportunity in struggling communities through programs, grants, and capital investments.
- **Anchor institutions** are economic engines that power sustainability and long-term well-being in their communities. Businesses can partner with—or become—anchor institutions to strengthen and expand an inclusive local economy. Hospitals and universities are prime examples of anchor institutions that leverage their own assets to create economic opportunities for individuals, businesses, and communities.

## **Social Enterprises**

Many factors combine to make a business successful: a company's strong, competitive products and services; market demand; a compelling brand and reputation; and well-trained staff and able leadership. Providing investments and services that make people and communities healthy, vibrant, strong, and resilient generally is viewed as a job for others and not part of a company's core work. But an array of enterprises *are* in that business, including social enterprises. Companies can partner with social enterprises, whose core business is knowing communities and effecting change to make them stable and help them thrive, all while operating a successful business. Social enterprises are a hybrid of sorts; they

- Are mission driven with an identified social issue they have set out to address,
- Are commercial businesses (either nonprofit or for-profit) invested in addressing that issue,
- Balance their goals of achieving societal impacts within the requirements of the market, and
- Can be effective partners for businesses that similarly want both social and financial returns on their investments.

This approach has been termed “impact investing.”

Companies in the “business of doing good” are forging innovative partnerships with other businesses to create positive results for all parties, recognizing that health and prosperity are inextricably linked for both business and communities. Two examples describe how business and community organizations can partner to meet their goals for mutual benefit.

### **A Real Estate Company and a Nonprofit Organization Build a Partnership**

Beacon Communities, a privately owned real estate firm (<https://www.beaconcommunitiesllc.com/>), develops, invests in, owns, and manages multifamily housing properties, approximately 22,000 apartments—including affordable-, market rate-, and mixed income-housing—in the Northeast and Mid-Atlantic regions of the United States.

Beacon Communities’ renters are primarily people and families with lower incomes. A review of evictions for nonpayment of rent found above-average eviction rates in some of Beacon Communities’ developments. Evictions were bad for Beacon Communities’ business. Costs included lost income through vacancies, legal expenses tied to the eviction process, and negative effects on the morale of property managers charged with evicting families. Evictions were also bad for Beacon Communities’ goal of contributing to building stable communities for their residents. Beacon Communities reduced its eviction rate when it began working with HomeStart.

HomeStart, a nonprofit organization (<https://www.homestart.org/>), works to end homelessness in the Greater Boston, Massachusetts, area by helping individuals obtain housing and settle into the community. HomeStart observed that evictions for nonpayment are a primary driver of homelessness and that eviction is associated with a cascade of long-term consequences. Once evicted, a family’s credit is ruined, they lose their possessions, they plunge into debt, their employment becomes unstable, and family cohesion often dissolves.

HomeStart was historically a U.S. Department of Housing and Urban Development (HUD)-supported program to assist people experiencing homelessness in their search for housing. Frequently, people came to HomeStart with an eviction notice, seeking help

with a housing search. HomeStart endeavors to prevent homelessness before it starts, so the organization began to test a new program. HomeStart would meet a family appearing in housing court for nonpayment of rent, and make a small payment to the property owner to prevent the eviction and buy time. Then HomeStart would work with the family to identify the causes of the eviction notice, help the family repay any debt, and develop a plan to cover the family's rent. After 12 months, 97% of the families supported through this process by HomeStart could maintain housing on their own.

Because of HomeStart's assistance, (a) families could avoid the long-term consequences of eviction; (b) housing owners could avoid costly evictions; and (c) employers could retain stable employees.

To quantify the impact of its efforts, HomeStart worked with the Boston Housing Authority (BHA) (<http://www.bostonhousing.org/en/Home.aspx>) to establish the costs of evicting a family and evaluate the efficacy of its program. The analysis was compelling: BHA's cost to evict a family was about \$10,000, but HomeStart's cost was only \$2,000 to prevent the eviction. HomeStart and BHA tracked 300 households that HomeStart had supported. After 48 months, only 5% of those families had been evicted for nonpayment. Based on these positive long-term social and financial results, HomeStart created the first-ever per-intervention reimbursement rate contract with BHA. BHA now pays HomeStart to *prevent* families from being evicted, which saves the city the costs of eviction and provides a lifeline to struggling families. HomeStart receives 75% of the payment upfront for each household supported and the remaining 25% at the end of 12 months, if families remain stably housed. Through this partnership, HomeStart helps BHA mitigate the government's financial risk and negative social outcomes, and in 2017 alone, saved BHA more than \$1,000,000 in eviction-related costs.

Based on HomeStart's experience with BHA, Beacon Communities, the private firm trying to stem evictions, quickly agreed to HomeStart's reimbursement rates and began a partnership to reduce evictions. Beacon Communities' evictions have been dropping ever since, and Beacon Communities has initiated conversations to roll out the HomeStart partnership to other properties, reaching thousands of individuals and families.

*"Our partnership with HomeStart is changing the trajectory of the lives of our residents while simultaneously reducing the number of families that experience homelessness. The value of this partnership goes beyond dollars and cents; it is change management at its core. It is the right thing to do, and the successful outcomes underscore the importance of this program."*

—Dara Kovel, CEO, Beacon Communities

Beacon Communities' partnership with HomeStart is an example of marrying good business with community impact—for all residents and property managers—and serves as a model of how private industry can accelerate a positive, social impact.

## **Corporations, Investors, and a Nonprofit Social Enterprise Do Business Together**

In 2018, First Step Staffing (FSS) (<https://firststepstaffing.com/>) expanded operations from its Atlanta, Georgia, home to Philadelphia, Pennsylvania, replicating a successful model of purchasing a for-profit staffing agency and converting it into a workforce social enterprise—that is, an organization that helps people overcome barriers to employment and find and succeed in jobs. In its first year in Philadelphia, FSS retained 100% of the prior for-profit agency's corporate clients and added 14 new clients.

FSS provides employment services for people transitioning from homelessness, including veterans, formerly incarcerated individuals, and others with barriers to employment. As an alternative staffing agency, FSS places men and women into temporary and temp-to-hire positions with local businesses, and provides supports, including job coaching and transportation to and from work, to make its employees successful. As a nonprofit social enterprise, FSS offers the support services at no additional cost to corporate clients. Rather, the organization reinvests the profits from the staffing agency into these services and obtains additional grant funding to cover the costs.

FSS serves both the business client that is paying for reliable and well-supported staff and the staff who are reentering the workforce and need support to succeed in the workplace and address other challenges, such as unstable housing, health issues, a criminal record, or other obstacles to employment. FSS makes several promises to its business clients:

- Guaranteed on-time employees by providing transportation when needed and incentives for employees who consistently come to work on time and prepared;
- Skills-matching, specialized training, life coaching, and extended job training hours for employees; and
- Competitive pricing with all profits reinvested in the program, services, and people.

FSS also makes the case that working with people transitioning out of homelessness is beneficial to the entire community and local economy. FSS (a) helps people achieve the first step toward economic self-sufficiency and earning power sufficient to maintain stable housing; (b) pays wages to workers whose purchasing power will in turn support local businesses; and (c) potentially reduces the need for costly government services, creates employees who may become tax payers, and supports making the community a more attractive place for new business and investments.

Besides being a client of FSS staffing services, a business can invest in FSS through debt and philanthropic equity. For example, Nonprofit Finance Fund, a New York-based national CDFI, provided loans to support FSS' expansion into Philadelphia. Additional investments and resources came from other CDFIs, philanthropy, the City of

Philadelphia, and social investment funds. Opportunities for other businesses and individuals to invest will continue as FSS expands to other cities, as it recently did to Los Angeles, California.

## **How Businesses Find Partners**

Business partnerships with community organizations are good business. But how do businesses identify community partners and make collaborative arrangements? Various paths exist. Some partnerships come from a business's deep knowledge of the local community and its relationships there. Others can be identified through such resources as the Build Healthy Places Network's Partner Finder tool

(<http://www.buildhealthyplaces.org/partners/>). This tool contains directories of many national networks of community development organizations, including the National Alliance of Community Economic Development Associations, the National Association of Latino Community Asset Builder, the National Coalition for Asian Pacific American Community Development, NeighborWorks America, and Opportunity Finance Network. The Democracy Collaborative also has an informative toolkit

(<https://hospitaltoolkits.org/investment/>) for place-based investing. Although the toolkit focuses on healthcare partnerships, it provides several resources that are relevant to all types of businesses. Businesses that invest in people and communities will reap both social and financial rewards most readily when they invest in partnerships with community organizations and social enterprises whose businesses *are* the social good.

## **Public Health**

Collaborations often form when problems are complex, affect multiple stakeholders, and require shared, sometimes risky solutions. Individual organizations may not know where to start, may chip away at the edges of a larger structural problem, or may turn to other mitigation strategies (like relocation) that leave the problem either unaddressed or worse than before. Taking effective action to address longstanding and complex social problems requires multiple partners with a variety of perspectives and a host of tools, strategies, and know-how to drive solutions. Loose collaborations that share a clear vision and can operationalize a plan, with each partner contributing to the whole based on their specific strengths, connections, and opportunities, may be the most efficient approach. Such successful collaborations deploy an asset-based approach where community partners contribute their own micro assets to achieve macro solutions that are coordinated and more effective than the component parts. Public health departments are often at the heart of these community collaborations.

Public health departments collaborate with a variety of organizations to meet shared goals and address the conditions that shape health. They can be creative, dependable, and effective partners of businesses seeking to improve the health of employees (including future employees), families, and communities. Companies seeking to engage their communities and take actions to improve community health, wealth, and well-being can look to their local public health departments as effective partners.

As a part of city, county, or state governments, public health departments are tasked with an enormous responsibility: protecting the health of the people they serve. They do this by collecting and analyzing data to understand the health threats to a population and where diseases occur in a community. They provide tools and resources and broadcast critical messages to the public that help communities take precautions against a wide range of infectious diseases such as coronavirus, measles, influenza, HIV, and viral hepatitis. Public health departments also collaborate with the communities they serve to develop strategies for preventing and managing chronic conditions; adopting healthy behaviors; and even preparing for weather emergencies, such as hurricanes, tornados, and snowstorms.

Staff of public health departments are well aware of the vital conditions that contribute to favorable health outcomes and have long worked to increase access to community and clinical preventive services. Examples of community preventive services include smokefree air policies, active transportation, and supportive housing; and examples of clinical preventive services include immunizations, cancer screenings, and management of diabetes and hypertension. In addition to providing this technical expertise, public health departments often are well integrated into and respected by the community. In fact, one of the roles of the public health department in the 21st century is to be the chief health strategist of a community, joining with and at times leading community members and stakeholders to solve critical community problems.

Delivering on that role may be a challenge for health departments facing budget constraints, inability to hire critical talent, and the weight of bureaucratic demands. However, when public health departments successfully address community problems and improve community health, it is often because of strong leadership, a creative and talented workforce, essential infrastructure to meet community needs, and strategic partnerships with businesses and other community organizations, including healthcare delivery and academic institutions. The tools used to protect the public's health are also used by businesses, such as robust data analytic capabilities and clear metrics to monitor progress. Flexible and sustained funding and a talented workforce are necessities to support effective public health initiatives. In short, the kinds of supports that foster success for health departments are familiar to every organization or business tackling high-stakes projects.

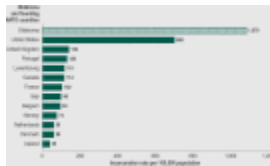
The following example from Oklahoma City, Oklahoma, highlights how public health departments and business leaders worked alongside mission-driven nonprofit organizations to address a complex community problem of critical importance to all.

### **Criminal Justice Reform in Oklahoma City**

The Oklahoma City County Health Department is recognized by peers and colleagues across the state as a “go-to” leader and partner to help solve a range of community challenges. The health department's multi-agency data sharing framework provides a holistic understanding of a range of community issues, and its collective impact model

to better serve the community's most needy citizens had already caught the attention of area business leaders. When concern developed in the business community about overcrowding at the Oklahoma County Jail, attendant health and safety issues, and potential federal intervention, the local chamber of commerce approached the challenge as a business problem to solve, and the local health department brought its resources and expertise to bear on finding a solution.

Criminal justice reform may not seem like the obvious challenge to bring together business and health leaders. However, leaders in the business community were concerned about the image of having the highest incarceration rate in the nation ([Figure 5.1](#)) created for the city, as well as the moral issues around maintaining an overcrowded jail. For its part, the public health department was concerned about getting residents with mental health or substance use conditions into treatment (rather than jail), keeping families intact, and preventing seemingly modest violations, like a broken taillight, from derailing employment and landing a family in poverty.



**[Figure 5.1](#)**

Incarceration rates in Oklahoma and founding NATO countries.

Incarceration negatively affects the broader labor market by creating barriers to current and future employment, and is associated with high rates of death from drug overdose, lower median household incomes, and poor health outcomes. Incarceration also has long-term implications for families and children; even a few days in jail can result in the loss of a job, disrupt childcare arrangements, and affect school attendance and performance. In addition, children of incarcerated parents are six times more likely to become incarcerated themselves.

For businesses in Oklahoma City, cycling thousands of city and county residents through the jail was a workforce issue. For community members, the overcrowded jail reflected poorly on the city and county they called home and did not align with the future they were trying to build. Oklahoma City leaders recognized the business, community, and social dimensions at stake and the health, wealth, and well-being implications for the city and county.

Understanding why so many people were in jail in the first place led business, community, and health leaders to see the problems at the jail as a community-wide issue and both a symptom of and contributor to community concerns like workforce, education, safety, quality of life, civil rights, and justice. Although criminal justice issues are not typically considered health or business issues, business, health, and community leaders could see the connections between (a) pathways to jail, jail overcrowding, and

disparities in treatment at the jail and (b) community health, wealth, and well-being and the potential to thrive. As business leaders weighed in on the levels of incarceration, other concerns became evident. H. E. “Gene” Rainbolt, founder of BancFirst said, “We’re running a felony factory. It requires so much state appropriation it takes money away from things that really make a difference such as education, mental health, rehabilitation, and family structure.”

The Greater Oklahoma City Chamber of Commerce convened the Oklahoma County Criminal Justice Reform Task Force and brought in the Vera Institute of Justice to help assess the problem. Findings from the analysis opened the community’s eyes to solutions beyond increasing jail capacity. For example, many incarcerated individuals would be better served, at lower cost, by other city and county programs; and most people in jail had not yet been found guilty of a crime. They were in the pretrial phase and unable to post bail. With a better understanding of how the justice system worked (or did not work) in Oklahoma City and County, community stakeholders, under the chamber’s leadership, turned their attention to reform. They worked with elected leaders; business, health, and education leaders; judges, prosecutors, and attorneys; law enforcement officials; and the public to change practices from the point of citing someone for a violation through jail admission and the court process. Judges started assessing offenders’ abilities to pay before imposing bail and fines. Law enforcement officers were offered alternatives to arresting low-level offenders. State laws were changed so that law enforcement and justice professionals could work with mental health professionals to provide alternatives to jail for those with mental health disorders. Within 14 months, the jail’s population had declined by one-third. By 2017, the number of people in jail fell below 2,000 for the first time in years. Studies suggest community members will be safer and healthier as a result, and crime rates trended down from historical highs in 2008 to 2010 and leveled off through 2017.

With local businesses and the public health department working together, along with other partners, under the auspices of the Greater Oklahoma City Chamber of Commerce, the City and County were able to address a real and perceived blight to the city’s image and the future it wants to create, in a way that builds value for people and place and increases opportunity for greater community health, wealth, and well-being.

### **A Promising Partnership**

While collaboration can be challenging and time-consuming, addressing entrenched community problems requires cooperation among stakeholders who may have limited experience working together and, in some cases, may represent competing interests. Including a range of stakeholders, however, brings more assets and greater “buy-in” to address the problem in the first place and to implement the identified solution in a sustainable manner. Public health departments, given their interdisciplinary nature and their broad mandate of protecting the public’s health, are a flexible and effective partner for businesses. With expertise in population health and health promotion, trusted



relationships with the community and community organizations; knowledge of pathways to make policy- and system-level improvements; and expertise in data collection, analytics, and interpretation, public health departments can bring rich resources to the table.

Strengthening the vital conditions that produce health is a shared responsibility. Forming local collaborations and alliances that bring in the leadership, assets, financial resources, strategic thinking, and know-how from multiple entities and organizations in the public, private and nonprofit sectors is necessary to improve community health and increase economic prosperity.

With expertise in population health and health promotion, trusted relationships with the community and community organizations; knowledge of pathways to make policy- and system-level improvements; and expertise in data collection, analytics, and interpretation, public health departments can bring rich resources to the table.

## **Philanthropy**

Partnerships across sectors, including public, private, and nonprofit sectors, have traditionally been viewed as reserved for large capital campaigns (as described in [Chapter 4](#)). However, with increasing frequency, communities turn to these partnerships, on behalf of a variety of issues—including health, poverty, and child development—and do so in ways that advance community health, wealth, and well-being. Foundations and philanthropies can be critical additions to these partnerships. Whether operating at the local, regional, or national levels, foundations and philanthropies are often effective partners that increase impact, contribute innovative strategies, and help align investments. They can bring rich community knowledge, long-standing relationships, and a range of resources, including investment resources, to the table to achieve shared goals.

*“Successful companies are asking themselves not whether charity donations would build their reputation but how they can make a lasting difference in the world.”*

—[Waterford.org](http://Waterford.org)

Working with foundations and philanthropies, as with any partnership, takes a commitment and can be challenging, even for business partners. Each foundation works differently and has its own set of guidelines and funding priorities. Expectations for open communication, follow through, and strategy alignment can become mired in stifling processes that slow progress. Successful partnerships with philanthropy require leaders who are aligned with each other, understand their shared goals, and have a clear understanding of how the assembled organizations can work together.

When aligned and focused on impact, philanthropies, like businesses and nonprofit organizations, invest to achieve efficient, effective actions that address societal problems and achieve shared goals. Indeed, partnerships and collaborations make

success more likely. Philanthropies bring resources to the table, including funding, flexibility, adaptability, skills and experience, particular expertise (such as working with media) and high expectations. Additionally, philanthropies often have powerful networks and connections with donors, elected representatives, and community leaders that can contribute to the success of an investment.

Philanthropies operate in three ways to pursue goals and create value for the purpose of furthering a social change agenda aimed at improving communities:

1. **Organization funders** seek to nurture and drive additional funding toward specific grantee organizations that have high-performing leaders and can execute on business and philanthropic investments.
2. **Field builders** seek to grow community capacity to address community problems and focus on making that capacity resilient, sustainable, and effective.
3. **Goal aligners** are more loosely collaborative, identifying strategic overlap among philanthropic, corporate, and governmental goals and seeking to coordinate grants and investments that foster consistent progress toward an overarching goal.

Understanding which of these purposes the partnership is engaged in is essential to working effectively together, as is being clear about the value each partner brings to the table and expects to produce as a result of the partnership.

Effective partnerships and collaborations, especially in the service of complex community projects, almost always require a backbone organization to help maintain focus and provide essential convening functions, such as strategy sessions, administrative and office support, and fundraising for community programming. Overhead is essential to maintaining these kinds of routine but critical supports for community change efforts. When grantwriting to foundations or inviting foundations to the table, asking for 15–25% overhead on program grants can help to fund the administrative and office supports required to get these efforts off the ground and functioning well. Alternatively, businesses and philanthropies might step forward to serve in the backbone role or provide funding or offer space, staff, resources, and knowledge to ensure the backbone functions are delivered.

### **The Collaborative Model**

Collaborative philanthropy, also known as impact philanthropy ([Box 5.1](#)), involves working together with other funders, businesses, nonprofit organizations, and even investors to accomplish what none of the entities might be able to accomplish on their own. By pooling together financial, technical, and knowledge resources; time; and staff, these collaborations can chart a path to solve thorny societal problems. Especially when social initiatives are embedded in a foundation's or company's long-term strategy and

core operations, the organization's success may depend on the value the collaboration is able to deliver to society.

