HEALTH CARE in 2020

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Where Uncertain Reform, Bad Habits, Two Few Doctors and Skyrocketing Costs Are Taking Us

Steve Jacob

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Dedicated
to the loving memory of
Mary Jo Dorsam Yentes, 1922-2011

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Part 1

Introduction

Chapter 1

Health Care in 2020

A defining decade

U.S. health care will change more in the next decade than it has in the last half-century. The health-reform law, if it survives, will be fully implemented by 2020.

Nearly 40 percent of the nation's doctors will have reached retirement age by then. The estimated physician shortage by 2020 is expected to surpass 90,000. About one-third of nurses are 50 or older, and more than half of those want to retire before 2020. Estimates of the nursing shortage by 2020 range from 600,000 to more than one million.

There is no end in sight for medical cost increases that annually surpass the growth of the nation's economy and the Consumer Price Index.

Health reform survived a raucous political debate, defied historical odds against passage and forged ahead despite the worst recession since the Great Depression. The U.S. faces financial risks that have not been confronted since World War II. When President Obama took office in 2009, the federal budget deficit was $6.3 trillion, or about $72,000 per household. The Congressional Budget Office estimates the deficit will be more than $20 trillion—or $172,000 per household—by 2020. The U.S.

debt-to-gross domestic product ratio was 55 percent in 2009. That is expected to rise to 90 percent by 2020. A significant portion of this will be driven by health-care spending.

By 2020, nearly 20 cents of every dollar spent in the U.S. will be spent on health care. The size and scope of these costs have an enormous impact on the nation's financial well-being. Whether the nation comes to grips with controlling them will be pivotal. Since the creation of Medicare and Medicaid in 1965, medical costs have grown faster than the U.S. economy and have resisted cost-control measures except for a brief period in the 1990s. If the price of gasoline had risen at the same rate as health-care spending since 1980, it would be $9 per gallon.

Donald Berwick, administrator of the Centers for Medicare and Medicaid Services, wrote an article in the journal *Health Affairs* in 2008 (before he was appointed by President Obama) outlining what he called the "triple aim," or three goals that needed to be pursued simultaneously:

- Improving the experience of patient care. He pointed to six dimensions of care from a 2001 Institute of Medicine report on quality: safety, effectiveness, patient-centeredness, timeliness, efficiency and equity.
- Improving population health by addressing "upstream" causes of disease, such as poor nutrition, physical inactivity, and tobacco and alcohol abuse.
- Reducing per-capita costs.

When Berwick assumed his role in the Obama administration in 2010, he reaffirmed that the triple aim was "my main focus" in his new job.

Declaring a full-scale revamping of health-care quality and population health while lowering costs is a daunting task. That

tension is highlighted by what Yale University professor William Kissick calls “the iron triangle” of health care: quality, cost and access. Each component competes for resources at the expense of the others. Costs can be cut but, if that is done incorrectly, quality and access suffer. Access can be broadened, but it inevitably will cost more and may harm quality. Improving quality also likely will cost more and may restrict access.

Nowhere does this conflict play out more often than in the Medicare program. More than one-quarter of Medicare outlays are spent on beneficiaries in their last year of life. Sharon Kaufman and Wendy Max, professors at the Institute for Health & Aging at the University of California, San Francisco, note the “societal tension” between the program’s cost control and “the value of open-ended technology” to extend life. As the baby boomers join the program’s ranks in record numbers, an increasing number of patients and their families will find it difficult to resist physicians who recommend potentially beneficial, but expensive, treatments.

Cost-effectiveness and value are important to Medicare’s solvency, but are certainly not considerations in individual treatment decisions. Bioethicists Daniel Callahan and Sherwin Nuland call chronic disease “the front line” of U.S. medicine in the near-future. They point out that the medical system has not made much headway in conquering specific diseases but its “main achievements today consist of devising ways to marginally extend the lives of the very sick ... for a relatively short period of time—at considerable expense and often causing serious suffering to (the patient).”

Callahan and Nuland acknowledge that the views of most Americans regarding the medical system are much more optimistic: belief in limitless medical advances; the notion that major lethal diseases, in theory, can be cured, and that scientific progress is affordable if well-managed.