Value for businesses that engage in philanthropic collaborations can include improved employee morale, enhanced brand loyalty, expanded product reach, and financial returns on business investments, especially if the problem is addressed by way of a profitable venture. Philanthropies and nonprofit organizations accrue value as well, including greater resources for social innovation, mission fulfillment, strengthened reputation, and even strategic enhancements gleaned from business partners. For all collaborators, the achievement of the sought-after community improvement is the major value.

### **BOX 5.1 THE COLLABORATIVE MODEL IN ACTION**

"Blue Meridian Partners [<https://www.emcf.org/our-strategies/blue-meridian-partners/>], launched in 2016, has raised more than \$1.7 billion in investment capital from 14 funding partners and has approved a total of \$350 million for its first nine recipients. 'We are trying to identify the most promising strategies, with an evidence base, that can potentially move the needle for the most disadvantaged kids in poverty in the United States,' said Nancy Roob, president and CEO [chief executive officer] of the Edna McConnell Clark Foundation and Blue Meridian Partners' founding CEO. 'We seek out leaders who have a vision for solving a national problem and help them achieve that goal by reaching the national scale required. So we measure our progress on whether or not our investments help leaders achieve that objective. And each one is different.' Blue Meridian Partners grantees work to create large-scale change in a range of fields—including healthcare, child welfare, and criminal justice."

"The core funder value proposition ... includes surfacing promising investment opportunities, conducting due diligence, and, in many cases, building grantee capacity and monitoring grantee performance. Blue Meridian Partners, for example, supports its grantees to develop detailed scaling plans and uses these plans as a way to measure progress. George Pavlov, who directs philanthropic giving for the Sergey Brin Family Foundation and participates as a general partner in Blue Meridian Partners, explained that there is 'no way we could build the same capability for our share of the annual expenses. [Being part of this collaborative] gives us best-in-class capabilities and flexibility'."

Financial investments are a critical part of collaborative philanthropy ([Box 5.2](#)), but much more than grantmaking and gift-giving is required to achieve the desired impact (also see [Chapter 3](#)). Thus, while collaborative philanthropy demands more of the collaborators—more than just money—it is the collaboration among participants that helps to ensure the additional contributions of time, knowledge, strategic thinking, accountability, and support are spread across the participants who can remain focused on their main priority of running a business (corporate, philanthropic, nonprofit, or otherwise).

## **BOX 5.2 REJUVENATION OF THE HIGHLANDER NEIGHBORHOOD: A PHILANTHROPY-LED PARTNERSHIP**

Highlander neighborhood is situated on 34-acres just north of downtown Omaha, Nebraska. The neighborhood, a former public housing site, consistently experienced the highest rates of crime in the state. The local housing authority partnered with Seventy Five North to redevelop the area into a mixed-income neighborhood, tying it to the turnaround of nearby Howard Kennedy Elementary School. Seventy Five North is a nonprofit organization established by The Sherwood Foundation, an Omaha-based private foundation, for the purpose of redeveloping the neighborhood. Highlander neighborhood is bordered by a local federally qualified health center and the Urban League of Nebraska, setting the stage for a rich collaboration to strengthen the neighborhood.

An award-winning community accelerator forms the heart of the revitalized Highlander neighborhood. Community accelerators are convening places for people and organizations to find project support, build networks, and develop collaborations. The accelerator hosts several amenities for residents and surrounding neighborhoods. The local private college and the community college hold courses, from basic literacy to computer science, at the accelerator. A technology center gives students and residents access to wi-fi and shared working space.

During the summer months, the Highlander neighborhood is filled with public markets, movie nights, and weddings at the event hall. Three restaurants and a bar have also opened. As a result of the evident progress, the U.S. Department of Housing and Urban Development awarded Seventy Five North and the City of Omaha a \$25 million Choice Neighborhood Implementation Grant to redevelop another public housing site nearby. To date, the local philanthropic partners have committed more than \$35 million to these associated redevelopment efforts, adding their funding to government funding to help produce the best possible outcomes. In addition to the capital expenses, foundation support includes program grants to a variety of local nonprofit organizations that focus on food security, education, child welfare, financial wellbeing, arts, health, and mental health.

Omaha's corporate community contributed time, expertise, and financial resources to redevelop the Highlander neighborhood. For example, a local restaurateur advised on the design and management of the restaurants at the accelerator; a senior vice president from a local business served on the board of directors of Seventy Five North; and an area developer assisted with contract negotiations for the project.

Although many foundations and philanthropies were established by business leaders, corporate philanthropy is a subset of philanthropy overall. Corporate philanthropy continues to evolve as the practice becomes more focused, more outcomes-oriented, more specifically aligned with business strategies and goals, and more deeply integrated into business operations. As part of this evolution, businesses are responding

to the demands of customers while employees and shareholders are (a) seeking a competitive advantage, greater reach, and richer brand loyalty and (b) recognizing the need to share the benefits of the company—the value created—with the communities they call home or service. The rich partnerships forged through collaborative philanthropy can create success in each of these areas, for all collaborators. Philanthropy is almost always an exceptional partner when contemplating efforts to help a community thrive, to increase economic opportunity, and to unleash human potential.

## **Anchor Institutions**

Healthcare systems and educational institutions are some of the largest employers in many states and regions of the United States. These businesses spend more than \$1 trillion a year on employees and goods and services, have endowments in excess of \$750 billion, and employ 8% of the U.S. labor force. These businesses have significant effects on local economies and are powerfully positioned to improve the health and economic ecosystems of the communities in which they reside.

Anchor institutions are place-based economic engines with an embedded social mission that is inextricably linked to the long-term well-being of their surrounding communities. They can be public, private, or nonprofit businesses and employers. Hospitals and universities are leading examples of anchor institutions and can play critical roles in strengthening the communities they serve by better aligning institutional resources with the needs of those communities.

An anchor mission framework is a systems approach whereby institutions use their resources—like hiring, purchasing, and investing—to intentionally improve the financial security of area residents, strengthen the local economic ecosystem by making it more economically and racially equitable, and address the community conditions that shape health. The anchor mission framework strives to build wealth for the community and meaningfully address the vital conditions of health in a community.

For example, the University of Massachusetts Memorial Health Care (UMMHC) is an anchor institution that implements the anchor mission framework. In 2017, executives at UMMHC noted the significant toll of poor social and economic conditions on community health outcomes.

UMMHC embraced the anchor framework to tackle poverty and unemployment, poor housing, lack of access to care, food insecurity, safety and violence, and other problems. After thoroughly assessing the impact of adopting and implementing the anchor mission framework, UMMHC's board of directors voted to proceed with several anchor mission strategies:

- Allocate 1% of its investment portfolio to targeted community investments with an expected return;

- Provide targeted technical training for entry-level positions for current and prospective employees;
- Intentionally recruit trainees from targeted neighborhoods; and
- Build an effective system for local purchasing.

With these strategies for anchor institutions in place, UMMHC implements best practices for sustained community impact.

The following section explore several strategies for anchor institutions and include examples from healthcare, higher education, and other businesses.

### **Inclusive Local Sourcing**

To increase the income and economic health of local neighborhoods, anchor institutions seek to do more business with local businesses. Hospital systems nationwide spend \$472 billion on goods and services annually, and institutions of higher education spend more than \$43 billion annually on goods and services. Shifting even a small fraction of this spending to local, minority-owned, women-owned, or employee-owned businesses is a powerful way to improve community health and address racial, social, and economic inequities.

- **Cleveland Clinic**, located in Cleveland, Ohio, is increasing its procurement and construction purchasing from minority- and women-owned businesses and facilitating a mentor–protégé program to build the capacity of those businesses. Cleveland Clinic supports the Evergreen Cooperative, a network of start-up, worker-owned businesses in the community. Through this support, the Cooperative expanded the capacity of its laundry services business, creating 100 local jobs and building community wealth by allowing employees to share business ownership in the hospital’s supply chain.
- **Metropolitan State University** in Minnesota is a member of the Central Corridor Anchor Partnership, a group of education and medical institutions aggregating demand to support local suppliers in low-wealth neighborhoods along Metro Transit’s Green Line between Minneapolis and Saint Paul. The university implemented a pilot program to connect farmers in the Hmong American Farmers Association (HAFA) with the university’s catering vendors. HAFA is a cooperative in Minnesota that promotes locally produced foods. A local healthcare anchor, Fairview Health East, also has a partnership with HAFA for Community Supported Agriculture programs to increase access to healthy, affordable produce for patients at several of its clinics.
- **Virginia Commonwealth University (VCU)** is committed to diversifying its procurement supply chain as part of the Commonwealth of Virginia’s Small, Women- and Minority-owned Businesses (SWaM) Procurement Initiative. VCU solicits diverse businesses to participate in its procurement and encourages

contractors to look for opportunities to engage SWaM firms as subcontractors. To track and assess progress on the SWaM goals, VCU maintains a public dashboard that documents outreach and participation.

### **Inclusive Local Hiring**

To increase the income of neighborhood residents, anchor institutions often hire local employees and create pathways to turn entry-level jobs into careers, especially for those with barriers to employment and advancement. These are ways through which anchor institutions create economic opportunities for the communities they serve.

- **RWJBarnabas Health**, a network of independent healthcare providers in New Jersey, is a founding member of the Newark Anchor Collaborative. The collaborative seeks to grow economic opportunities and well-being in the City of Newark. For example, the Newark 2020 initiative aims to hire 2,020 additional Newark residents by 2020. By January 2020, RWJBarnabas Health had hired 466 residents of Newark, exceeding its goal of 350 hires.
- **Fairview Health Services** in Minnesota has an internal workforce development team to develop hiring pipelines and career pathways for employees, students, and community residents. Fairview Health Services has funded apprenticeships, on-the-job training, and tuition support for 4-year degrees and other credentials for 220 nurses and healthcare workers, including recruitment of women and members of minority groups. In addition, Fairview Health Services sponsors 200 paid internships and career pathways annually. As a result of the developmental work of Fairview Health Services, 43 residents have been hired through the Cedar Riverside Opportunity Center, 75 students have been hired through the Central Corridor College Fellows program, and 99% of participants in the work-learn program have been retained for work.
- **Rutgers University–Newark’s (RU–N’s)** anchor mission is one of the highest priorities of its strategic plan launched in 2014. The plan calls for RU–N to invest in kindergarten through high school, associate, bachelor, and graduate degree educational pipelines and pathways; strong, healthy, and safe neighborhoods; arts and cultural districts and initiatives; regional economic development; and science and the urban environment. RU–N has partnered with the City of Newark and other local anchor institutions, like RWJBarnabas Health, on Hire.Buy.Live.Newark initiative to reduce poverty and unemployment and strengthen the city’s economy.

### **Equitable Economic Development and Place-Based Investing**

Anchor institutions, particularly healthcare anchors, play a unique role as place-based investors—using their long-term financial reserves locally and strategically tapping underutilized assets to fill market gaps in lending and investment. By allocating a portion of their investment portfolios to projects and aligning them with other discretionary

funds, investors can combine stable returns with social impact and create long-term solutions.

- **CommonSpirit Health (legacy Dignity Health)** has an organizational policy to allocate up to 5% of its investment portfolio for low-interest loans to nonprofit organizations that are supporting community health and well-being. In 2016, CommonSpirit Health provided a \$3.1-million loan to support the construction of a transit-oriented complex in central Los Angeles. The complex includes 50 permanent and 450 transitional housing units for more than 500 people experiencing homelessness.
- **Bon Secours Mercy Health** is investing up to 5% of its long-term reserve fund in community development financial institutions that serve low- and moderate-income communities. ([Chapter 4](#) provides more details about community development financial institutions.) Bon Secours Mercy Health has worked toward achieving this target by annually increasing its asset allocation by approximately \$3 million. Since instituting this policy in 2008, the health system has shifted \$34 million, or about 3% of its \$1.1 billion long-term reserve fund, to support affordable housing, economic development, community facilities, and other projects that benefit the health and well-being of members in the communities it serves.

Inclusive planning can improve the development of workforce pipelines and strengthen local and diverse business development. Collaborating with community residents helps to build trust with community members, allows for deeper partnerships, and shifts the anchor institution from “doing for” to “doing with” the community.

- **University Hospitals Rainbow Center for Women and Children** in Cleveland, Ohio, is a 40,000-square-foot, three-story facility designed with the help of a community advisory board to better meet the needs of the community. The board comprised about 60 members of the community, including neighborhood residents and individuals working in areas connected to community health and well-being, such as public health, education, and employment. Because of the community advisory board, a significant design element was added that provides residents with a one-stop center for their essential needs: co-locating multiple services, including health services; legal services; Women, Infants, and Children (WIC) Program office; and a pharmacy.

## **A Role for Businesses**

Businesses of all types can serve important roles as anchor institutions, as investors, and as part of anchor collaboratives to support locally targeted job training and hiring, local procurement, and equitable development. Like health systems and universities, other businesses have relationships with the communities in which they operate, understand the reciprocal nature of healthy environments (i.e., when the community



thrives, businesses thrive), and are often committed to supporting their communities. However, many businesses have not yet learned about the anchor mission framework and how they can be more socially engaged and intentionally align their resources to strengthen neighborhoods to be healthy and wealthy for the long term.

Other businesses have already engaged as anchor institutions (or joined with anchor institutions) to be part of the solution.

- **Quicken Loans**, the nation's largest mortgage lender, took an all-in stance in its headquarters in Detroit, Michigan, and found new life. In 2011, the company moved its entire Michigan workforce to downtown Detroit, including some 17,000 employees of Quicken and related companies. In the neighborhoods, Quicken's philanthropic arm has initiatives to prevent foreclosures and rehabilitate blighted homes, seed new businesses, and prepare workers to take part in the growth of specific industries.
- **Prudential Financial** is deeply rooted in the community, having conducted business for more than 140 years in Newark, New Jersey. Prudential Financial is one of several partnering organizations in Hire.Buy.Live.Newark and Newark 2020—both of which are part of an economic development vision designed to connect city residents to job opportunities. Prudential Financial is a founding member of the Newark Anchor Collaborative, which launched in 2018 to grow economic opportunities and well-being for the City of Newark. Other founding institutions include [Audible.com](https://www.audible.com), RWJBarnabas Health, New Jersey Institute of Technology, New Jersey Performing Arts Center, RU–N, and Rutgers Biomedical and Health Sciences. By working with diverse and committed partners to do more purchasing, hiring, and investing at the local level, more resources can be leveraged for the benefit of the local community.
- **New Orleans Business Alliance (NOLABA)** provides another model of private sector involvement and engagement with anchor institutions. NOLABA oversees the city's strategic plan for economic growth. Industry councils and working groups implement many of NOLABA's recommendations. NOLABA strives "to unite a diverse community of stakeholders to catalyze job growth, create wealth, and build an equitable and sustainable economic future for New Orleans." LCMC Health; such corporations as JPMorgan Chase, Entergy Corporation, Harrah's New Orleans Hotel & Casino, and Shell Oil Company; and such foundations as Surdna Foundation and W.K. Kellogg Foundation have invested in the strategic plan.

*"Anchor institutions are unique in the strength that they bring to the city where they're housed, whether it's our purchasing power, the power of our employees, or the resources that we have at our disposal. This three-pronged approach is a very comprehensive way of using what's best about our institutions to create good by helping to drive inclusive economic growth for Newark's residents. Hire local—how do we think*

*about training and employing Newark residents? Live local—how do we think about encouraging and incentivizing our employees and associates to live in the city where they’re working? And buy local—how do we direct our dollars to support local businesses, which in turn are hiring local residents?”*

—Lata Reddy, Head of the Office of Corporate Social Responsibility at Prudential Financial

Finally, new models of business enterprise are emerging that support community health, wealth and well-being through other frameworks and mechanisms, including employee ownership ([Box 5.3](#)).

### **BOX 5.3AN EMERGING MODEL OF THE BUSINESS ENTERPRISE IN COMMUNITIES**

Some mission-led, employee-owned private companies are taking other approaches to help strengthen their communities and employees. This emerging model embodies a powerful enterprise design: businesses that benefit society and larger living systems of the earth. The Democracy Collaborative calls these firms “next-generation enterprises.” More than 50 of these companies operated in the United States in 2019. Employee ownership of these firms takes one of many forms, such as Employee Stock Ownership Plans (or ESOPs), worker cooperatives, or employee ownership trusts. The common best practice is that employees own at least a 30% stake in the company. These companies often have a clear and authentic mission to benefit the public, which often includes environmental and social benefits.

Next-generation enterprises range in size from only a few employees to thousands of employees. Recology, a San Francisco-based waste management and recycling firm with revenues of \$1.2 billion, has 3,500 employees and is 100% employee owned. Next-generation enterprises operate across a variety of industries and include such nationally known brands as Eileen Fisher and the King Arthur Flour Company, as well as lesser known companies.

“Many CEOs of these firms are leaders in sustainability and workplace democracy. All of these companies are experimenting with multiple approaches—participatory management, multi-stakeholder governance, alternative leadership models—to create businesses that are good for employees, good for the environment, grounded in the community, and governed by a mission.”

This new mission-led, employee-owned business model promotes environmental sustainability and social equity, providing a glimpse into how businesses might operate in an economy that truly embodies the values of equity, sustainability, and community.

Anchor institutions are some of the largest employers and businesses in their areas. As significant economic engines, they play an important role in catalyzing local economies and building community wealth that, in turn, improves health and economic

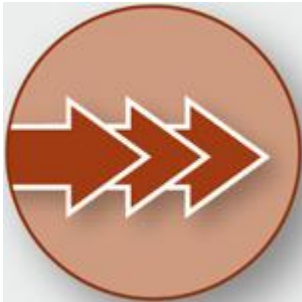
opportunities for residents. For-profit businesses can help to build the economic ecosystems of their surrounding neighborhoods by becoming anchor institutions or supporting anchor mission strategies and engaging with anchor institutions and anchor-involved collaboratives. This is an opportunity for companies to align their values, corporate culture, staff volunteerism, and customer and community expectations with strategies that build healthy, sustainable, and thriving communities.

## APPENDIX A TOOLS AND RESOURCES

[Appendix A](#) identifies tools and resources addressing topics explored in [Chapter 5](#). The tools and resources were created by such businesses and organizations as American Institute of Certified Public Accountants; Centers for Disease Control and Prevention; The Democracy Collaborative; Public-Private-Partnership Legal Resource Center, World Bank Group; and others.

### THE CHICKASAW NATION: Investing in Community

|                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|-------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|   | <p><b>Community Challenge</b>   Imagine living in an area described as a severely distressed census tract—meaning few jobs, plenty of high school dropouts, poor housing options, high rates of incarceration, large swaths of prime-age adults not working, and a poverty rate greater than 31%. The struggle to achieve a satisfactory quality of life can be overwhelming in such a place.</p> <p>Now, imagine being a part of the Chickasaw Nation, which has made extraordinary progress to lift its people out of poverty and improve opportunities in severely distressed communities. Leaders of the Chickasaw Nation have created businesses to support the tribal government and offer opportunities to tribal citizens and community members. Despite such success, the lack of broadband Internet access limits opportunities for members of the Chickasaw Nation and the larger community.</p> |
|  | <p><b>Scenario</b>   As a sovereign nation, the Chickasaw Nation has built a broad portfolio of businesses to generate revenues that support tribal programs and services. These economic development efforts have accelerated dramatically under the leadership of Bill Anoatubby, governor of the Chickasaw Nation since 1987, with the development of a number of businesses across several industries, including technology, entertainment, hospitality, media, and health. With a reliable revenue stream, the Chickasaw Nation began to diversify its business and social program portfolios. However, strengthening economic development, education, and healthcare throughout the</p>                                                                                                                                                                                                               |

|                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|-----------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                   | <p>Chickasaw Nation depended on reliable broadband Internet connectivity.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|  | <p><b>Action Taken  </b> More than 60% of people who live in the Chickasaw Nation’s 13-county service area in Oklahoma did not have access to broadband Internet service. Recognizing the need to address the poor infrastructure for quality Internet service, the Chickasaw Nation Secretary of Commerce, Bill Lance, requested \$14–\$20 million from Governor Anotubby to install a 250-mile fiber optic cable that would encircle the Chickasaw Nation’s territorial boundaries. “To ensure we would be able to meet demand for future generations,” the Chickasaw Nation Deputy Secretary Dakota Cole said, “the decision was made to install three pieces of conduit to supply three times our estimated long-term needs.”</p> <p>With the governor’s support, Trace Fiber Networks, LLC, launched in 2016. The name pays homage to Natchez Trace—a forest trail and trade route in Chickasaw’s historic homeland in Mississippi and Tennessee. With the limited liability company, the Chickasaw Nation worked with financial institutions, undertook competitive bidding for contracts, developed a team of contracting partners, and began conversations with stakeholders. The State of Oklahoma assisted with gaining rights of way and other technical aspects of the project. The Chickasaw Nation bartered with the Oklahoma Community Anchor Network, which already had 1,000 miles of high-speed fiber across Oklahoma, to swap out fiber in places with redundancies, and learned that the Federal Communication Commission had given tribal entities the right to claim, free of charge, whitespace spectrum for high-speed Internet access. As a result, the Chickasaw Nation expected to (a) provide more than 180 locations with high-speed Internet connectivity by the end of 2020 and (b) obtain a return on investment within 7 years.</p> <p>“This is just as much a story of equity as it is a story of connectivity. You can’t begin to level the playing field if you don’t have access to the same information,” the Chickasaw Nation Undersecretary of Technology &amp; Innovation Commerce Chris Shilling said. “This will provide a transformative opportunity for the group of citizens and individuals in rural Oklahoma that will chip away at capital inequity and education inequity that we see across the country.”</p> |



**Key Takeaway** | For the Chickasaw Nation to succeed, its businesses have to succeed. In today's economy, a gap in broadband services can leave people behind. Leaders of the Chickasaw Nation are determined to close that divide. "Access to broadband Internet is becoming increasingly essential ... to enhance education, economic development, housing, and career opportunities of the Chickasaw people," said Governor Anoatubby. "Enhancing these opportunities builds a foundation of prosperity that plays an important role in promoting community health."

## **CHAPTER 6 Data Steps for Businesses and Partners to Address the U.S. Health Disadvantage and Monitor the Business Impact**

### **OVERVIEW**

Businesses can use a data-driven approach to improve health and economic prosperity among employees and broader communities. Based on an environmental scan of validated outcome measures, this chapter explores processes and measurements that help businesses develop programs and policies to foster health and prosperity, with a focus on those most in need.

### **KEY TAKEAWAYS**



Businesses use data for their operations but often overlook the use of data to understand the impact of their business on the health, wealth, and well-being of employees, customers, and communities.



A data-driven approach to community engagement and investment

- Can help businesses identify strategies that (a) create a healthier workforce and more prosperous communities and (b) monitor their progress in achieving specific outcomes; and
- Offers businesses and employers a pathway to make broader improvements and measure their contributions and returns in the context of the larger ecosystem of communities and society.

### **Introduction**

As the coronavirus pandemic of 2020 has made abundantly clear in the United States, business-as-usual is no longer an option. The solution to the U.S. health disadvantage—a disadvantage exemplified by the spread and lethality of the virus and exacerbated by unprecedented job losses (and the loss of employer-provided health insurance)—lies in expanding equitable health, wealth, and well-being for all people and places across America. Although some people were averse to the idea of shutting down parts of the economy in order to protect health, others saw an opportunity to strengthen health and the economy together. For businesses that are ready to invest in communities, this report recommends a data-driven course of action to rebuild community health and economic prosperity in the United States in ways that are good for business and good for the whole of society.

Although businesses are used to using data to inform and track their operations, they often overlook the use of data to better understand the impact of their business on the health, wealth, and well-being of their employees, customers, and communities and fail to use data to identify the best opportunities and strategies and to monitor their progress. [Box 6.1](#) provides an example of using data to identify supply and demand for early child education, by neighborhood, to best seize business opportunities and meet consumer demand.

#### **BOX 6.1 USING DATA TO EXPAND HIGH-QUALITY EARLY CHILDHOOD EDUCATION**

Fund for Quality (FFQ) was launched in Philadelphia as an effort to expand quality childcare options in areas that are undersupplied. FFQ is a partnership between Reinvestment Fund and Public Health Management Corporation (PHMC) with support from the William Penn Foundation and the Vanguard Strong Start for Kids Program™. FFQ works to ensure that every child—no matter what neighborhood they live in or where their family works—has access to the best possible start in life through a high-quality early childhood education.

FFQ's strategy is to invest in projects that increase the availability of high-quality childcare in the areas of the city where data show it is most needed. FFQ offers business planning support and facilities-related funding for the renovation of existing centers or expansion to new facilities. The high-impact investments are based on a neighborhood-level analysis developed by Reinvestment Fund. The analysis identifies the gaps between the supply and demand, neighborhood by neighborhood. FFQ then targets investments that give more children the opportunity to get the high-quality early childhood education needed for a strong start. FFQ's strategy is driven by accurate information about unmet need in the community. Reinvestment Fund is replicating this model in Atlanta.

With additional support from the Vanguard Strong Start for Kids Program and Public Citizens for Children and Youth, Reinvestment Fund is expanding its analysis to provide more granularity on infant and toddler care—the time when important brain

development takes place. Vanguard, an investment advisor based in Malvern, Pennsylvania, is increasing its childcare support by working with Reinvestment Fund and PHMC to create financial tools and resources for early childhood education providers to improve their financial stability and guide business decision making. Known as the Early Childhood Education Fiscal Hub, the program allows providers to compare themselves to their high-performing, high-quality peers and to use those benchmarks for their own operations planning and budgeting decisions. Thanks to this robust collaboration, more children in Philadelphia will get the safe, healthy, and engaging care they need and deserve during the most critical stage of their lives.

Businesses generally have not adopted a consistent process to integrate health measures into their core planning processes. Some possible reasons include a lack of consensus about what to measure and how to measure it, and whether investing in health, wealth, and well-being improves the bottom line and leads to a return of value. What does help: simplicity, connection, and rigor in the data businesses collect and the outcomes they choose to measure. A data-driven approach can help businesses identify strategies that create a healthier workforce and more prosperous communities and to monitor their progress in achieving specific outcomes.

Businesses are already using data to identify the needs and best interventions to improve employee (people) and community (place) health and well-being, and to monitor progress in doing so. Common uses of data by businesses include (a) understanding the health and well-being of people an employer is associated with (e.g., using Health Risk Assessments for employees and their families, and mapping data to understand the communities in which they do business); (b) selecting populations to work with or health conditions to address to improve employee health (e.g., mental health); (c) establishing measures to assess short-term impacts of improvement initiatives (including anecdotal evidence and quantitative measures); and (d) measuring system, workplace policy, and culture changes (e.g., HERO Scorecard and the WELCOA Checklist).

*“What a society chooses to measure will in turn influence the things that it seeks. If a society takes great effort to measure productivity, people in the society are likely to focus more on it and sometimes even to the detriment of other values. If a society regularly assesses well-being, people will give it their attention and learn more about its causes.”*

—Centre for Bhutan & GNH Studies

Several organizations help businesses analyze data in a place-based way (e.g., Geographic Information System [GIS] mapping and HERO Culture of Health). Businesses are using these data to



- Map the value chain and understand total value or total return on investment of a set of initiatives (e.g., Shared Value Initiative, and Sustainability and Health Initiative for NetPositive Enterprise);
- Develop a balanced portfolio of strategies to improve employee, community, and system well-being (e.g., Pathways to Population Health);
- Measure impact over the short-, medium-, and long-terms using process outcomes related to specific initiatives (e.g., 100 Million Healthier Lives); and
- Understand the overall impact on population health and well-being across people and places (e.g., Well Being In the Nation measures).

These emerging strategies expand the playbook for action to align with a broader array of core business practices and extend beyond employee benefits, which have been the historical provenance of wellness programs. One such strategy, the Shared Value Initiative, focuses on the following:

- **“Reconceiving products and markets:** Meeting societal needs through products and addressing unserved or underserved customers
- **Redefining productivity in the value chain:** Changing practices in the value chain to drive productivity through more efficient use of resources, employees, and business partners
- **Enabling local cluster development:** Improving the available skills and supplier base and supporting institutions in communities where a company operates to boost productivity, innovation, and growth.”

Pathways to Population Health (P2PH), developed through 100 Million Healthier Lives and adapted as part of Well Being In the Nation for Business, brings these three types of action together in a connected strategic approach to improving the well-being of people and place, with a focus on those most in need. This framework supports employers to improve the health and well-being of people they directly reach (customers and employees) by improving their mental, physical, social, and spiritual well-being and the well-being of places the business relates to (in terms of location, operations, and customer base) through focused action addressing vital conditions. Importantly, P2PH focuses on ensuring resources are mobilized for those who aren’t thriving, both as a priority for businesses and an opportunity to unlock human, community, and economic potential.

The Well Being In the Nation or “WIN” framework, which was released in 2019, and its associated measures, which were developed with support from the National Committee on Vital and Health Statistics with more than 100 organizations, businesses, and communities, is organized around nine core measures related to people and place and focused on those who are not thriving. The P2PH and WIN frameworks offer businesses



new opportunities and strategies to enhance their impact using levers already available to them. (See [Appendix B](#) for more information on these frameworks.)

### **Five Steps to Identify Measures That Matter**

Below is an implementation strategy for businesses seeking to create a practical and strategic measurement plan to identify and understand the impact of initiatives focused on improving community health, wealth, and well-being.

1.

**Develop a process for identifying measures that matter** together with employees, customers, community partners, and people in places that are not thriving. The process of looking at one's data, understanding the stories of people in the workforce or communities who are not thriving, and developing plans together with them can offer a powerful way to improve well-being and engage with the lives of employees and communities. Change efforts that do this are far more likely to achieve sustainable impact.

2.

**Choose a balanced set of process and outcome measures** that change over the short, medium, and long term. Short-term process measures and intermediate outcome measures are essential for driving improvement cycles and better align with business operations. Longer term measures are essential for knowing whether there is progress over time by focusing on long-term change, not just quick wins. [Box 6.2](#) presents additional criteria for selecting measures that might be relevant to businesses.

### **BOX 6.2 CRITERIA FOR SELECTING A MEASURE**

**“Overall (basic information for all nominated metrics)**

- Domain
- Subdomain
- Proposed metric
- Source of metric
- Link to website for more information
- Level of data available (national, state, county, subcounty, ZIP code, community, etc.)

### **Important**

- Potential to drive improvement in health
- Potential to drive improvement in social drivers of well-being

- Potential to drive improvement in equity
- Aligned with major national/global strategy
- Potential to develop new knowledge about what creates well-being

### **Objective and effective**

- Strong evidence that this improves health, well-being, and equity
- Valid
- Reliable
- Benchmarking available

### **Feasible**

- Data already collected, analyzed, and reported
- Cost of additional collection/availability of resources to support collection
- Burden of collection and reporting
- Groups ready to adopt

### **Usable and useful**

- Timeframe data changes within (rating: 3 if less than quarterly, 2 if less than yearly, 1 if yearly, 0 if more than yearly)
- Timeliness of data availability (rating: 3 if less than quarterly, 2 if less than yearly, 1 if yearly, 0 if more than yearly)
- Usefulness to communities
- Usefulness to researchers/national stakeholders
- Meaningfulness to people with lived experience
- Currently used by/could be used by? (Name initiatives/organizations actively using)
- Level of data availability”

3.

**Choose outcome measures that matter** to a wide range of stakeholders and apply across initiatives (this step is also known as a materiality assessment). The WIN measures offer a great place to start (see [Box 6.3](#) for an example). In addition to being helpful in supporting collaboration across sectors, WIN heavily emphasizes the relationship between economic prosperity and health and well-being throughout the framework, considering the well-being of both people and place.

## BOX 6.3A MEASURE OF WELL-BEING OF PEOPLE

One scale, Cantril's Ladder, asks people to rate their well-being by marking an "X" on a simple drawing of a ladder, where the bottom rung is their worst possible life and the top rung is their best possible life, today and 5 years from now. This measure has been tested for use by businesses via the Gallup-Sharecare Well-Being Index; has reliable, publicly available benchmark data by place in more than 150 countries and many counties in the United States; correlates to business outcomes that matter, such as workforce productivity; and also correlates with major population health outcomes, such as morbidity, mortality, and cost.

4.

**Identify process and intermediate outcome measures** aligned with a balanced portfolio of initiatives and measures related to improving the well-being of people and places, especially for those most in need. The environmental scan ([Appendix B](#)) identifies ways businesses are working to improve each of these three areas. Process and intermediate outcome measures should be tied to the specific strategies and initiatives.

- For example, suppose AnyBusiness, Inc., has, after conversations with employees and the community, identified access to safe and affordable housing as an urgent need in the community. AnyBusiness might consider a range of strategies to address the need, along with associated process and intermediate outcome measures.
  - Investing directly in affordable housing developments or providing rental subsidies to employees.



*Example process measure:* Number of employees living in affordable housing or using a company subsidy.



*Example outcome measure:* Percent of employee households paying 30% or more of their income on housing.

- Offering wages to employees that are commensurate with the cost of safe, quality housing in the area and encouraging other businesses to do the same.



*Example process measure:* Number of businesses offering commensurate wages.



*Example outcome measure:* Percent of employees earning commensurate wages or higher (compared with baseline).

- Investing in outdoor lighting and neighborhood peer safety groups in areas of the community (if residents have identified this as a potential solution)



*Example process measure:* Number of outdoor lights installed.



*Example outcome measure:* Percent of residents who feel safe walking in their neighborhoods after sunset.

- Supporting afterschool leadership and job training programs for youth or other initiatives that help to build hope, community resilience, and belonging, such as the development and funding of neighborhood councils.



*Example process measures:* Number of youth engaged in afterschool programming, number of neighborhood councils funded, or number of community-generated solutions implemented.



*Example outcome measures:* Percent of community members responding “yes” to, “People around here are willing to help their neighbors,” and scores on a youth well-being scale.

- Joining community revitalization efforts that preserve mixed-income and affordable housing.



*Example process measures:* Number of affordable housing units created or preserved.



*Example outcome measures:* Educational outcomes (e.g., high school graduation).

- Hiring people from the community.



*Example process measure:* Number of jobs and internships filled by people who live in particular neighborhoods.



*Example outcome measure:* Total income created in the community.

- Total return on investment, which calculates the overall impact on health, wealth, and well-being of interventions for both people and communities, offers another strategy for businesses to assess their progress over the course of their investment. Methods for valuing the well-being created by different initiatives and for modeling return over time are available. Using these methods to estimate total return on investment can help companies to select affordable strategies. Consideration should be given to investments that can leverage the contributions of others—to help drive collaboration and increase impact.

5.

**Prepare a measurement and learning system:**

- Identify a measurement and improvement team, and together with community partners, develop a strategy map, including a theory of change and a theory of implementation based on data about the well-being of people and communities. Baseline data on measures can be found in a wide array of places. Look to prior employee surveys and culture surveys for employees' baselines. Most core measures and leading indicators in WIN are available online (<http://www.winmeasures.org>). The WIN Measurement Framework presents a wide range of measures related to the well-being of people and places for each of the vital conditions.
  - Set aims for major outcome and process measures and gather baseline data.
  - Decide what measures will be collected or obtained, and for each one, with what frequency, who will do the collection/gathering, and how often the data will be analyzed together with stakeholders.
  - Develop and implement a set of initiatives (small or large) to improve these goals.
  - Bring together stakeholders within the business and community to engage in collaborative sensemaking at least twice a year—that is, to look at the data, understand the stories behind the data, reflect, and generate insight. Be sure to include employees and community residents most affected by inequities.
  - Plan a path forward and reassess regularly. Leading organizations will set improvement goals within each quarter toward the longer term aim and reassess at least quarterly.

[Box 6.4](#) describes the five steps applied to one company's journey to live out its mission and benefit a community in need.

## **BOX 6.4 FIVE STEPS APPLIED TO THE JOURNEY OF NEHEMIAH MANUFACTURING CO.**

The Nehemiah Manufacturing Company in Cincinnati, Ohio, was founded in 2009 with the mission to “build brands, create jobs, and change lives” (<https://www.nehemiahmfg.com/>). The for-profit company owns several brands of its own and also manufactures products for other companies. Nehemiah planned at the outset that it would contribute to the community and thrive as a business. The company focuses on hiring “hard to hire” people. Nehemiah’s journey is marked by each of the five steps to identify measures that matter.

**Step 1. Develop a Process Together:** Nehemiah partnered with the city of Cincinnati, community leaders, and social service organizations to select a neighborhood with people who most needed jobs and hope. They chose the West End and Over-the-Rhine areas of Cincinnati, which experienced high unemployment and few entry-level jobs.

**Step 2. Choose a Balanced Set of Measures:** The partners identified initial process and outcome measures that focused on manufacturing outputs, creating jobs, and hiring and retaining people from minority and low-income neighborhoods in West End and Over-the-Rhine.

**Step 3. Choose Outcome Measures That Matter:** As Nehemiah collaborated with local partners, it began to understand that chronic unemployment stemmed from structural and systemic inequities in people’s lives. One of the greatest barriers to employment was a history of incarceration. Nehemiah decided to focus on hiring people who had a prison record or a history of drug or alcohol misuse. Nehemiah refined its goals to recruiting, hiring, and retaining “second chance” workers and ensuring they comprised the majority of the company’s workforce.

**Step 4. Identify Process and Intermediate Outcome Measures:** Nehemiah’s first challenge was to identify a hiring supply chain. Nehemiah partnered with several nonprofit organizations—CityLink, St. Vincent DePaul, Jobs Plus, Beacon of Hope, and City Gospel Mission—to identify and develop potential workers with a special focus on creating supportive pathways for people to succeed. Nehemiah and its partners integrated social workers into the hiring process; created a weeklong training to help new hires get ready for work; and established biweekly check-ins with newly hired workers to build relationships and trust and to make sure the workers had the support they needed to be successful. Breaking down the steps and identifying specific process and intermediate measures showed the partnership exactly *how* they would accomplish the hiring goal. Nehemiah’s process measures include the number of nonprofits supported and the number of people placed in supportive housing or treatment for substance misuse.

**Step 5. Prepare a Measurement and Learning System:** Nehemiah and its partners learned much about change in the community:

- Drug addiction is difficult to beat. With guidance from workers, the partners created a policy and allocated funds to support treatment and provide other types of support for workers who disclosed a relapse into drug or alcohol misuse.
- Bad credit and poor financial decisions cause substantial stress. The partners established programs to help workers resolve financial issues.
- Housing is not affordable. The partners worked with developers to build affordable housing for workers near their places of work.
- Unresolved legal issues prevent people from attending work fully. The partners collaborated with legal service firms to offer legal support to workers who needed it.

As a result of these learnings and actions, Nehemiah has given people jobs and the support they need to succeed, and has created a stable workforce with an enviable 90% retention rate. All but 10 of 179 jobs have been filled by second chance workers. By providing these jobs and the associated support, Nehemiah helps to restore dignity, hope, and well-being to people in the community who need a second chance. Nehemiah describes its workforce as one of the hardest working and most loyal in the country.

Nehemiah has combined the well-being of its business with the well-being of the community and has partnered with investors who understand that Nehemiah's mission is more than making money with a great bottom line. In addition, Nehemiah pursues its mission to impart an even stronger topline of impact on society. This combination of governance, community partnership, and continuous learning leads to a healthy business that is on the leading edge of creating well-being in the world.

## Conclusions

Businesses are essential to the lifeblood of communities. This chapter offers actions, measures, and frameworks for companies seeking to do more to improve the well-being of the people they reach and the places they serve. Businesses that engage in this kind of stewardship, using data to identify the people and places to engage, the best interventions to deploy, and the sharpest measures to assess impact, have the opportunity to be leaders and influencers improving the health of employees, families, and communities and influencing broader societal conditions in a community, region, and whole country. Data-driven approaches offer businesses and employers a pathway to make broader improvements and measure their contributions to that improvement, while understanding their current engagement in the context of an even larger ecosystem of communities and society.