A 1994 Harvard study found that more than one-third of Americans believed that modern medicine could cure almost any illness suffered by those with access to the most advanced technology. Americans generally are happy with their own individual health care. It is the broader system that upsets them. A 2010 Gallup poll found more than 8 out of 10 consider their health care excellent or good, which is the highest percentage in a decade.

However, in another 2010 Gallup poll, only 40 percent expressed "a great deal" or "quite a lot" of confidence in the health-care system. Gallup conducted a worldwide poll on national confidence in health-care systems in 2006. The U.S. ranked 88th in confidence level out of 120 nations, scoring lower than countries such as India, Iran, Malawi, Afghanistan and Angola.

Paul Keckley, executive director of the Deloitte Center for Health Solutions, wrote in a foreword to that group's 2010 health consumer survey: "They (Americans) are neither patient nor patients; they are consumers ... 'They' want more value from the system, more transparency in pricing and quality, better use of technology and better service ... And 'they' do not want to pay more than they currently pay out-of-pocket, if at all."

The lack of confidence in the health-care system stems in part from insecurity about the future availability of health benefits. A 2010 Employee Benefit Research Institute survey, taken after health reform was signed into law, reflected that the federal legislation did not instill much confidence. Only half of respondents were confident that they would have job-based insurance in the future. About 59 percent were confident just one year earlier, and 68 percent were confident in 2000.

Patient engagement is lacking

The most effective way to cut health-care costs is to use less health care. And many Americans have control over this. A significant per-

centage of disease—especially chronic conditions—is self-inflicted. For example, a 2004 study found that lifestyle changes could prevent at least 90 percent of heart-disease cases. Nearly 4 out of 10 U.S. deaths are attributable to four behaviors: tobacco use, diet, physical inactivity and alcohol abuse. Declines in tobacco use have slowed in the past decade. Obesity has been increasing slowly but steadily. The rates of physical activity and binge drinking have barely improved since 2000.

And when they do need treatment, patients are not holding up their end of the bargain. Only half take medication in the prescribed doses. About half do not take referral advice, three-quarters do not keep follow-up appointments, and about half of those with chronic illnesses abandon medical care within a year.

About this book

Chapter 2, *Health Reform: Big achievement, limited results,* reviews the creation and impact of The Patient Protection and Affordable Care Act of 2010 (referred to in this book generically as "health reform"), the most far-reaching health-policy development since Medicare and Medicaid were created in the 1960s. A detailed account of legislation that encompassed more than 2,000 pages is well beyond the scope of this book. Several chapters include brief synopses of how the law affects several key players in the health-care sector.

The second section of the book examines American health behavior and its consequences. A 2003 *Health Affairs* journal article attempted to quantify the most important factors in determining health and premature death. The authors concluded that controllable factors—health behavior, environmental exposures and social disadvantages—made up a majority of causes. Medical care, which accounts for 95 percent of U.S. health-care spending, affected only 10 percent of premature deaths.

That research provides the framework for this section's chapters. Chapter 3, *Life Expectancy: Going in the wrong direction,* explores why there was a surprising dip in U.S. life expectancy in 2008. Many suspect that rising rates of obesity and poverty are beginning to overwhelm the positive effects of decreased cigarette smoking and medical advances.

Chapter 4, *Health Behavior: The four habits that count most,* discusses how crucial but difficult it is to change destructive habits and replace them with healthy practices.

Chapters 5 through 8 cover the four most important behaviors that raise—or lower—the risk of disease and death. Chapter 5, *Nutrition: Taste, convenience and price rule,* notes that the average American consumed 500 calories more per day in 2000 than in 1970. The price of many processed foods has decreased in the past 20 years, while the cost of fruits and vegetables has risen significantly.