## Appendix A Tools and Resources

[Appendix A](#) identifies tools and resources addressing topics explored in [Chapter 6](#). The tools and resources were created by such businesses and organizations as Health

Enhancement Research Organization, Intel, Well Being In the Nation (WIN) Network, and others.

[Go to:](#)

## GREYSTON BAKERY: Baking With Purpose



**Community Challenge** | Communities are healthier when people have jobs and steady income. Healthy communities enjoy less violence and substance misuse, more family stability, and better education for their children. Tax bases increase, civic participation grows, and the very people given a chance to work at a quality job tend to give back to the community and to others. But all too often, preconceived notions and rote hiring rules leave too many people without an opportunity to gain employment.



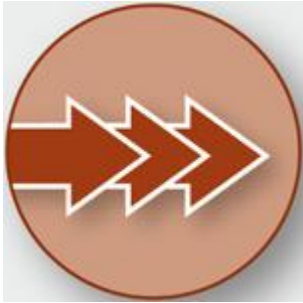
**Scenario** | Zen Master Bernie Glassman noticed the number of unemployed people in the Bronx and Yonkers (New York). Job prospects were thin because of limited education, work experience, and individuals' past records of incarceration or substance misuse. In the early days of Greyston Bakery, Glassman literally pulled people off the street to help him bake cakes. When he later met and partnered with Ben Cohen and Jerry Greenfield of Ben & Jerry's Ice Cream, Greyston bakers began to provide baked goods for two of the top five flavors of Unilever's Ben & Jerry's Ice Cream.

Greyston has more than 400 people on its waiting list to become bakers. With Greyston's Open Hiring process, anyone who walks through the door can fill out a one-page questionnaire with their name, address, and phone number; affirm their willingness to work 12-hour shifts and lift 50-pound bags of flour and sugar; and confirm their eligibility to work in the United States.

Applications sit on the waiting list for an average of 6 months. Once called, the new hire's first day includes an orientation and full pay and benefits. Next, he or she is offered an apprenticeship that lasts 6–9 months. Upon completion, bakers have access to union membership. "We don't care about folks' past, we want to invest in their future," said Joseph Kenner, president and CEO of Greyston.

The Open Hiring framework has been refined over time. For example, if an employee does not show up on time or stops showing up altogether, there is likely a reason—perhaps childcare issues, domestic violence, or housing eviction. Working



|                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|-------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                     | <p>with Westchester Jewish Community Services, Greyston created an Employment PathMaker position to provide support services to bakers. Thanks to this support, the turnover rate at Greyston was two points better than the industry average in 2019.</p> <p>The Open Hiring concept pioneered by Greyston has benefited members of the southwest Yonkers community, and Greyston now wants to take this hiring approach to other businesses, with the goal of helping them make their hiring practices more inclusive.</p>                                                                                                                                                                                                                                                                                                                                                                                                      |
|    | <p><b>Action Taken  </b> Greyston launched the Center for Open Hiring in June 2018 to train and provide tools to businesses. Business leaders cite liability insurance and fears of violence among the most frequent barriers to adopting an open hiring concept. “Our premiums and liability rates are no different from any other manufacturer,” Kenner said. “It’s not total chaos at the bakery!” Another hurdle for businesses is the belief that the hiring practice hurts turnover rates. “Yet these very same managers will go through extensive interviews and costly background checks and some people don’t work out either,” said Kenner. “Wouldn’t it be better to invest in helping people succeed instead of keeping people out?” As a measure of early success, a 3,000-store beauty retailer adopted Open Hiring at its North American distribution center, generating a 60% reduction in employee turnover.</p> |
|  | <p><b>Key Takeaway  </b> If given an opportunity and the training, large segments of the unemployed population will succeed in the workplace. But many of them are excluded because of their backgrounds or other factors that say nothing about their abilities to be successful on the job. “If you make these types of investments, you are going to learn new things about your employees,” Kenner said. “Folks want to feel like someone is invested in them, and that’s a huge piece of what open hiring is—everybody has a place.” Companies can start by Open Hiring one person for an entry-level position.</p>                                                                                                                                                                                                                                                                                                          |

## OVERVIEW

The health status of American workers and participation in the labor force have been declining for decades. Businesses can play an important role to reverse this trend by simultaneously expanding community health and economic prosperity. This chapter outlines a path toward a well-being economy that can reverse poor health outcomes and sustain hard-won gains. The path is built on business engagement with stakeholders to produce shared value, working together as stewards of health, wealth, and well-being in a common world.

## KEY TAKEAWAYS



Businesses and employers are stakeholders in their communities, and communities are stakeholders in businesses.



To enhance community health and economic prosperity over the long term, businesses may choose to

- Produce goods and services and operate in ways that expand the vital conditions that all people and communities require;
- Create shared value for companies and communities by combining social purpose with business opportunities; and
- Engage all stakeholders to achieve the best long-term value for those upon whom business success depends (i.e., stakeholders).



Businesses of all types and sizes can execute one or more of seven concrete business strategies in the short term to engage with and invest in communities. Businesses may select the engagement and investment options that best suit the needs of their stakeholders and their business.



Given the powerful role of business in the United States, even sweeping efforts to strengthen and sustain community health and economic prosperity will not be sufficient without associated actions by business.

## Introduction

To begin to address the U.S. health disadvantage ([Chapter 1](#)) and to strengthen communities to support vibrant employees, families, and residents ([Chapter 2](#)),

businesses and employers must act to ensure a sustainable and equitable capitalist democratic future for themselves and for society.

Businesses and employers are stakeholders in their communities and also serve communities as one of the many stakeholders whose interests they seek to enhance as they strive to prosper ([Chapter 3](#)). In collaboration with community changemakers ([Chapters 4–5](#)), businesses have opportunities and responsibilities to create shared value (i.e., value for the business and the community), join with others to effectively steward systems (e.g., healthcare systems, service delivery systems, governmental policy making systems, tax and regulatory systems, banking and financial systems, ecological systems) in the interest of thriving communities and people and to produce prosperous business environments. Businesses have opportunities and responsibilities to do well by doing good, and to nurture systems to better align private value and public good to the benefit of all.

Americans know a great deal about what it takes to expand health, wealth, and well-being on a massive scale. Across the country and around the world, modern innovations have done more to add years of healthy life and lift millions of families out of poverty over the past two centuries than in the previous 19 centuries combined. But even after such impressive progress, all is not well. Past advances are insufficient, and many problems are getting worse. Hard-won gains remain fragile or are reversing; whole groups of people have been harmed or left behind while others have benefitted (see [Box 7.1](#)); and responses are slow to an increasingly complex set of intertwined threats that endanger both people and planet—and therefore, profit. As noted in [Chapter 1](#), life expectancy in the United States is barely recovering from a downturn not seen since World War I, and for the first time in U.S. history, members of today's youngest generation may not live longer, more prosperous lives than their parents.

### **BOX 7.1 LEGACIES OF UNTAPPED POTENTIAL**

Most modern achievements have not benefitted everyone in the United States. Many advantages have been systematically denied to certain groups. For example, while racial segregation has been illegal for 65 years, America's public education system continues to produce substantial disparities in educational achievement, largely driven by residential segregation and racial/ethnic differences in family socioeconomic resources. Such differences leave harmful effects on health and prosperity over generations.

Virtually every achievement in the modern era has been diminished by stark differences between those who benefit and those who do not. For example, although women make up an increasing share of the labor force and a majority of college graduates, they are underpaid, underrepresented in senior-level positions, and less likely to be members of boards of directors relative to men overall and men with similar education, experience, and work performance. African Americans, Hispanics, American Indians, and Alaska Natives of both sexes are underrepresented and undervalued in the workforce to an

even greater degree relative to White men. Times have changed for many people, but a vast amount of human potential remains untapped that could contribute to full and fair inclusion for everyone in America.

## Businesses as Creators of Sustained Value

All people depend on vital conditions to reach their potential for health, wealth, and well-being (see [Chapter 1](#), [Box 1.1](#) and [Table 7.1](#)). However, these vital conditions are not shared equitably and are currently under threat in many communities across the country, as well as for future generations. Businesses, in partnership with others, can play a profound role in securing these vital conditions, which in turn would reverse the U.S. health disadvantage and help to ensure the fair opportunities that businesses and society need to survive and thrive. Businesses can (a) produce goods and services and operate in ways that expand the vital conditions that all people and communities require; (b) create shared value for companies and communities by combining social purpose with business opportunities; and (c) engage all stakeholders to achieve the greatest long-term value for all those upon whom business success depends. Each of these, alone and together, would enhance community health and economic prosperity. Businesses can integrate these activities into their business operations. Doing so, this report argues, will help businesses compete more effectively and generate value for businesses and society.

Table 7.1 Outstanding threats to health, wealth, and well-being (2020–future)

| Vital conditions                  | Outstanding threats                                                                                                                                                                                                                                             |
|-----------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Basic needs for health and safety | <ul style="list-style-type: none"> <li>• Aging population, caregiver strain</li> <li>• Addiction (tobacco, alcohol, opiates)</li> <li>• Adverse childhood experiences</li> <li>• Antibiotic resistance</li> <li>• Hunger, food insecurity, junk food</li> </ul> |

**Table 7.1**

Outstanding threats to health, wealth, and well-being that require combined efforts to resolve (2020–future).

Recognizing that “a thriving company requires thriving communities” and that businesses play an important role in addressing shared societal challenges, businesses acting as stewards, creating shared value, and engaging stakeholders can be rewarded with a range of benefits or types of value, including

- Healthier workers and lower healthcare costs,
  - For example, annual healthcare costs to employers for employees with diabetes are more than \$4,000 higher than for employees without diabetes;
- More productive on-the-job employees,

- For example, workers who live in healthier communities are more likely to arrive at work on time and have fewer unplanned absences than workers who live in less healthy communities;
- Greater ability to recruit and retain talent,
  - For example, four business exemplars described in this report (Belden, Inc., Greyston Bakery, Bank of America, and Hyatt Hotels) point to specific community-strengthening strategies that substantially reduce recruitment costs and increase retention rates;
- Greater brand recognition and more loyal customers,
  - For example, in a Nielsen survey, 66% of respondents said they are willing to pay more for products and services from companies committed to positive social and environmental action; According to a Cone/Porter Novelli study, 88% of consumers would buy from and 66% would switch purchases to a purpose-driven company;
- Greater profitability,
  - For example, according to one analysis, publicly traded companies with a stated purpose, generous compensation, and quality customer service that invest in their communities and minimize their adverse impact on the environment outperform less values-focused companies by a factor of 10.

Beyond the value that accrues to a company, the societal value, as business investment and engagement become more widely practiced, has the potential to advance the United States closer toward its founding ideals as a land of equality and opportunity. Unlike conventional leaders, those who choose to nurture healthy and inclusive systems—as “system stewards”—tend to think about purpose, power, and resources in distinctive ways:

- **Purpose** is larger than oneself or one’s own organization;
- **Power** is built and distributed with others, not consolidated; and
- **Resources** are invested, not withheld, to create long-term value and to alleviate urgent needs.

Any person or organization can be a steward if they are willing to work with others to create conditions that expand health, wealth, and well-being. In a country as vast and diverse as the United States, stewards work through a mosaic of cultures, corporate climates, and local circumstances that stretch across boundaries and spheres of influence. Leaders and changemakers in business and society work across differences and collaborate with others, including other stewards, to build thriving communities and vibrant economies.

The belief that corporations have no inherent social responsibilities, popularized 50 years ago by Milton Friedman, has since broken down (as noted in [Chapter 3](#)), as approaches like social investing and corporate social responsibility emerged in the 1970s and 1980s and as companies became more attentive to metrics and rating systems focused on the environmental, social, and governance aspects of corporate performance. Environmental, social, and governance metrics are becoming more widely reported and examined by investors, consumers, and employees. As illustrated by several exemplars in this report, some businesses recognize—in their role as members of society and as stakeholders in communities—that their own success depends on strengthening the vital conditions on which businesses, employees, customers, and consumers all depend.

In fact, a broad coalition of the world's largest companies, asset holders, and asset managers (together controlling more than \$30 trillion) has publicly declared that all companies must show how they contribute to larger social goals, or risk losing financial support. As the flaws in Friedman's logic become increasingly obvious, business leaders are repositioning their firms to compete on the basis of how well they generate sustained value for all stakeholders, not just a small group of shareholders. These business leaders could join together to become some of the strongest system stewards, advancing societal good, creating shared value, and meeting the needs of stakeholders.

Some companies are embracing the concept of creating shared value—that is, value gained by the company while serving a community need or solving a community problem (as described in [Chapter 6](#)). Specifically, creative and innovative business leaders are seeing business opportunities in achieving social goals and are solving social problems as a means of making money. Whether investing in local entrepreneurs to strengthen and increase efficiencies in local supply chains (thus creating local jobs and strengthening the local economy); establishing pathways to employment for the homeless, the formerly incarcerated, or those without a high school diploma (thus filling critical entry-level positions with career ladders less expensively and with less turnover); or developing a product that meets a community need and earns a profit, some companies are discovering shared value is a win for both business and community.

Although stakeholder theory (described in [Chapter 3](#)) is not new, it has sometimes been managed as not much more than a risk mitigation exercise. More recently, companies are recognizing that successful businesses tend to be those that (a) engage with all stakeholders required for the business to exist—employees, customers, vendors and suppliers, the communities in which they reside or conduct business, investors and shareholders, and others—and (b) ensure value for each stakeholder (e.g., [Box 7.2](#)). These are companies that integrate stakeholder engagement into business operations and company strategies, ensuring that relevant stakeholders provide input and feedback across all aspects of the delivery of goods and services. Although the goal may be to build a stronger, more successful, and more resilient business, the outcome may be progress toward a more equitable society.

## BOX 7.2 PROFILE OF JUST CAPITAL

To build a more just marketplace that better reflects the priorities of the American people, JUST Capital

- **Asks** people how they want companies to behave,
- **Rates and ranks** firms to show how well they meet expectations, and
- **Offers investments** in the most just companies.

Just companies not only make more money (about 6% higher return on equity), they also pay workers better, have safer workplaces, create more U.S. jobs, give more to charity, produce less waste, and yield other benefits.

As with system stewardship and shared value, stakeholder engagement contributes to a more collaborative, networked, and strategic business enterprise and more inclusive, resilient, and sustainable communities, where the interdependence between business and society is embraced and strengthened to mutual advantage.

### **Advancing Business Goals by Meeting Stakeholder Needs and Creating Shared Value**

Business have taken a variety of actions to improve community health and increase economic prosperity for their own benefit and the benefit of their stakeholders and society at large. This section provides nearly a dozen examples of businesses and the actions they have taken to meet stakeholder needs and create shared value while solving a business problem or securing a return of value to the business.

A common strategy is to consider the needs of the community when solving business problems and choosing and implementing solutions that also strengthen the community. Belden Inc., Greyston Bakery, and Bank of America have taken this approach as they sought to fill job vacancies with dependable employees and discovered a talented source of workers who thrived with an investment of support (see detailed Exemplars about each company elsewhere in this report).

Investing business profits in ways that strengthen communities is a similar strategy. Many communities need affordable housing for employees and families, retirees, and the unemployed; affordable care and learning facilities for young children; and grocery stores.

- **UnitedHealthcare** provided a \$22-million, low-interest loan to the nonprofit Chicanos Por La Causa to acquire nearly 500 units of rental housing in the Maryvale neighborhood of Phoenix, Arizona. Up to 100 units are set aside for UHC clients at reduced rents and will include vital supportive services. In addition to loan repayment with interest, UHC already sees improvements in client health. Joe Guadio, chief executive office of UnitedHealthcare, said, “We’ve seen emergency department visits reduce considerably. We’ve seen inpatient rates

reduce considerably, which is what we'd expect to see. In the aggregate, we're looking at healthcare costs being reduced by over 50 percent when you compare their cost pre-housing versus post-housing."

A job can be one of the most fulfilling aspects of life, bringing meaning and purpose to employees and their families. But jobs can also be dangerous; demoralize workers; keep workers and families in poverty; and offer few, if any, opportunities. Improving wages, salaries, and benefits can turn even an arduous and repetitive job into an opportunity and a livelihood. Businesses are using this strategy to align business success with the needs of a healthy and prosperous society.

- **The Wonderful Company**, an agricultural company based in California, sought an effective intervention to improve the lives and health of its employees and their families. Their solution: a \$15 minimum wage. The company implemented this wage increase for all employees earning less than \$15 per hour and created tiered increases for those making more than \$15 per hour. By instituting a wage structure that helps workers and their families to meet basic needs for housing, healthy food, transportation, quality childcare, and recreation, The Wonderful Company anticipates healthier workers, lower turnover, and stronger communities.

*"This substantial investment [in wage structure] in our workers will have an immediate and meaningful impact on their lives. In addition to providing our Central Valley employees and their families free healthcare and education, we are now able to help them achieve a significantly improved standard of living."*

—Lynda Resnick, Vice Chairperson and Co-Owner of The Wonderful Company

- **American Express**, with a workforce about two-thirds younger than 35 years of age and about two-thirds female, knew it would have to strengthen its benefits package to attract and retain the best workers. The company implemented a policy that includes 6–8 weeks of maternity leave and 20 weeks of parental leave, adding up to about 6 months of paid leave for a new mother. American Express expects this benefit to improve its abilities to recruit and retain talented employees. Through this policy, American Express is also investing in the next generation of employees.
- **Patagonia®**, a maker of outdoor gear, provides on-site child development centers (and subsidizes tuition for parents who are employees) at its headquarters in Ventura, California, and distribution center in Reno, Nevada. For children, quality early childcare can have positive social and health impacts that last into adulthood; parents can work and earn wages knowing their children are in good care. Patagonia calculates that, although expensive, this investment is almost fully recouped through federal tax benefits and higher employee retention



and engagement. Caring for its employees in this way promotes better health in the long run—a win for the company, employees, and families.

Businesses can strengthen communities in need by supporting vendors and suppliers from local and distressed communities. Focusing on the needs of local communities and investing in small businesses and entrepreneurs who may have difficulty accessing capital, can help businesses solve supply-chain problems while helping to create jobs, build wealth, and support businesses locally.

- **Prudential Financial** takes its community stakeholder role seriously in its hometown of Newark, New Jersey. The company more than doubled its purchasing from local businesses; built a new headquarters in Newark; kept 5,400 jobs in the city; and invested in pathways to employment for young people in the community. Prudential Financial is committed to “spreading economic and social opportunity across the city, creating meaningful and lasting change.”

Businesses may choose from a variety of enterprise design options, from for-profit and nonprofit corporations and limited liability companies to cooperatives and employee ownership structures. Some structures can be more beneficial to stakeholders and communities than others.

- **King Arthur Flour**, founded in 1790, before Employee Stock Ownership Plans (or ESOPs) and B Corporations existed, has always been committed to stewardship, community, and its employees. As the fifth-generation owners considered how to sustain the company’s quality, mission, and values over time, selling the company to employees was an obvious solution. Employee ownership confers value to society, ensuring the company remains invested in its community and broadening and deepening local prosperity by sharing wealth with those who help create it.

Many businesses engage in philanthropy as a way to strengthen communities and strengthen business–community relationships. But not all businesses expect their philanthropic investments to deliver outcomes in the same way as they expect their business investments to do so. Businesses can help to ensure that their charitable contributions benefit the community by focusing their investment portfolios and holding themselves accountable for outcomes.

- **JPMorgan Chase** aligns its philanthropic and business goals to deliver both community value and business opportunity. Its \$500 million investment in Detroit and other distressed cities is half philanthropy and half low-cost lending, with a goal of enhancing inclusive growth (i.e., equitable growth across all races/ethnicities and income levels) for the business and the community. The philanthropy focuses on building jobs, skills, and financial health for workers; expanding small businesses; and revitalizing neighborhoods, and the bank develops and serves new markets in need of banking services, including the new

Entrepreneurs of Color Fund, which provides low-cost loans to minority-owned business and start-ups.

Businesses are stakeholders in their communities and states and in the nation. As stakeholders, they are powerful advocates for advancing business interests. By turning their attention to advancing the laws, policies, and practices that strengthen vital conditions and expand health, wealth, and well-being for all, businesses can reinforce their roles as stewards and stakeholders and contribute to the improvement of community health and economic prosperity.

- **Greater Kansas City Chamber of Commerce** coordinated activities across numerous local businesses in the Kansas City metro area in support of “Tobacco 21,” an initiative to raise the minimum age for purchase of tobacco products from 18 years of age to 21 years of age. Because of the coordinated approach, the policy was enacted in 22 jurisdictions in the metro area at the same time, which facilitated effective enforcement and promises to contribute to reductions in tobacco use across the metro area over time. Business engagement was based on the recognition that tobacco use among employees and families is a leading driver of healthcare costs and contributes to lower productivity on the job.

In these and other ways, businesses have acted to meaningfully increase economic opportunity and equitably improve the health, wealth, and well-being of communities, employees, and families.

### **Unlocking America’s Full Potential**

Individuals and families must always make personal choices about health, wealth, and well-being. These decisions are based on personal and familial motivations and on the options available in the surrounding community. Those options, in turn, are shaped by the combined activities and influences of government, business enterprise, and the community. That is why efforts to expand health, wealth, and well-being require collaboration and every stakeholder doing their part.

Given the central role and resources of business in the United States, even sweeping efforts to reframe narratives, redefine rules, redirect resources, and implement new public policies and practices may not be enough to create social change without associated changes in business. The kind of large-scale socioeconomic change needed to address the U.S. health disadvantage requires the support and collaboration of business. The business sector offers a powerful route to social change.

### **Toward a Well-Being Economy**

Despite an expansion of the modern American economy, happiness has remained flat or eroded. The problem is that markets often reward products that undermine health and well-being and do not place enough value on the vital conditions that actually enhance feelings of freedom, security, justice, connection, and self-determination. To

get those benefits, values for health, wealth, and well-being must be brought into the market.

*“... [A well] run, values-centered businesses can contribute to humankind in more tangible ways than any other organization in society.”*

—John Mackey

Other nations have reached a similar conclusion and are transitioning toward a “well-being economy.” For example, in 2018, New Zealand introduced the world’s first national well-being budget backed by a detailed living standards dashboard. Focused on advancing the health and life satisfaction of its citizens, in addition to economic growth, the Government of New Zealand expects to use these tools to more effectively address the needs of the country’s citizens.

Some businesses, corporations, and capital markets are beginning to work more purposefully for the well-being of people and planet (as a way to enhance their own profit). In conventional competitive capitalism, corporate executives are caught in constant tension. They must make as much money as possible—as quickly as possible—for shareholders (who are often mistakenly portrayed as the only true obligation for companies), while also satisfying the interests of other stakeholders (including customers, employees, supply chain partners, communities, and even the natural environment) whose cooperation they require to be successful.

*Regarding the new corporate imperative, “[p]rofits are in no way inconsistent with purpose—in fact, profits and purpose are inextricably linked.”*

—Larry Fink, CEO, Blackrock

That balancing act can feel impossible, but it becomes irrelevant when a business’s or corporation’s purpose is to generate sustained value for all stakeholders over time. Under that theory ([Chapter 3](#)), the most competitive companies are those that deliver the best long-term value for their stakeholders. Shareholders profit when a company consistently meets the goals and needs of all those with whom it does business and on whom the business depends. In other words, “investing is for people in place, with profit the result, not the primary aim.” Balancing people, place, and profit is a tilt toward a well-being economy.

A list of people’s goals and needs might begin with the vital conditions. All people and organizations have vested interests in expanding the vital conditions because lives, livelihoods, and a sustainable and equitable prosperity depend on them. The achievements in [Figure 7.1](#) affirm the possibility of making gains in every area; and the threats in [Table 7.1](#) make clear that such gains are fragile and not universally distributed.



**Figure 7.1**

Shifting prominence and landmark achievements in public health and healthcare, 1800–2008. <sup>a</sup> Relative prominence reflects the frequency that each term appears in writing over time. <sup>b</sup> Many of the landmark achievements are not unqualified goods but [\(more...\)](#)

Each vital condition requires care to be sustained for current and future generations. If success in business depends on fulfilling an important social purpose and requires inputs of labor, talent, and supplies and of customers to purchase goods and services, then companies everywhere would be wise to channel their ingenuity and investments toward expanding one or more of the vital conditions, without excluding anyone. Any shortfall represents untapped human and economic value ([Table 7.2](#)). The best companies would devote themselves to this work as if their survival as a business—and ours as a people—depend on it.

| Business priorities                         | Benefits from expanding                                                                                                                                                                                       |
|---------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Just behavior and sustained long-term value | <ul style="list-style-type: none"> <li>Greater ability to generate long-term value;</li> <li>Greater ability to meet public expectations (workers, customers, products, environment, shareholders)</li> </ul> |
| Profitability                               | <ul style="list-style-type: none"> <li>Higher demand for healthier products and services</li> </ul>                                                                                                           |

**Table 7.2**

Businesses can benefit from strengthening vital conditions for all.

### The Future in Three Possibilities

America's future holds both promise and uncertainty. [Figure 7.2](#) shows the relative trajectory of three possibilities (or pathways) that could play out over time. Each possibility has different near- and long-term consequences. [Table 7.3](#) summarizes the main features of each.

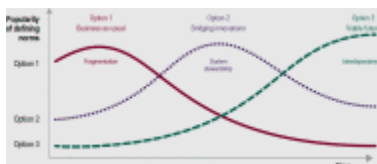


**Figure 7.2**

Three options for expanding health, wealth, and well-being.

| Features    | Option 1: Fragmentation                                      | Option 2: System stewardship                 |
|-------------|--------------------------------------------------------------|----------------------------------------------|
| Focus       | Separate problems (diseases, body parts, issues, industries) | Connect clusters (con health and prosperity) |
| Objective   | Short-term gain                                              | Long-term value                              |
| Forum       | Marketplace                                                  | Networks                                     |
| Investments | Uncoordinated, underfunded programs                          | Sound strategy and integrative activities    |
| Exchanges   | Transactional                                                | Transformative                               |

**Table 7.3**

Features of the three options for expanding health, wealth, and well-being.

The first possibility continues the status quo by focusing on discrete problems and short-term gains and managing immediate obligations. The third possibility requires embracing new ways of doing business in pursuit of a visionary future that will take decades to emerge. The middle (or second) option moves away from the fragmented, transactional, and divisive conditions of today and moves closer to the equitable, productive, and just possibility in the future. This second possibility is both attainable and transformative. It focuses on improving the health of communities and increasing economic prosperity—equitably, commensurately, and inclusively.

As the coronavirus pandemic of 2020 has demonstrated, threats to health are threats to the economy. The two are highly interdependent, and both must thrive together if either is to be strong. The current state is ineffective, inequitable, and inefficient for all parties. To move beyond the status quo requires stepping up to the second option as engaged stewards to expand health, wealth, and well-being together. In this possibility, a widening network of entrepreneurs, elected officials, community leaders, developers and changemakers, business leaders, and everyday people devise new ways to expand the vital conditions, especially among people and places that have been left out and are suffering, thus reversing the U.S. health disadvantage. As these endeavors become more common, the complexion of the U.S. economy and democracy changes such that everyone belongs and can contribute, and the interdependence of business and society is embraced.

More work, stronger partnerships, and greater collaboration across the public, private, and nonprofit sectors would be needed, over generations, to achieve the third possibility, where self-destructive struggles over who gets how much of a fixed pie finally give way to productive working relationships that simultaneously grow the pie and give everyone a fair chance to participate in a thriving commonwealth.

The examples of companies and communities presented in this chapter and throughout this report describe discrete actions to move beyond the status quo of Option 1 and through the intermediate improvements of Option 2, en route to a future state of interdependence and mutuality (Option 3) where everyone has a fair chance to participate and thrive. [Chapter 4](#) presented rich examples of businesses and organizations—public, private, and nonprofit—working with community development

and community finance to invest in and develop people and communities, especially those that are not thriving, using concrete policies, tools, and know-how to help solve some of the barriers and challenges that hold back people and communities. Although the work is inspiring and the tools are effective, the scale is too modest to transform our world and launch us into a fully inclusive and prosperous future (as noted in [Chapter 4](#)). Add in the enhanced power of business to nurture and strengthen people and communities they themselves depend on to thrive over the longer term, and the pathway to a healthier, wealthier, and more prosperous future—together—comes into view. Adopting new models of business enterprise, designed for the 21st century, including stakeholder engagement, shared value initiatives, and system stewardship, can help tackle the problems that current enterprise models have fostered, such as income and wealth inequality, environmental harm, and the U.S. health disadvantage. Current models reinforce the status quo and stand in the way of community health and economic prosperity.

*“We earn our profits from society and they should go back into society.”*

—Shubhro Sen

## **Conclusions**

Three pathways present alternative futures that carry high stakes—for us, our children, our businesses, and our world. The choices are stark, but no one needs to act alone or start from scratch. No matter the situation, there are opportunities to rethink past practices and connect with others who are ready to do business differently—together. Innovators and changemakers today can write the next chapter in American history by dispelling illusions of separateness and replacing them with experiences of interdependence. That shift alone could help to unlock health, wealth, and well-being on a greater scale.

To harness those opportunities, governments cannot dictate the way; doctors cannot prescribe a quick fix; and businesses cannot stand on the sidelines or engage only in philanthropy. All efforts—as individuals, institutions, and industries—must combine in new ways if society wants to survive and thrive in a rapidly changing world. Fortunately, even amid despair and division, leaders across the country are stepping up as engaged stewards and forming new partnerships with stakeholders and changemakers, precisely because they want to accomplish results that cannot be accomplished alone and that produce benefits across people and communities. This trend is relatively young, and many partnerships are not yet as mature as they need to be. With a growing awareness of interdependence, greater engagement of all stakeholders, and stronger alignment of business earnings and societal gains, such partnerships and investments can ripen into healthy communities and a more sustainably prosperous economy, upon which all people depend.

When faced with uncertain futures, business leaders and community changemakers of today may be best poised to rely on a proud tradition of American pragmatism—knowing that the best way to predict the future is to create it, together.

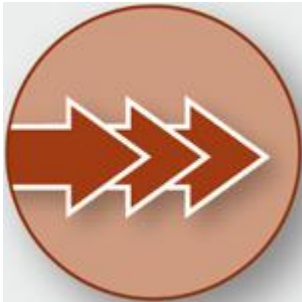
## APPENDIX A TOOLS AND RESOURCES

[Appendix A](#) identifies tools and resources addressing topics explored in [Chapter 7](#). The tools and resources were created by such businesses and organizations as Business for Social Responsibility, Harvard Business School, Institute for Local Self-Reliance, Massachusetts Institute of Technology, and others.

[Go to:](#)

### BANK OF AMERICA: The Path to Participation

|                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|-------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|   | <p><b>Community Challenge</b>   Companies need employees who understand their customers, but competition for talent is steep. How can companies recruit and retain employees who can effectively serve their customers?</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|  | <p><b>Scenario</b>   Headquartered in Charlotte, North Carolina, Bank of America (BOA) is a financial institution that serves individual consumers, small- and middle-market businesses, and large corporations. Many BOA financial centers conduct business in low- and moderate-income communities.</p> <p>As demographics change in communities across the country, BOA wants to ensure that its labor force remains responsive to the needs of low-income communities. BOA builds its business on client relationships, so it needs employees who understand the financial challenges customers face. “BOA is keenly focused on recruiting, developing, and retaining talent,” said Jennifer Andrew, senior vice president of The Academy.<sup>1</sup> “Not just hiring but seeking talent for meaningful and sustainable long-term careers.”</p> <p>As the United States climbed out of the Great Recession, BOA’s leadership grew concerned about future hiring and the prospect of losing employees in a tight labor market. There is a cost to hire and retain employees. BOA was an active recruiter at</p> |

|                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
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|                                                                                   | <p>colleges and universities, but many employment opportunities were not being filled. How could BOA find good employees?</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|  | <p><b>Action Taken  </b> Looking for answers in early 2018, BOA managers started digging through data around open positions and applications. They discovered they were often not recruiting from the communities where jobs were available, and many positions at BOA did not require a college degree.</p> <p>“We began reaching out to community partners to provide better perspective on the opportunities BOA offered and the skills we are seeking,” Andrew said. “We wanted people to realize that Bank of America has job opportunities for people with all different educational backgrounds.”</p> <p>Andrew and her team at BOA launched the Pathways Program in 2018. Through this program, BOA is committed to hiring 10,000 people from low- to moderate-income neighborhoods by 2023. “As part of Pathways, we increased our recruiting from nonprofit partners who provide professional skills training,” Abigail Hollingsworth, senior vice president, BOA Foundation, said. “We found that nonprofits differ from one market to another, so we have to take a very localized approach to find organizations that are preparing talent for the jobs we have available.”</p> <p>By the end of 2019, BOA employed 80% of new employees hired through the Pathways Program, and some of them had even been promoted. BOA also learned a lot about low- to middle-income workers. These learnings made BOA a better employer of all employees and prepared managers to be sensitive to the many hurdles employees face every day (e.g., problems finding professional attire, care for children, and transportation to and from work). Managers were given the flexibility to remove obstacles to successful employment. In 2020, BOA increased its minimum wage to \$20 per hour. As a result, entry-level employees have more financial security than employees in similar roles at other companies. “By hiring from the communities we serve and helping our teammates develop their careers at the bank, we are helping our clients—and employees—lead better financial lives,” Andrew said.</p> |





**Key Takeaway** | By thinking differently about where to recruit talent, BOA discovered a group of potential employees capable of working in the financial industry. BOA now provides livable wages and financial literacy to employees who in turn can teach better money habits to their friends and neighbors in the communities in which they live and work.

[Go to:](#)

## Footnotes

1

The Academy is BOA's coaching and development organization dedicated to the success of every employee.

## CHAPTER 8Report Recommendations

### OVERVIEW

This chapter recommends actions that businesses can take to strengthen community health and economic prosperity, develop a competitive business advantage, and build resilience for both community and business.

### Report Recommendations

The Surgeon General recommends the following actions to strengthen community health and economic prosperity, develop a competitive business advantage, and build resilience for both community and business. These approaches can help solve the U.S. health disadvantage and help companies account for the interdependence between business and society, and between community health and economic prosperity, when making business decisions. These strategies can help address the U.S. health disadvantage and help to ensure that the vital conditions are met for all Americans.

The Surgeon General notes that this is not an exhaustive list of all possible positive actions that businesses can take to strengthen community health and economic prosperity. Instead, this set of actions comprises a solid starting point based on real-world examples. Businesses will continue to innovate and collaborate together across sectors to discover, develop, and test ways to strengthen capitalism in the United States to the benefit of business and society, and community health and economic prosperity.

### 1. Learn More About Your Stakeholders

Stakeholders are all those who participate in a business and are essential to its success—including everyone from employees to suppliers to investors. Valuing the needs and interests of all stakeholders, and avoiding prioritizing one stakeholder at the expense of another, helps ensure success.

- **Fully understand the cost of poor health and other community challenges and the impact of these challenges on your company.** Addressing challenging conditions in communities can improve opportunities for businesses, employees, customers, suppliers and other stakeholders and help create a thriving environment. Understanding the broader community you live in and developing business models that work to enhance that world help make explicit the connections among good business practices, profitability, and responsibility to community and society.

**Example**—Businesses can help meet stakeholders’ needs through investments in quality affordable housing and education, by providing meaningful work and wealth, and by restoring or sustaining a thriving natural world. [Box 4.5](#) in this report describes the negative impact of high housing costs on businesses’ ability to recruit, hire and retain employees. This creates an opportunity for business investment in affordable housing.

- **Join the dialogue on community health, wealth, and well-being.** As this report goes to press, community dialogue abounds on bending the COVID-19 curve and addressing the impact of racism on health, wealth, and well-being. Even before the events of 2020, communities, businesses, and leaders were engaged in conversations about how to create a more equitable, just, and prosperous society—including addressing health, wealth, and well-being gaps across communities. A critical component of effective dialogue is viewing problems, policy options, and solutions from the perspective of the well-being of others.

**Example**—Hillenbrand, Inc., established such a dialogue in their community of Batesville, Indiana. The Hillenbrand Community Leadership Series annually assembles 20 people from the company and community to engage in strategic discussions with business and civic leaders. The group is often used as a “think tank” for the community, studying and solving large issues facing the community, including diversity and inclusion, workforce skills, and the development of a vibrant downtown to build Batesville and Southeastern Indiana into attractive places to live and work.

- **Meaningfully engage all stakeholders on ways to optimize value.** Many companies recognize the value that each stakeholder brings to the business enterprise. Meaningfully engaging each stakeholder—employees, customers, suppliers, communities, investors, and shareholders—brings innovative ideas to the fore, increases productivity and commitment to the enterprise, improves business practices, and creates more sustainable operations.

**Example**—Sodexo creates value for its stakeholders by integrating actions that support health and wellbeing into the core of its business operations. By creating value for all of its stakeholders, Sodexo can grow in a way that is better, safer, healthier, and more sustainable for people and the planet.

- **Identify the interdependencies between your company and your stakeholders and between your business and society, and work toward ways of operating that benefit these stakeholders and society.** Businesses depend on their stakeholders in order to exist and earn a profit. Businesses depend on society for essential infrastructure, such as a skilled workforce; a fair, transparent, and well-functioning legal system; education and training of the labor pool; community services like libraries and parks; and transportation and delivery infrastructure. Society and stakeholders likewise depend on businesses—for jobs, goods and services, and tax revenue and to bring innovations to the market. Paying attention to these interdependencies and delivering value to multiple stakeholders can help a business succeed.

**Example**—BSR identified several trends and their implications for business's engagement with stakeholders, including the growing expectation that business (a) has a role in driving an inclusive economy and reducing inequality; (b) should prioritize investment in ecosystems and deep local engagement; and (c) should develop collaborative solutions to systemic challenges.

## **2. Foster a Culture of Stewardship**

Stewardship refers to a company managing its impact on society. System stewardship is the role of enterprises and organizations in solving problems that government alone cannot solve. The U.S. health disadvantage is such a problem, with roots in community conditions, inequality, and opportunity gaps. Stewards of systems will address these causes at a systems level: policy, taxation, investment, education, environment, healthcare, and more.

- **Embrace the positive role of business to strengthen communities.** Businesses are perhaps the most powerful institutions on earth. Wielding that power for good has been a successful strategy for business.

**Example**—Businesses have invested in programs to create local jobs (e.g., Starbucks) and in efforts to strengthen educational outcomes (e.g., Visa) and expand access to early childcare and education (e.g., Patagonia), all of which strengthen communities, especially when targeted to communities that are not thriving.

- **Support local, state, and federal policies that meaningfully increase economic opportunities and equitably improve the health of communities, employees, and families.** Government policies (including spending) have the potential to strengthen communities, reduce inequality, and expand opportunity. Businesses have a powerful voice that can shape policy, including spending and

implementing policies that have equitable impacts, with the most beneficial impacts on those most in need.

**Example—**Health policies like smokefree air and community water fluoridation; tax policies that strengthen opportunity for all and reduce income and wealth gaps; and regulatory policies that optimize outcomes for the greatest number of stakeholders are some of the many ways in which businesses can advocate for outcomes that meet the needs of all stakeholders.