In Chapter 6, *Physical Activity: No medicine like it,* the overwhelming evidence of physical activity's benefits contrasts starkly with how few Americans are meeting recommended guidelines. Only about 5 percent of U.S. adults exercise vigorously on any given day. The No. 1 self-reported "moderate activity" was food and drink preparation. Chapter 7, *Weight Control: The U.S. as an "obesogenic" society*, explores how overweight is the "new normal" in the United States and how obese people have to absorb society's scorn. Ten years ago, the percentage of people considered clinically obese was less than 20 percent in 28 states. That is the case now in only one state—Colorado. Moreover, in nine states, more than 30 percent of the residents are now obese. Obesity is the fastest-growing public-health issue the U.S. has ever faced. Obesity is expected to account for more than 20 percent of health-care spending by 2018.

Chapter 8, *Tobacco and Alcohol: Progress has stalled,* examines what are considered vices. One of the greatest public-health achievements of the last century was cutting the smoking rate in half from its peak in the 1960s. However, it remains the No. 1 preventable cause of death. Half of all smokers can expect to die of tobacco use. Americans are drinking more than they have in the last 25 years. It is not clear whether, on the whole, that is good or bad. Temperance has long been considered a virtue. Nevertheless, an onslaught of research has found that moderate drinking extends life and combats a number of health risks.

Chapter 9, *Personalized Medicine: Its promise remains elusive,* discusses the impact of genes on health and the elusive promise of personalized medicine. Genetics is important to health, but is often given far too much credit or blame for health outcomes. Genes load the gun, but environment pulls the trigger. Genes affect how a body will react to its environment. They are either suppressed or expressed because of health behavior or environmental factors. Personalized medicine, or tailoring medical treatment to an individual's genetic profile, represents an important frontier in combating disease.

Chapter 10, *Health-Care Disparities: "Causes of causes" of death and disease,* explores the social determinants of health. Ironically, rapidly rising health-care costs are crowding out funding for federal and state programs that have a greater effect on health than medical interventions do. Public and preschool education, nutrition programs, environmental controls, public health and public housing are being cut because of rapidly growing government insurance programs. Medical care is a contributor to only 10 percent of premature deaths. Social circumstances—where people are born, live, work and play—and environmental factors determine 20 percent of disease and death. People with low income

and education are more exposed to environmental harm. Disadvantaged circumstances also help drive health behavior and gene expression.

As Chapter 11 *Prevention: What's too much and what's too little* points out, prevention has a reputation that it cannot live up to. Most believe more preventive care saves money. However, less than 20 percent of preventive services do so. Prevention advocates correctly argue that holding prevention to a different standard is unfair. After all, most curative care does not save money. The larger issue, proponents say, is to determine the best way to allocate health-care dollars to improve Americans' health. Other experts believe preventive care is often overused, leading to overtreatment either by finding "pseudo-disease" that never would harm the patient or through false-positive test results.

Workplace wellness programs, the subject of Chapter 12 *Workplace Wellness: Health as a tangible asset*, have surged in larger American companies. Forward-thinking businesses believe employee health is too important to rely on the broader health-care system. They create healthy environments that reward individual effort and build self-esteem. They help pay for the treatment of illness, but they place equal emphasis on keeping employees' health from deteriorating.

Chapter 13, *Patient Engagement: Paying attention pays off,* points out that patients who are actively engaged in their health have better outcomes and more years of healthy life. They are not deterred by the complexity and fragmentation of the health-care system. They practice good health habits. They manage over-the-counter medications, minor wounds, illnesses and injuries on their own. They collaborate with their providers and participate in making treatment decisions. They seek out reliable information on their own. Health reform and the growth of high-deductible health plans will require patients to become better health consumers.

Chapter 14, *Chronic Disease: Health care's big-ticket item,* covers chronic disease, which accounted for 85 percent of health-care spending in 2004. Viewed optimistically, the prevalence of chronic disease is a testament to medical and public-health advances in the 20th century. In 1900, life expectancy was 47 years. Most people died of infectious disease, accidents and childbirth, at a point in life well before today's chronic conditions could develop. Chronic disease is increasing. It is closely tied to the aging of the U.S. population and to the rising obesity rate, which contributes to diabetes, high blood pressure and heart disease. Successful chronic-disease management is tricky but, if successful, could take a huge bite out of the nation's health-care costs.