- **Use hiring and procurement tools to strengthen communities and explore opportunities to unleash untapped potential at the local level.** Most businesses have relationships with other businesses, as suppliers and customers. Emphasizing local businesses in these relationships can help strengthen struggling communities and expand opportunities. By focusing on the needs of local communities and underserved populations and by investing in small businesses and entrepreneurs that may have difficulty accessing capital, businesses can solve hiring and supply-chain problems while strengthening communities. Disadvantaged communities and people with low incomes represent untapped potential to improve equitable access to the conditions that shape health, wealth, and well-being.

**Example—**This report highlights several businesses (e.g., Greyston Bakery, Belden Inc., Bank of America, and Hyatt Hotels) that specifically hire individuals who may be passed over by other employers due to such barriers as lack of education, previous incarceration, and substance misuse. As these companies have discovered, such employees often prove to be highly effective, productive, dedicated, and loyal; and having jobs and incomes increase their potential as consumers.

- **Invest business profits in strengthening communities.** Increasingly, both for-profit and nonprofit businesses are recognizing the potential to improve community conditions, especially affordable housing, while also receiving a financial return. Businesses can invest in other businesses, entrepreneurs, community development, and more while prioritizing investments that meet a community need and support commercial success.

**Example—**UnitedHealthcare, a large for-profit health insurance company, provided a low-interest loan to a nonprofit partner to acquire nearly 500 units of rental housing. Up to 100 units are set aside for UnitedHealthcare clients at reduced rents and will include vital supportive services. In addition to loan repayment with interest, UnitedHealthcare already sees improvements in client health and associated cost reductions.

### **3. Develop Strategic Cross-Sector Partnerships**

Businesses that wish to engage with and invest in communities need not go it alone or figure out what to do from scratch. Indeed, most efforts to improve community health, wealth, and well-being involve partnerships that bring a range of expertise and

additional resources. Effective partners for business include community development organizations, philanthropic foundations, government agencies (including public health), and other businesses (including social enterprises).

- **Collaborate with local, regional, and national partners from across sectors to implement effective solutions.** It is no coincidence that each of the exemplars presented in this report addressed a community problem while seeking a solution to a business problem—and did so in collaboration with local, regional, or national partners. That is because complex societal challenges—like opioid misuse, disengaged young people, and even lack of access to broadband Internet in rural areas—demand resources, knowhow, and creativity that multiple organizations working together provide.

**Example**—See Exemplars after each chapter in this report.

- **Partner with community development corporations (CDCs) and community development financial institutions (CDFIs).** CDCs and CDFIs have long been in the business of community building and providing financial and other services and supports to those most in need—both communities and people. Collaborating with these partners accelerates the work of increasing opportunity and brings specialized skills, financial expertise and resources, and deep community knowledge and trust.

**Example**—Morgan Stanley, an investment bank and financial services company, partnered with Local Initiatives Support Corporation (LISC), a national CDFI, and the Kresge Foundation to create the \$200-million Healthy Futures Fund (HFF), which supports financing of community health centers and affordable housing in underserved areas. So Others Might Eat (SOME), a nonprofit community development corporation, used funds from HFF to develop the Conway Center in Washington, DC, which provides homeless families with affordable housing, a health center, and job training—all adjacent to a transit station.

#### **4. Measure Performance Using Meaningful Indicators of Community Health and Well-Being**

Many companies have key performance indicators to evaluate performance in major areas of business operations. Consider whether your company's performance metrics can be improved by including community health indicators.

- **Ensure that philanthropic giving strengthens community health and economic prosperity.** Businesses can help to ensure that their charitable contributions benefit the community by focusing their investment portfolios and holding themselves accountable for outcomes.

**Example**—To spur job creation in struggling communities after the Great Recession, Starbucks collaborated with the Opportunity Finance Network on an initiative called,

“Create Jobs for the USA.” By carefully measuring and reporting loans made and jobs created or retained, Starbucks was able to assess the impact of its investment on communities.

- **Redefine productivity in the value chain to include the economic costs from societal problems.** Societal problems create economic costs in a company’s value chain. Addressing problems in the value chain—for example, by using resources more efficiently or implementing stronger employee health and safety protections—can optimize productivity and benefit both business and society.

**Example—**Hyatt Hotels and Bank of America each recognized the costly societal issue of young people being disconnected from education and employment. To successfully transition to employment, these individuals required additional training and support. By refocusing HR resources and supports and partnering with a nonprofit organization, both businesses were able to recruit and retain this untapped young talent. Monitoring inputs, outputs, and outcomes over time demonstrated the return on investment to the companies and the potential societal impact.

- **Align wages, salaries, and benefits with the needs of a healthy, equitable, and prosperous society.** A job can be one of the most fulfilling aspects of life, bringing meaning and purpose to employees and their families. But jobs can also be dangerous, demoralize workers, and keep workers and families in poverty. Improving wages, salaries, benefits, and working conditions can turn an arduous and repetitive job into an opportunity and a livelihood.

**Example—**The Wonderful Company, an agricultural company, recognized the value to people, community, and company of providing a \$15 minimum wage to its farm workers. The more robust wage structure helps workers and their families meet basic needs for housing, healthy food, transportation, and quality childcare.

- **Create shared value for companies and communities by combining social purpose with business opportunities.** Shared value happens when profitable business strategies produce real societal benefits. Business can uncover these opportunities by choosing to help solve a particular social problem and doing so in a way that creates or augments a business opportunity.

**Example—**First Step Staffing is a social enterprise providing employment services for people transitioning from homelessness, including veterans and formerly incarcerated individuals. It serves business clients in need of reliable staff, is itself a successful business, and welcomes investments from other businesses as it grows. A more diffuse example is Intel’s investment in education, especially building the computer and technology skills of students and teachers across the country and around the globe, which further develops the market for Intel products.

As a powerful force for good, businesses have multiple opportunities to increase the health, wealth, and well-being of people and places, especially those that are not thriving; to expand business opportunity; and to increase business and societal value. These recommendations offer opportunities for business, working together with others, to more purposefully embrace their role as stakeholders in a society that works for everyone. With growing awareness of interdependence, greater engagement of all stakeholders, and an alignment of business earnings and societal gains, such partnerships and investments can ripen into healthier people and communities, a more equitable and just society, and a sustainably prosperous economy upon which everyone depends.

## GRADS OF LIFE: Helping Businesses Build a Talent Pipeline



**Community Challenge |** Before the coronavirus outbreak in spring 2020, an estimated 3 million young people (7.6%), 16- to 24-years of age, were not working and not in school. Known as “opportunity youth,” these young people are driven, motivated, and ready to work. But they often juggle many responsibilities, lack access to professional networks and higher education, and may be overlooked by traditional hiring methods. Although opportunity youth are an untapped talent pool of young adults, business managers must manage differently to attract and support the success of opportunity youth. Grads of Life helps managers seize these opportunities.



**Scenario |** Elyse Rosenblum has been in the business world long enough to know that many people equate a college degree with having credible skills for employment. She also knows that young adults without college degrees have tough times landing good jobs. Rosenblum founded Grads of Life, a national organization based in Boston, Massachusetts, to close this opportunity divide. Grads of Life works with employers and businesses to hire young adults without postsecondary credentials. “We bucket our work into two big categories,” Rosenblum said. “One is changing how employers think about opportunity youth and young adults without 4-year degrees as a valuable source of talent, and the other is changing their business practices to reflect that.” Rosenblum and her team designed a process that helps employers diagnose barriers to hiring and develop and deliver scalable and sustainable solutions to recruit, hire, and retain opportunity youth.

Small and large businesses are interested in opportunity youth as potential employees, but the reality is that frontline managers

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|                                                                                   | <p>often fall short when working with this group of youth. “You can have a great initiative and successfully roll it out,” said Rosenblum. “But if the person interfacing with the talent is not prepared and supported in understanding how to retain and advance people who may not have been in that work environment, things tend to go awry.” This is one of many hiring difficulties that Grads of Life addresses for employers.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|  | <p><b>Action Taken  </b> Recognizing patterns where the employment journey falls apart for opportunity youth, Grads of Life developed tools and made them widely available to employers. Grads of Life codified principles and practices around what it means to be a good opportunity employer, and then launched Opportunity Navigator (OPT-N). Built around five principles, OPT-N provides individualized recruitment, hiring, and retention blueprints for employers.</p> <p>The first two principles of OPT-N set the stage for employers to organize their own internal affairs: articulating a commitment to inclusion and respect and having a data-driven opportunity employment strategy. “Employers may try innovative practices and pilots,” Rosenblum said. “But they are not necessarily tracking the pilot data to their norm to know whether they are getting a return on their investment.” Often the problem is that pilot champions do not have access to human resources data.</p> <p>The third principle of OPT-N focuses on being proactive and intentional around the recruitment of opportunity youth. This means partnering with community organizations to source talent and offer work experiences, such as apprenticeships. Additionally, removing the requirement of a 4-year degree for entry-level and middle-skilled jobs also removes barriers to employment. The fourth and fifth principles of OPT-N focus on practices for employers after they have opened the door to opportunity youth: providing livable wages and benefits and offering career development to grow in the job.</p> |





**Key Takeaway** | Opportunity youth are an available, capable, and motivated pool of talent that is often overlooked in the workforce. Companies can leverage the talent of opportunity youth by implementing hiring strategies that create diverse and inclusive talent pipelines. Grads of Life continues to develop innovative tools and resources that help companies meet their hiring needs and remove employment barriers for opportunity youth. By investing time and resources to hire, develop, and retain talent from the communities they serve, companies can increase their community engagement and enhance their bottom line.

## Perspectives From Business Leaders

### OVERVIEW

This section presents perspectives from business leaders who describe multifaceted investments in communities. They explain what was done and why it was done, the impact on community health and economic prosperity, and the value for business. Read about their principles, the importance of childcare and families for the future, and how to build lasting collaborations that strengthen health and prosperity. Perspectives from three organizations are presented: Centene Corporation; Hillenbrand, Inc.; and Shakopee Mdewakanton Sioux Community.

### Centene Corporation Perspective

#### Authors

Michael F. Neidorff<sup>1</sup>.

#### Affiliations

<sup>1</sup> Chairman, President, and CEO, Centene Corporation

### The Power of Community

At Centene Corporation (Centene), we believe that economic prosperity relies on investment. When Betty Brinn started Family Hospital Physician Associates (FHPA) in 1984, some 19 million people were eligible for Medicaid across the United States. Once a child in the foster care system and later a mother of four, Brinn was determined to make quality healthcare available to those in need. In her 8 years of pursuing that mission, Brinn grew FHPA from a pilot, nonprofit, Medicaid-managed care plan, housed in the basement of a hospital in Milwaukee, Wisconsin, to a \$40-million, for-profit company with 40,000 members.

This purpose and growth attracted me to join the company as chief executive officer in 1996, renaming it Centene in 1997. I appreciated the values of Brinn's organization and shared her belief that every person is entitled to quality healthcare delivered with dignity. From this point, I set out to bring the company's managed care services to as many people as possible. Prior to joining Centene, I had learned to harness the power of local brands. Having spent years in the consumer products industry, I brought these lessons to Centene and believed the company could grow by tailoring healthcare to specific community needs and allowing bold, independent health plan leaders to retain authority and accountability in their local markets. This approach became the foundation of Centene's business model and culture.

Today, Centene has become the largest Medicaid managed care organization (by membership) in the United States, a national leader in managed long-term services and supports, and the top insurer in the nation on the Health Insurance Marketplace. Annual revenues exceeded \$74 billion in 2019. Centene goes beyond traditional healthcare by partnering with states and other stakeholders to offer programs and services that address the health and social needs of the country's most vulnerable populations. Centene provides healthcare coverage to approximately 1 in 15 individuals across the nation.

Headquartered in St. Louis, Missouri, Centene employs more than 69,000 people. Centene's presence in the St. Louis area is evident across the city's landscape, from its global headquarters in downtown Clayton to its \$35-million service center in Ferguson. The service center exemplifies Centene's commitment to the region.

In August 2014, the world focused on the St. Louis suburb of Ferguson as protesters and police violently clashed following the shooting death of 18-year old Michael Brown, Jr., by a Ferguson police officer. The city's businesses and residents were besieged by fires, vandalism, and riots, and the future of this small community hung in the balance. Ferguson's problems were not unique to Missouri and could have taken place in any community in the United States.

Centene was among the first of many corporations in St. Louis to see the importance of supporting the community of Ferguson. Plans for a new facility in Ferguson moved quickly; fewer than 18 months elapsed between the site announcement and the grand opening. The new facility, named the Centene Service Center, opened in Ferguson in April 2016 and provides many amenities for employees and the community, including a community education center, internship programs, and an early childhood development center. It also brought 250 new jobs. Reaching young people in Ferguson and surrounding communities became part of Centene's strategy to help Ferguson move forward. Centene partnered with Normandy High School to connect students in the Ferguson area with a mentor and an internship at the service center. Dr. Charles Pearson, superintendent of the Normandy Schools Collaborative, said the partnership

with Centene, “is another way to help our students make the connection between what they’re learning in the classroom and how it can have a positive impact on their futures.”

Centene also partnered with the Greater St. Louis Boys and Girls Club to launch Ferguson’s first Boys and Girls Clubs in two of the city’s elementary schools, paving the way for 400 children to enroll in the club’s summer and afterschool programs. Additionally, Centene partnered with the Urban League of Metropolitan St. Louis to build a new job training center on the site of the former QuikTrip location that was destroyed during the protests.

Centene is an important partner in the St. Louis region and in Missouri. Centene’s Missouri subsidiary, Home State Health, is also headquartered in the St. Louis area and serves families enrolled in the state’s Medicaid program. Since 2012, Home State has partnered with local and statewide physicians, hospitals, and other providers to care for more than 315,000 members across Missouri.

### **External Influences on Well-Being**

We at Centene recognize the vital conditions that influence community health. Coincidentally, these conditions align with our company’s industry sector and underscore the scope of our impact: Centene can successfully provide for the health of its members only if we address the underlying conditions that often stand in the way of members achieving health in the first place.

Through our health plans, Centene has piloted several programs that address areas of influence over health (housing, food, education, employment and transportation), for example:

- **Transportation.** Rideshare pilot programs demonstrate improvement in quality of service and reduction in cost across several populations—that is, a 16-percentage point increase in on-time arrivals to appointments (from 83% to 99%) and a 15–18% reduction in cost for non-emergency medical transportation.
- **Community navigation.** Social prescribing services assess support needs and connect individuals with local resources. A partnership between a health plan and community hub provides navigators who help families access local services and provides interpersonal support. For those engaged, birth outcomes improved for high-risk members, demonstrating a 136% return on investment (\$2.36 for every \$1 invested).
- **Housing.** Participating in a continuum of care, which uses homelessness data from the U.S. Department of Housing and Urban Development to ensure coordinated entry for members experiencing homelessness, resulted in improved health outcomes and costs, including a 9% reduction in inpatient behavioral health visits per month.

### **Experimentation and Investments to Transform the Status Quo**

The path to these programs requires a recognition of the importance of complex systems; the challenges are too large and complex to be solved by a single organization or industry. There is a discernable need to transform the healthcare industry from a series of single-actor silos to cross-sector partners.

Our approach contributes to operational practices and data analytic capabilities. We initially test our pilot initiatives through health plans in individual states, and when appropriate, bring our work to the national conversation. Below are a few ways in which we continue to experiment and invest in serving the health and social needs of our country's most vulnerable populations.

- Centene's Social Determinants of Health Innovation team leverages our local and national relationships to advance the healthcare industry's approach to addressing the barriers that keep members from achieving optimal health. Across multiple states, our health plans have implemented community-integrated social services technology platforms to connect members with community benefit organizations. For example, Buckeye Health Plan, Centene's subsidiary in Ohio, participates in the Pathways Community Hub partnership to identify and address barriers to care for vulnerable persons. By connecting members to community supports and resources via the Hub, Buckeye Health Plan has significantly (a) improved birth outcomes for women who are most at risk of low birthweight deliveries and (b) reduced admissions to neonatal intensive care units.
- Through a partnership among Centene, Washington University in St. Louis, and Duke University, the Centene Center for Health Transformation fosters research collaborations, demonstrates thought leadership, and initiates innovative new programs. For example, a study of the Centene Center for Health Transformation indicated that interventions to help identify and manage unmet social needs may improve health by lowering stress levels and increasing positive health behaviors. In addition, the Centene Center is currently working with Centene's health plans in Louisiana, Missouri, and Florida to evaluate the impact of peer coaches on reducing childhood obesity, specifically through dietary and activity habits.
- Centene's Social Health Bridge™ Trust is designed to bring data-driven and evidence-based approaches to such entities as physicians, hospital systems, Accountable Care Organizations, payers, and health departments to address conditions that shape the health of individuals and communities.

## **Investing in Alliances**

Firms operate in social and political contexts. The importance of strong relationships with states and local communities should not be underestimated. Strengthening relationships is not easy and takes time. Even in this domain, we've embraced a longtime mantra of mine: "We have to be different. Be first."

This means that, as with our business approach, we make thoughtful investments into communities that may not pay off for years. Also, because scientific research is not always available, we must experiment, test, verify, and expand, often while leading others. We do this because the fate of our business units is inextricably tied to our communities.

[W]ith our business approach, we make thoughtful investments into communities that may not pay off for years.

In recent years, we have expanded our presence in several cities, with an eye to increasing the economic health and development of these areas, including Sacramento, California and Farmington, Missouri. We have many instrumental partners who have enabled our economic, civic, healthcare, and educational involvement at the local level—all of which contribute to an enriched environment that empowers healthier decisions to create more vibrant families and communities.

On February 21, 2019, Centene dedicated the cornerstone of a new 68-acre campus in the North Natomas region of Sacramento, California. The facility represents the biggest private sector job recruitment in the modern history of Sacramento. Construction is underway, and the campus will serve as a regional hub for Centene. Sacramento Mayor Darrell Steinberg recognized the power of Centene's presence in California: "We are welcoming a new community leader to Sacramento. Centene and Health Net are at the forefront of serving some of the community's most vulnerable people." Health Net, Centene's health plan in California, is a wholly owned subsidiary of Centene that was acquired in 2016.

*"When a growing city and a great company are serious about creating jobs and real opportunity for people, we can both move mountains."*

—Darrell Steinberg

Centene's expansion was noted as a victory for Sacramento. Mayor Steinberg praised Centene's partnership with Sacramento on this effort: "The way this all came together says a lot about both Sacramento and Centene. When a growing city and a great company are serious about creating jobs and real opportunity for people, we can both move mountains. The Centene agreement may not be the exception; in fact, it's the model of where the public sector and the private sector coming together is both a big winner for the city and for the company."

### **Strategic Growth and Continued Partnerships**

While Centene believes that businesses have opportunities to address social and economic disparities through investments and creativity, we also recognize that state and federal governments play a role in aligning incentives and supporting provisions for these services. We support policies that enable innovation, such as (a) state Medicaid actions to include any nonemergency medical transportation benefits in their Medicaid

managed care programs and (b) removing regulatory barriers to health plans developing innovative ridesharing programs.

We also support policies that increase financial support to pay for these services through public programs, such as Medicare Advantage policies that encourage health plans to innovate. For example, some health plans now offer supplemental benefits and other demonstration programs that can test the effectiveness of these investments. More can be done to allow states and localities to combine and utilize all relevant public funding streams to better target and develop a full suite of services to facilitate whole-person care.

We must develop new products and partnerships to better serve the needs of the community. Sustaining growth requires increased differentiation from competitors. Centene realizes that setting the terms of competition by being the first to enter a market or by using a particular strategy, such as having affiliated in-house companies provide a seamless whole-person approach to care, positions the company for continued success. Success also requires a measured appetite for risk, an ability to act quickly, and a foundation of patience and disciplined investment to build relationships in each new market and to design products that meet the changing needs of local communities.

With continued investments in communities and a steadfast commitment to the guiding principles of the enterprise, Centene strives to improve the health of its members; works to combat health inequities; and returns value to our shareholders, our partners, and, most importantly, the communities we serve.

## **Hillenbrand, Inc. Perspective**

### **Authors**

Joe Raver<sup>1</sup>.