The third section of the book examines rapidly increasing health-care costs and their consequences. Chapter 15, *National Health Costs: Technology and market power drive increases,* approaches spending from a national perspective. The current trend is sobering. Health-care spending is on track to consume 119 to 142 percent of current U.S. per-capita spending over the next 75 years. That means health care would crowd out other valuable areas of the budget, such as national defense and education. Medical technology accounts for an estimated one-half to two-thirds of spending growth. Another major factor is the market power of dominant health-care organizations, which can dictate steep annual prices increases.

Chapter 16, *Consumer Health Costs: Struggling with bills and higher deductibles,* looks at the impact of rising medical expenses on households. About 40 percent of Americans had trouble paying medical bills in 2010, up from 34 percent in 2005. More than one-quarter of insured households reported problems with medical debt. The disturbing result is widespread self-rationing. Nearly 6 out of 10 adults say they have delayed care because of cost. About 40 percent of those in fair or poor health did not

fill at least one prescription in the past year. People with chronic conditions who fail to take medication are flirting with disastrous consequences.

Chapter 17, *Waste and Overtreatment: No incentive for efficiency,* considers what the Institute of Medicine (IOM) calls health-care system's "overuse, underuse, misuse, duplication, system failures, unnecessary repetition, poor communication, and inefficiency." The IOM estimates that 30 to 40 percent of health-care spending is of no benefit. The FBI estimates an additional 3 to 10 percent of spending is fraudulent.

Chapter 18, *Private Insurance: Heart and soul of reform,* covers individual and employer insurance. The new law will help put small businesses and individual health-insurance buyers on a more equal footing with large employers. Health-insurance exchanges, scheduled to begin in 2014, will lower administrative costs and provide a more orderly insurance market. Insurance coverage will be more comprehensive, and plans will be more transparent in their offerings. However, it remains to be seen whether employers will continue to offer insurance to their employees or shift them to the exchanges.

Chapter 19, *Government Insurance: Here comes reform*—and *baby boomers,* details the expansion of government insurance programs. Medicare and Medicaid, government's health-insurance programs for elderly and low-income Americans, are going to expand significantly by the end of the decade. The number of Medicare recipients is expected to grow from 47 million to 64 million, as more baby boomers enter its ranks. Medicaid will nearly double by 2021 to 100 million recipients, as health reform expands eligibility. More than half of Americans will be enrolled in at least one of these two programs or the Children's Health Insurance Program (CHIP) by the beginning of the next decade.

The fourth section of the book deals with health-care delivery.

Chapter 20, *The Doctor: Overworked and underappreciated,* considers the plight of the beleaguered family physician, the most revered member of the health-care system. These primary-care physicians are the front line of medicine. Their income essentially has stayed the same since the 1990s, while their practice expenses have steadily increased. Their workdays are brutal. They have to fight to collect every dollar. Primary-care physicians' share of the U.S. health-care dollar is only 7 cents. However, primary-care doctors *control* 80 cents of the health-care dollar by sending their patients to hospitals, referring them to specialists and handing out prescriptions.

Chapter 21, *The Hospital: Reinventing itself by necessity,* explores how hospitals are attempting to remake themselves. A key goal for new health-care delivery models is to provide care that results in fewer hospitalizations and emergency-room visits. Hospitals are buying physician practices at a rapid pace to enhance their bargaining power and to strengthen their referral networks.

Chapter 22, *Pharmaceuticals: Industry at a crossroads,* points out that the pharmaceutical industry is facing major near-term challenges. Worldwide sales of brand-name prescription drugs could be cut in half by 2015 as lucrative brands lose patent protection. For decades, it lived off what it called "blockbuster" drugs: patented medications aimed at broad populations with chronic conditions. Cheaper generics now account for more than 3 out of 4 U.S. prescriptions.

Chapter 23, *End-of-Life Care: Quality of death,* deals with end-of-life care, shamelessly smeared by headline-seeking politicians braying about nonexistent "death panels." The most important issues to any patient are how to live and die. The U.S. health-care system does a good job enabling the former, and an awful job with the latter.