### **Affiliations**

<sup>1</sup> President and CEO, Hillenbrand, Inc.

## **Hillenbrand Today**

Hillenbrand, Inc. (Hillenbrand) is a global diversified industrial company headquartered in Batesville, Indiana. We employ more than 12,000 people worldwide at multiple leading brands that serve a wide variety of industries. The company is also an anchor institution in the Batesville area.

Our portfolio includes companies that design, develop, manufacture, and service highly engineered industrial equipment, and Hillenbrand's legacy company, Batesville, is a recognized leader in the death care industry in North America.

Hillenbrand strives to provide superior return for shareholders, exceptional value for customers, and great professional opportunities for employees and to be responsible to our communities.

### **Hillenbrand's Roots**

Despite operations in more than 40 countries, we remain headquartered in the heart of the United States. Batesville is a small city in Southeastern Indiana, nestled halfway between Indianapolis and Cincinnati (Ohio). The relationships between this community of 6,000 people and the company are deep and resilient.

John A. Hillenbrand planted the company's roots in Batesville in 1906 when he rescued a small, struggling casket company. Since then, the company has recognized the importance of the relationship between an anchor institution and a community and the value that keeping innovation and continuous improvement in focus brings to both.

The company was then, and is today, a true community partner, employing hundreds of the city's residents and helping to fuel growth in education, the arts, and the economy.

### **Challenges in Small, Rural Communities**

Remaining headquartered in a rural community in the United States poses several challenges that require partnerships to develop practical solutions. We have learned this about being an anchor institution and community partner: No institution can single-handedly overcome challenges or create and sustain solutions on its own.

No institution can single-handedly overcome challenges or create and sustain solutions on its own.

Consider the challenge of rural population growth: it is flat at best and in decline at worst.

While Hillenbrand continues to grow, the population of our hometown and surrounding rural communities is dwindling, posing a serious challenge for Hillenbrand and other companies seeking qualified workers. Students are leaving for college and not returning to the local workforce; the birth rate is declining as the existing population ages; and immigrants and their families are settling in larger cities. These trends leave companies like Hillenbrand facing a steady decline of available working-age employees and a gap in skills needed to perform critical jobs.

- To help rural communities thrive, policymakers, business leaders, and educational institutions must work together to reduce the population decline, address the skills gap, and attract and retain new workers. For example, rural communities need quality healthcare with nearby access to obstetric and gynecologic (OB-GYN) services so young families can grow without having to drive 2 hours to an OB-GYN appointment; and

- Formal programs are needed to close gaps in skills and provide talent pipelines to sustain and grow local businesses.

Each of these is a long-term investment that might not yield immediate dividends, but they are important to the vitality of the community and the company. Hillenbrand has focused on these and other efforts to foster a talent ecosystem that attracts and retains the next generation of workers and creates sustainable communities.

### **The Unique Role of Anchor Institutions**

Students, graduates, and young families are opting first for quality of place. They are moving, with or without a job or income, to interesting locations with the amenities they seek. Because rural communities often do not have these amenities—such as diversity, arts, and cultural experiences—rural communities develop quality of place for themselves.

To better understand and address the various challenges facing rural communities, Indiana’s Task Force on Rural Affairs built a coalition of rural business and thought leaders, including representatives of Hillenbrand, from across the state for a year. The task force discovered that quality of place for rural communities hinges on the presence of quality education and industry (business and employment), an anchor institution, and a hospital or healthcare facility with an obstetric practice. The lack of public transportation in rural communities means these essentials must exist within 30 miles of a city’s center.

With these insights, Hillenbrand joined with others to make hospital services in Batesville a priority, and to focus philanthropic, workforce, and community relations efforts on education, industry, and healthcare. These community assets will determine the vitality and sustainability of our rural communities for years to come.

### **Building Regional Capacity**

Building on the successes of similar programs, the Hillenbrand Community Leadership Series (HICLS) annually assembles 20 people from the company and community to engage in strategic discussions with business and civic leaders. The group is often used as a “think tank” for the community, studying and solving large issues facing the community, including diversity and inclusion, workforce skills, and the development of a vibrant downtown to build Batesville and Southeastern Indiana into attractive places to live and work. Indeed, quality of place featured prominently in a 2015 HICLS survey showing that a lack of entertainment, dining, and shopping are among the top reasons people who work in Batesville chose to live elsewhere.

Indianapolis, just 50 miles northwest of Batesville, is home to a world-renowned symphony orchestra. People looking to enjoy this level of art and culture were not finding it in or around Batesville. Hillenbrand worked with the Batesville Area Arts Council to create a 3-year strategic partnership with the Indianapolis Symphony



Orchestra (ISO). The partnership coordinates the Star-Spangled Symphony. ISO transports a stage and its musicians to Batesville for a concert. The performance is accompanied by fireworks, bringing to Batesville a patriotic event that most area residents would have to travel a significant distance to see otherwise. A network of regional sponsors helps to make the event successful, including financial and volunteer support from Hillenbrand, the Batesville Area Arts Council, the City of Batesville, and across Southeastern Indiana. But the partnership does not focus only on the concert; to support programming leading up to the concert, ISO's musicians engage with area schools and community leaders to promote the arts.

Events like the Star-Spangled Symphony benefit more than the arts. They enhance economic development by enabling smaller businesses to cross-sell to new groups of consumers who travel to communities to attend events. Arts act as a type of tourism department that most smaller communities cannot afford.

### **The Interdependent Economy: Donations and Talent**

In 2015, Hillenbrand launched One Campaign, a corporate initiative around four concepts to improve the communities where Hillenbrand operates: 1 day of service, 1 week of community partnership, 1 month of educational awareness, and 1 year of significant corporate contributions. As One Campaign grows, its focus has evolved from one-and-done volunteer projects to a platform linking business strategies with communities and aligning strategies with the United Nations Global Compact's Sustainable Development Goals. In 2019, the company's initiatives focused on quality education and helping employees foster educational partnerships in communities.

Employees at Hillenbrand in Batesville volunteer as tutors in a summer camp that teaches students about science, technology, engineering, arts, and mathematics—or STEAM. The camp serves students in kindergarten through sixth grade and links to Hillenbrand's workforce talent pipeline.

We also provide opportunities for students in seventh through ninth grades to further their interest in manufacturing. For example, in Manufacturing Camp, a project that benefits a local not-for-profit organization, seventh graders provide backpacks full of school supplies to children in need across Southeastern Indiana. With oversight from company volunteers, students design a production line to fill backpacks with supplies. In doing so, they apply critical thinking to overcome everyday business obstacles, such as power outages, supply shortages, and tariffs. The students assemble 800–1,000 backpacks that are delivered to families in need in 16 counties surrounding Hillenbrand's headquarters.

Donations of time and talent are important components of workforce-related programming and activities, but ultimately, they come with a price tag. Financial contributions or expenditures are often necessary to drive meaningful change, but if

these are not strategic, a company risks sponsoring events with no meaningful link to the company's strategic community and workforce initiatives.

Hillenbrand's financial contributions align with the company's values to pursue growth in the organization and to increase value for the community. We look for opportunities that are community-focused, mutually beneficial, and support growth through engagement.

Hillenbrand's contributions are often mutualistic, benefitting both the company and the community. Consider how Manufacturing Camp works: Hillenbrand donates money to a not-for-profit organization working in the community, and then contributes time and volunteer talent to execute the task of filling and distributing the backpacks. Filled backpacks make their way to students in need in the region, who take their backpacks to area schools, where Hillenbrand recruits future employees.

### **The Opioid Crisis and Rural Communities**

Unfortunately, many communities are grappling with the opioid crisis. Through our partnership in legislative affairs with the local hospital, we found additional needs and startling statistics related to the opioid crisis and health, recovery, and housing in rural communities. Hillenbrand partnered with Margaret Mary Health in Batesville to determine how, as an anchor institution, Hillenbrand could join the conversation and play a role in leading solutions.

Clinicians in the hospital's Addiction Services Program determined that while treating addiction is important, long-term success is rooted in improvements outside the clinical setting. The conditions that shape health—such as access to healthy food, housing, clothing, and often income—must be met to achieve long-term sustained changes in health behavior and are often difficult for a local company to address.

The hospital's Addiction Services Program helps patients find employment, but many patients also experience housing insecurity. Lack of sober living facilities and homeless shelters and limited or nonexistent public transportation in rural communities are barriers to success.

Hillenbrand worked with the hospital to identify community stakeholders who could look for short- and long-term solutions to the barriers, and then hosted a roundtable conversation to gather different perspectives. The establishment of sober living facilities and additional housing for this population is still in its early stages, but sometimes having these challenging conversations in a rural community is the most difficult first step. Hillenbrand often serves as a convener for broader conversations in the community.

### **Closing Skills Gaps**

The challenges inherent in the location of Hillenbrand's headquarters in rural Batesville are not unique to communities in the United States. Companies like Hillenbrand must think differently about how to attract and retain employees at home and abroad. We

realize that developing and maintaining global partnerships to address changing workforce demographics will fuel business and community success.

Hillenbrand is partnering with Batesville High School and a school in Germany near one of our manufacturing sites, and creating opportunities for students in both countries to travel to each other's sites, learn about the company, gain exposure to manufacturing facilities, and consider possible careers. Hillenbrand hopes ongoing collaboratives and hands-on activities will foster interest in manufacturing careers in the United States and abroad.

### **Building a Sustainable Future**

Since the early 1900s, Hillenbrand has embraced its role as an anchor institution in Batesville and in the communities it serves around the world. As an anchor, Hillenbrand has a responsibility and opportunity to strategically invest in communities to provide increased access to education and workforce training, hospitals and health and wellness programs, and cultural opportunities.

In July 2019, Hillenbrand announced its intent to acquire a similar-sized company based in nearby Cincinnati. Shortly after the news of the acquisition was released, community leaders were all asking one question: "Where will your headquarters be?" They were expecting Cincinnati. But we have not moved from Batesville.

For years, Hillenbrand has invested money, time, talent, and leadership to improve Batesville, Indiana, and surrounding communities, as well as all of the communities in which we operate abroad.

We have learned that no single effort will overcome the challenges that rural communities face in terms of workforce, education, and health. But having a strong community strategy and building rich relationships have helped Hillenbrand create a talent pipeline, build regional capacity, infuse arts and culture into everyday life, and improve the health of the people who live in the region. As CEO, I am pleased to share our commitment to help meet the needs of the present while making improvements for future generations. We believe the positive impacts of our people, products, and partnerships will help to enhance the environments in which we operate.

### **Shakopee Mdewakanton Sioux Community Perspective**

#### **Authors**

Chairman Keith Anderson<sup>1</sup>.

#### **Affiliations**

<sup>1</sup> Vice-Chairman Cole Miller, and Secretary/Treasurer Rebecca Crooks-Stratton, Shakopee Mdewakanton Sioux Community

## **Ancient Values and Business Success Spur Community Health and Economic Prosperity**

Shakopee Mdewakanton Sioux Community (SMSC) is a federally recognized, sovereign Dakota tribal government located just southwest of Minneapolis—St. Paul, Minnesota. Our sovereign nation existed before the formation of the United States. Our ancestors have resided in this region for centuries.

Our tribe owns several businesses, or enterprises, first opening a tiny bingo hall in the 1980s that later became Little Six Casino. In 1992, our tribe opened Mystic Lake Casino Hotel, the premier gaming facility in the Midwest. SMSC enterprises have continued to grow and diversify over the years. Our tribe's more than 15 enterprises include a fitness club and natural food market on the reservation, a nearby biomass energy facility, and a luxury hotel located adjacent to the Mall of America in Bloomington, Minnesota.

With more than 4,100 employees and nearly \$177 million in annual payroll, our tribe is now the largest employer in Scott County, Minnesota. We also work with more than 2,000 vendors in a 25-mile radius and pay \$300 million to vendors annually.

Like every responsible government, we provide for the well-being of our residents and employees and maintain important services and infrastructure, including roads, water and sewer systems, parks and green spaces, and emergency services. Unlike other governments, we fund these essential services with earnings generated from our enterprises. We do not have property, income, sales, or other tax revenue to sustain and grow our community and ensure that our community members are healthy and have opportunities to thrive.

Supporting the growth of our enterprises is very important to our tribe. As our enterprises have grown over the years, we have seen that our business success is closely tied to the success of neighboring communities and the wider region. When neighboring businesses and communities grow and thrive, so do our enterprises and our community. Therefore, we invest time and earnings back into the region and into other Native communities. We focus our investments on three strategic areas: our region and partners, our employees and community, and Indian Country.

### **Our Values**

Investing our business earnings into our communities to ensure that we all succeed, grow, and thrive together keeps both our enterprises and our communities strong. Our decisions are led by a commitment to our citizens, our culture, and our heritage.

### **Tribal Sovereignty: The Inherent Right of Tribes to Self-Governance and Self-Determination**

The Dakota people have lived in the Minnesota and Mississippi River Valleys for thousands of years. The sovereignty of tribal governments predates—and is affirmed by—the U.S. Constitution and U.S. Supreme Court.

“The Congress shall have the power to ... regulate commerce with foreign nations, and among the several states, and with the Indian tribes” (Article 1, Section 8, U.S. Constitution).

As sovereign nations, federally recognized tribes maintain a government-to-government relationship with all levels of government. Tribal members are citizens of their tribe, state, and the United States.

“Wo’ okiye” is the Dakota word for generosity and helping others. The Dakota people have a longstanding tradition of partnership and sharing resources, which we honor through our business practices; community investments in the region; a \$500-million loan program across Indian Country; and our philanthropy program that has provided more than \$350 million to other tribes, local governments, and nonprofit organizations.

The Dakota tradition of planning seven generations ahead also shapes our business and community decisions. We constantly consider how our decisions will impact people seven generations from now. This imperative influences our enterprise ventures and our stewardship of the environment.

### **Investing in Our Region and Partners**

SMSC partners with neighboring governments and organizations to benefit the region by addressing shared priorities, such as public safety, natural resources and the environment.

For example, SMSC partnered with Rahr Malting in 2007 to create a sustainable energy plant called Koda Energy. This combined heat and power plant is the only facility in the United States that burns exclusively natural, non-manmade materials. Using a suspension boiler for maximum efficiency to burn only renewable products, its rate of heat conversion is approximately 87%, which is substantially higher than that of coal (63%). This renewable and sustainable source of energy produces electricity and other forms of power.

The jointly owned facility continues the tribe’s tradition of stewarding the environment and earning revenue from selling excess energy.

### **Governance Structure**

We are charged with promoting the health, education, and welfare of our tribal members now and for generations to come. This includes making decisions that shape SMSC’s role as an employer and member of the broader community.

The highest governing body of SMSC is the General Council, comprised of all enrolled members of our tribe 18 years of age and older. This council meets monthly to discuss important issues, make decisions and set policies, and approve the annual budget of our community. The General Council also elects three members of the Business

Council (chair, vice-chair, and secretary/treasurer) and members of other governing bodies.

The Business Council is responsible for running the day-to-day operations of the tribe and implementing the decisions of the General Council.

Clean water is essential to our communities. SMSC and the City of Prior Lake worked together to build a water treatment plant for both communities, treating up to 3.5-million gallons of water per day for use by the tribe and the city. SMSC provided \$22.5 million for the project, and the city invested \$2.2 million for the equipment necessary to deliver treated water now and in the future. The plant is designed for future expansion as each community grows. By sharing the facility, we reduce redundancies and achieve significant savings for both communities.

Our tribal government is also committed to collaborating and communicating with neighboring governments in Scott County. For example, the Scott County Association for Leadership and Efficiency (SCALE), developed in 2003, is an award-winning local government collaboration between SMSC; Scott County; and the cities, schools, and townships in Scott County. SCALE welcomes entities as equal and voluntary partners who work together to serve the region's growing population more efficiently and effectively. SCALE's initiatives and projects have benefited SMSC and the region, saving all entities money by pooling resources and avoiding redundancies.

Following the success of SCALE, SMSC and its neighbors in Scott County and the Cities of Prior Lake and Shakopee formed the Intergovernmental Working Group (IWG) in 2012. IWG focuses on specific issues, such as land development rights. Like SCALE, IWG provides a forum for governments to come together and find solutions to shared challenges.

### **Investing in Our Employees and Community**

The success of our enterprises is the result of contributions made by many people. Our tribe recognizes the importance of our people, including employees; we take pride in being a good employer that employees are proud to work for.

SMSC demonstrates its values and its appreciation for members and employees by providing them with a comprehensive benefits package and a wide range of services. Employees receive medical and dental insurance and a health flex spending account. They have access to the on-site Mystic Clinic and Shakopee Dakota Clinic, as well as to the tribe's vision and dental clinics. Employees receive discounts at our fitness center, Dakotah! Sport and Fitness, and our natural food market. Beyond health benefits, team members have access to a 401(k) retirement plan, tuition reimbursement, life and disability insurance, weekly pay, free beverages while working, and free uniforms and laundering. Employees at SMSC and its enterprises receive a 50% discount at Playworks, an on-site childcare and early childhood education facility. Many employees

also receive access to free transportation to and from work through a variety of options, including a partnership with the Metro Valley Transit Authority.

Part-time employees receive medical insurance for those working an average of 30 or more hours per week, a 401(k) retirement plan, discounts on health risk assessments and health education, and a discount on membership at Dakotah! Sport and Fitness.

Our employees are some of our biggest advocates, and many stay with us for a long time. The average tenure for SMSC employees is 8 years, which is twice the national average.

### **Investing in Indian Country**

As a Native American tribe, SMSC places particular importance on collaborating with and supporting other tribes and Native American communities. Our investments aim to strengthen individual tribal communities and all of Indian Country.

Many tribes struggle economically; solutions, such as building and maintaining enterprises, are expensive. A lack of economic development means many Native American communities are deemed high risk from a loan perspective, and tribal governments have difficulty obtaining bank loans to cover such investments. To help meet this need, SMSC's loan program has provided more than \$500 million to help spur economic development across Indian Country. The loans help tribes start up and expand enterprises that provide jobs and income for their citizens and enhance their region's economy. The loans also provide interest return for our own tribal community. For example, SMSC funded Red Lake Nation's casino and hotel in Warroad, Minnesota, with a \$27 million loan. The facility opened in 2014 with a state-of-the-art gaming floor and hotel, drawing in new visitors to their reservation and providing about 100 new jobs for tribal and nontribal members in the Warroad area.

As our enterprises have grown over the years, we've seen that our business success is closely tied to the success of the wider region. When neighboring businesses and communities grow and thrive, so do our enterprises and our own community. Therefore, we invest time and earnings back into the region....

The loss of traditional foods and extreme poverty have caused many Native Americans to suffer from poor or inadequate diets. This has led to obesity, diabetes, and other health problems. In fact, Native Americans are twice as likely as the rest of the U.S. population to have nutrition-related health problems.

To improve nutrition and restore healthful diets among Native Americans in our community and nationally, we established an organic garden and natural food market and launched Seeds of Native Health, a \$10-million national philanthropic campaign including grantmaking, advocacy, and research. For example, we contributed \$80,000 toward the implementation of the Navajo Nation's "junk food" tax, which leveraged an additional \$262,000 from three other funders. The Seeds of Native Health campaign

collaborated with MAZON: A Jewish Response to Hunger, to jointly fund the Indigenous Food and Agriculture Initiative’s model tribal agriculture and food code project. The partnership made the policy research project possible and involved a new organization in efforts to improve Native dietary health.

## **Building a Sustainable Future**

Our tribe has forged many relationships, strengthened partnerships, and made investments with the goals of serving our citizens and our Dakota values and of helping the broader community reach their goals. By investing in our region, partners, employees, and community and in other sovereign Native nations, we strengthen our own enterprises and strengthen our people and communities.

Our traditions of “wo’ okiye,” or helpfulness, and of planning seven generations ahead inform our decisions and contribute to the success of our region and of Indian Country as a whole. Not only are these important values, but our tribal community and enterprises have succeeded thanks in part to these traditions. As a tribal government and an owner and operator of many successful enterprises, we have seen firsthand how investing in the broader community benefits our own community and enterprises, which—like many businesses—brings value to our region. Our success is interconnected and shared.

We have seen this interconnection and shared values when building partnerships with competitors, providing high-quality employee benefits and training programs, and helping other Native communities access capital for community development. Our story underscores how putting values into action and building up other governments, businesses, and communities can help everyone achieve great things.

## **Afterword**

### **Afterword to the Surgeon General’s Report**

#### **Authors**

Mike Leavitt<sup>1</sup>.

#### **Affiliations**

<sup>1</sup> Founder and Chair of Leavitt Partners, 14th Governor of Utah, Administrator of the Environmental Protection Agency (2003–2005), and Secretary of the U.S. Department of Health and Human Services (2005–2009)

I have long been passionate about finding ways to better our country through the creativity and innovation that results from the public and private sectors working together toward a common good. I am pleased that the Surgeon General is, through this



report, exploring the important role that the business community plays in improving our country's health, and demonstrating so clearly the inextricable link between community health and economic prosperity.

As I pen this, we are at an unparalleled moment in our nation's history because of the wide-ranging impacts resulting from the arrival of COVID-19 on our shores. Of course, this Surgeon General's Report was conceived quite some time ago, when the next pandemic was only theoretical and far from top of mind for most Americans. COVID-19 presents a formidable challenge to the world and to the United States. Because of COVID-19, we have lost loved ones and colleagues, families have endured difficult economic circumstances like job loss, our daily lives have been disrupted, and our perspectives on health and the economy have been altered.

Our national focus on responding to this public health emergency does not take away from the important messages in this report. In fact, it now seems prescient and highly relevant that the Surgeon General chose to focus on the connections between community health and economic prosperity and the role of business, particularly investing in one to achieve the other. The inextricable link between the health of businesses and the health of communities has never been more apparent. From employees and customers to suppliers and service providers, it is strikingly obvious how interconnected and interdependent we are today.

I would like to reflect on the impacts of this pandemic and some of the truths it has revealed. To address this public health emergency, federal, state, and local governments have had to make difficult decisions, including temporarily suspending activities to create the physical distancing needed to flatten the curve. The phrase *flattening the curve* was foreign to all but public health officials at the beginning of 2020, but that phrase is now common parlance as everyone's cooperation is needed to address the COVID-19 pandemic.

The private sector has also made tough choices, including voluntarily adapting on short notice to working remotely, canceling long-planned conferences and business travel, suspending sports leagues, and altering operations or even closing businesses for periods of time to keep employees and customers safe. These choices have affected nearly all business settings, from office jobs and restaurants to manufacturing, packaging, and retail operations.

Through this pandemic, company leaders have stepped up to take actions in the public interest despite the effects those actions have on their bottom lines. There is no doubt that these decisions are hard on businesses. From one-person start-ups to major multinational corporations, nearly all have felt the pain of the slowdown in business and the impacts on revenue. But ultimately, these dramatic actions are needed to protect the health of the American public, our businesses, our economy, and our future.

But the story does not stop at the health and economic devastation resulting from this pandemic. A broader lens reveals how we can use this experience to ultimately improve our health and our economy and prevent similar devastation from a future threat. While our battle against COVID-19 is not yet over, I am eager to begin documenting our collective observations, perspectives, and lessons learned from confronting this challenge. It may be too early at this point to draw definitive conclusions, but I am certain that we must begin this work now, before too much time passes and we have moved on to other concerns or forgotten what we saw in the first half of 2020. Next, I will share some of my reflections about the underlying problems this pandemic has spotlighted and how our systems can adapt to meet the needs of our population.

First, in addition to showing the clear link between business and health, this pandemic has revealed, sometimes in stark terms, how social and economic stressors influence health. I cofounded the National Alliance to Impact the Social Determinants of Health (NASDOH), partly out of recognition that we need to engage the business community to articulate the whole-of-society value proposition for addressing the social determinants of health—or what this report refers to as the vital conditions that shape health, wealth, and well-being. NASDOH encourages public and private sector leaders to work together to address the conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect health, functioning, and quality-of-life outcomes and risks.

## **NATIONAL ALLIANCE TO IMPACT THE SOCIAL DETERMINANTS OF HEALTH**

NASDOH is a multisector group of stakeholders that works to systematically and pragmatically build a common understanding of the importance of addressing social needs and determinants as part of an overall approach to improve health. NASDOH focuses on advancing public and private sector policy environments to support the development of the evidence base upon which work in the field can build, innovate, and be sustained.

In past emergencies like natural disasters, we have seen that some communities are particularly vulnerable to the health and economic effects stemming from such tragedies. With the spread of COVID-19, we have seen that racial and ethnic minorities, older individuals, and those with underlying health conditions—such as obesity, diabetes, and hypertension—are particularly at risk of complications and death from the virus. As a result, individuals with these conditions have had poorer outcomes than those without such underlying circumstances. The fact that these conditions are so common in America has created additional demands on the healthcare delivery system.

Now we can see that we would be better off if we had invested more to prevent the development of chronic conditions in these higher risk communities and to better manage the conditions once they are diagnosed. As this report discusses, business plays a critically important role in promoting community health—to both business and community—and we should work together to help position ourselves better before the

next emergency. Many of the actions that will ease the impact of an emergency like COVID-19 can also help to address the conditions that cause premature death every day in America. This report highlights several of these actions, including (a) helping more Americans to become financially secure and gain the skills and support they need to be successful on the job and (b) increasing access to quality affordable housing and safe green spaces, quality early childcare and development programs, and reliable transportation. These efforts will remain public health urgencies long after COVID-19 is a memory.

The economic disruptions caused by COVID-19 have hit Americans hard, particularly vulnerable communities. Unemployment and food insecurity have skyrocketed, and many workers have lost their healthcare coverage. Many people who work in the service sector, the “gig work” economy, and other customer-facing jobs have not transitioned easily to working remotely, resulting in tens of millions of furloughs and job losses. Workers deemed “essential”—such as grocery store and food service employees, bus drivers, home health aides, convenience store workers, and first responders—have retained their jobs but at the cost of being far more likely to be exposed to the virus. Financial insecurity and a lack of paid sick leave meant staying home from work when ill was not a viable option for most of these lower-wage workers.

Second, when we look back at the country’s response to this pandemic, I think it is important to remember all it took to fight COVID-19. The immediate response to this crisis required testing capacity, personal protective equipment to protect our healthcare work force, medicines and equipment to treat those who were sick, and vaccine development to protect the population as a whole. But medical care for individual patients is only part of the story. We also needed public health functions, like contact tracing; social services, like food pantries for the food insecure and meal delivery for the homebound; and childcare supports and transportation options to help essential workers report to their jobs. And we had to work together to make and support decisions that benefit all of us, not just one sector, population group, or location.

Our healthcare workers on the frontlines of the pandemic face immense challenges just to keep up with the demands and changes in practices to ensure that patients and staff are safe. Our social care systems are also strained, having to adapt and create new ways of delivering services amidst the demands and challenges from the pandemic.

When we think in the future about the infrastructure and personnel that our country needs to support health, I hope we will remember the importance of

- Hospital beds, equipment, and frontline healthcare providers;
- Public health and social services programs, personnel, and systems;
- Community cohesion and neighborhood resources; and

- The vital conditions that shape health, wealth, and well-being, which are missing from too many American communities.

Moving forward, we must address all the factors that contribute to worse health and economic outcomes and higher risk for so many Americans, so that next time we can reduce (a) the economic impact and the burden of disease on those individuals and (b) the overall burden on healthcare delivery.

Finally, the COVID-19 pandemic has showed to us the broad view needed to restore health and economic prosperity across sectors and to better strengthen and prepare resilient communities, so we can sustain health and economic prosperity for all our neighbors. The actions we'll need to take to recover and rebuild from the pandemic will challenge us all to play a part—as individuals, families and communities, as well as the public, private, and nonprofit sectors.

This report recognizes that business plays an important role in strengthening communities, creating value, and building shared prosperity. Business can also be an important partner to public health departments, social services systems and enterprises, and community development organizations that have proven so vital in this pandemic and in the decades-long efforts to build healthy and resilient communities and expand opportunities for more Americans. Let us not waste this opportunity to learn from what we have been through and to challenge businesses to engage with communities and serve as leaders in improving health for all.

As this report so eloquently demonstrates, business can and should play a role in improving community health and economic prosperity for all. Now, more than ever, we need the business community's commitment, energy, and devotion to do so. To make the biggest impact and do the most good as we emerge from this pandemic, business leaders should listen to their communities about their unique needs. The challenges in each community varied before this crisis, and communities will emerge from it with different needs as well. I believe we serve best when we listen and learn first, and all of us, including the business community, should rise to the challenge with this spirit in mind.

I will leave you with a final thought. In time, COVID-19 will be conquered by human ingenuity. Until then, it is a problem that must be managed daily. The virus presents a new set of risks that we must learn to navigate together. Although the sense of suffering the pandemic brings is most unwelcome, it will also bring renewal. Hardships like this have a way of renewing our collaborative spirit, inspiring innovation, breaking down bureaucratic obstacles, and scrapping away hubris. We can endure this and become better people and a stronger nation.

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<sup>i</sup> Life expectancy estimates from ChatGPT.

<sup>ii</sup> Estimates from ChatGPT and World Bank, Gross Domestic Products 2022  
<https://data.worldbank.org/indicator/NY.GDP.MKTP.CD>

<sup>iii</sup> Estimates from ChatGPT, primarily based on OECD Health At A Glance 2023 published data. The UK estimate comes from the UK Office for National Statistics.

<sup>iv</sup> 2009 spending estimate from Kaiser Family Foundation 'Trends in Healthcare Costs and Spending' March 2009. The 2020 spending estimate comes from AMA Policy Research Perspectives, 'National Health Expenditures 2020' by Apoorva Rama

<sup>v</sup> Paul Ryan's New and Improved Plan for Medicare and Medicaid, Avik Roy, Forbes, March 29, 2012

<sup>vi</sup> <https://www.hhs.gov/about/news/2018/12/03/reforming-americas-healthcare-system-through-choice-and-competition.html>

<sup>vii</sup> See Market Driven Healthcare and Who Killed Healthcare by Regina Herzlinger for example along with various commentators affiliated with the Manhattan Institute, Pioneer Institute, American Enterprise Institute, Cato Institute and Hoover Institution among others.

<sup>viii</sup> Piecework, Atul Gawande, New Yorker, March 27, 2005

<sup>ix</sup> See Enthoven et al, Toward a 21<sup>st</sup> Century Healthcare System, page xxix.

<sup>x</sup> CEO's Guide - Chapter 5: 7 Costly Healthcare Tricks Impacting Your Bottom Line, email received from Dave Chase July 12, 2024. Chase ended his email with "If you think this chapter is relevant to a colleague, please forward this email which includes this link to the full chapter PDF: [Chapter 5: 7 Tricks Used to Redistribute Profits From Your Organization to the Health Care Industry](#). Feel free to share <https://healthrosetta.org/friends/> broadly with your colleagues and friends. This will allow them to download any of my books." Mr. Chase allowed me to include his tricks in today's text, email of July 12, 2024

<sup>xi</sup> Among the people who think along these lines: **Atul Gawande** - Surgeon, writer, and public health researcher who has written extensively on the inefficiencies of the fee-for-service model. **Ezekiel Emanuel** - Oncologist, bioethicist, and vice provost of global initiatives at the University of Pennsylvania, who has been a vocal critic of fee-for-service payment structures. **Donald Berwick** - Former Administrator of the Centers for Medicare & Medicaid Services (CMS) and a strong advocate for value-based care. **Paul B. Ginsburg** - Health economist and director of the USC-Brookings Schaeffer Initiative for Health Policy, who has critiqued fee-for-service and proposed alternatives. **Robert Pearl** - Former CEO of The Permanente Medical Group and author of "Mistreated: Why We Think We're Getting Good Health Care — and Why We're Usually Wrong," who argues against fee-for-service. **David Blumenthal** - President of the Commonwealth Fund and former National Coordinator for Health Information Technology, who has written about the negative impacts of fee-for-service. **Uwe Reinhardt** (deceased) - Renowned health economist who was a strong critic of the fee-for-service model and its impact on healthcare costs and quality. This list comes from ChatGPT.

<sup>xii</sup> The savings estimate comes from the Physicians for a National Health Plan website <https://pnhp.org/>. They estimated a \$500 billion savings on the 2018 total healthcare budget of about \$3.6 trillion. In 2024, we will spend about \$4.5 trillion. My \$600 billion savings is about 14% of that.

<sup>xiii</sup> This verbiage and the next paragraph come from the PNHP's website <https://pnhp.org/>

<sup>xiv</sup> Brian O'Malley letter to the editor <https://www.bostonglobe.com/2023/05/14/opinion/letters-to-the-editor-prescription-for-aches-and-pains-of-mass-health-insurance-market/>

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xv These references are provided by ChatGPT: Wansink, B. & Hanks, A. S. (2013) found that people served themselves 92% more and ate 44% more calories at a buffet with large plates compared to smaller plates, Rolls, B. J., Roe, L. S., & Meengs, J. S. (2007) discovered that increasing the variety of food available led to greater overall food intake, Research published in the Journal of Nutrition indicated that buffet diners consumed significantly more calories than those dining in à la carte restaurants.

xvi Robert E. Hall and Charles J. Jones, 'The Value of Life and the Rise of Health Spending', Quarterly Journal of Economics, April 2006

xvii The Texas Star+ Medicaid program did this in the early 2000s.

xviii 'terribly complex, blatantly unjust, outrageously expensive, grossly inefficient' is the subtitle of Ezekiel Emanuel's book Reinventing American Healthcare about how the Affordable Care Act will improve our system.

xix Much of this section comes from ChatGPT

xx The Waiting Game, Kings Fund, 2010 <https://www.kingsfund.org.uk/insight-and-analysis/blogs/waiting-game-hospital-waiting-times>

xxi Two in Five Americans Report Unreasonable Wait Healthcare Wait Times, AANP News, July 12, 2023 <https://www.aanp.org/news-feed/two-in-five-americans-report-unreasonable-health-care-wait-times>

xxii Parts of this lengthy section come from ChatGPT

xxiii That's a slight overstatement. In 2024, foreigners owned about 22% of our \$35 trillion national debt, or about \$7.6 trillion.

xxiv This chart was downloaded in July 2024.

xxv Data from various sources including the Kaiser Family Foundation and Y Charts of US Government Spending [https://ycharts.com/indicators/us\\_government\\_medicare\\_spending](https://ycharts.com/indicators/us_government_medicare_spending)

xxvi I used the data posted above for 2010 and 2020. The 2024 Medicare expenditure estimate comes from the February 2024 CBO projection for the year. Medicare will have about 65.5 million beneficiaries, KFF estimate.

xxvii Margot Sanger-Katz et al, A huge threat to the US budget has receded. And no one knows why., New York Times, Sept 3, 2023. This article estimated \$3.9 trillion in cumulative savings.

xxviii This paragraph and the next couple come primarily from the New York Times *ibid*.

xxix These cost estimates from ChatGPT

xxx See, for example, the 2019 JAMA study 'Association of Primary Care Physician Supply with Population Mortality in the United States' <https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2724393> and Macinko, Quantifying the Health Benefits of Primary Care Physician Supply in the United States, 2007 <https://pubmed.ncbi.nlm.nih.gov/17436988/>

1 Alain Enthoven 'The History and Principles of Managed Competition' Health Affairs Supplement, 1993, page 27

2 *ibid.*, page 29

3 Alain C. Enthoven and Laura A. Tollen, editors 'Toward a 21st Century Health System' Jossey-Bass, 2004, page xxix

4 David Dranove, The Economic Evolution of American Healthcare, Princeton University Press, 2000, page 40

5 *ibid.*, page 39

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- 6 Much of this analysis is based on Regina Herzlinger, *Who Killed Healthcare*, McGraw-Hill, 2007, pages 36 - 46
- 7 *ibid.*, page 43
- 8 *ibid.*, page 47. Next quote *ibid.*, page 43
- 9 Much of this section comes from Jan Gregoire Coombs, 'The Rise and Fall of HMOs' University of Wisconsin Press, 2005, chapter 2
- 10 Gitterman, Weiner, Domino, McKethan and Enthoven, Rise and Fall of a Kaiser Permanente Expansion Region, *Milbank Quarterly*, Vol 81, No 4, 2003
- 11 Dranove, *op cit.* page viii. Much of this section is based on Chapter 3.
- 12 *ibid.* page 25
- 13 *ibid.* page 58
- 14 *ibid.* page x
- 15 CBO Testimony: Statement of Robert d. Reischauer, Deputy Director, Congressional Budget Office before the Subcommittee on Oversight, Committee on Ways and Means, US House of Representatives, June 27, 1979
- 16 Dranove, *op. cit.* pages 78 - 79
- 17 J. Wennberg, et. al. 'Are Hospital Services Rationed in New Haven or Over-Utilized in Boston?' *Lancet* 1 (1987): 1185-1188
- 18 See also Dartmouth Atlas of Healthcare, Jack Wennberg, ed (Chicago: American Publishing, 1996, 1999) which shows variation in a wide range of treatments diagnostic tests and drug therapies.
- 19 T. Wickizer et. al. 'Does Utilization Review Reduce Unnecessary Hospital Care and Contain Costs?' *Medical Care* 27 (1989): 632-47
- 20 V. G. Freeman et. al 'Lying for Patients: Physician Deception of Third Party Payers', *Archives of Internal Medicine* (1999): 2263 - 70
- 21 Sean Hennessy et. al 'Retrospective Drug Utilization Review, Prescribing Errors and Clinical Outcomes' *Journal of the American Medical Association*, Vol. 290, No. 11, September 17, 2003
- 22 Stephen Rosenberg, et. al. 'Effect of Utilization Review in a Fee-for-Service Health Insurance Plan' *New England Journal of Medicine*, Volume 333: 1326-31, November 16, 1995
- 23 Norman Kalant et.al. 'How Valid are Utilization Review Tools in Assessing Appropriate Care of Acute Care Beds' *CMAJ* June 27, 2000: 162(13)
- 24 Dranove, *op cit.*, page 84
- 25 Herzlinger, *Who Killed*, page 48
- 26 *Economist*, July 15, 2004
- 27 Alain C. Enthoven 'The History and Principles of Managed Competition' *Health Affairs Supplement*, 1993; 'Why Managed Care Has Failed to Contain Health Costs' *Health Affairs*, Fall 1993. Quotes in this section come from these two articles unless otherwise indicated.
- 28 Much of this discussion comes from Seven A. Schroeder, 'The Clinton Healthcare Plan: Fundamental or Incremental Reform?' *Annals of Internal Medicine*, Nov 1, 1993, Volume 119, Issue 9, pages 945 - 947
- 29 Much of this discussion comes from Derek Bok, 'The Great Health Care Debate of 1993 - 1994' available at [www.upenn.edu/pnc/ptbok/html](http://www.upenn.edu/pnc/ptbok/html)
- 30 Stephen M Shortell and Julie Schmittdiel 'Prepaid Groups and Organized Delivery Systems: Promise, Performance, and Potential' in Enthoven and Tollen, editors, 'Toward a 21st Century Health System' John Wiley & Sons, 2004
- 31 Herzlinger, *Who Killed*, page 47. Next quote from same source, page 48
- 32 Enthoven and Tollen, eds., *op cit.* Preface, page xxxi

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33 This section comes from Gitterman, Weiner, Domino, McKethan and Enthoven, Rise and Fall of a Kaiser Permanente Expansion Region, Milbank Quarterly, Vol 81, No 4, 2003

34 Regina Herzlinger 'Market Driven Healthcare' op cit. page 148

35 Enthoven and Tollen, op cit. page xxxi

36 Stephen M Shortell, op cit. page 14

37 Enthoven, History and Principles of Managed Competition, page 34. Emphasis added.

37 Dranove, op cit. Introduction



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