

Healthcare reform

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National Organization of State Offices of
Rural Health Meeting
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Health

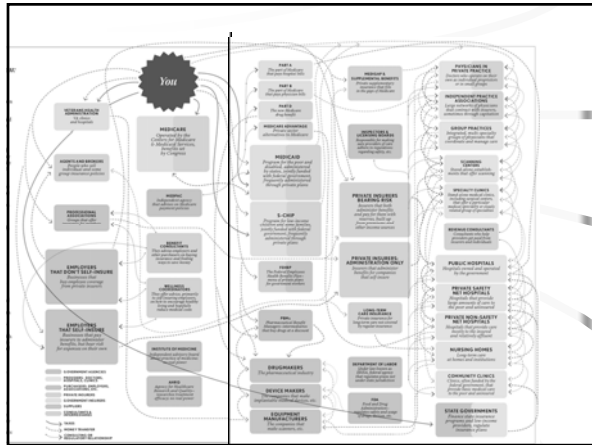
- ...state of complete physical, mental, and social wellbeing, and not merely the absence of disease or infirmity
WHO 1958

Causes of death 1920

1. Endocarditis and organic heart disease
2. Pneumonia
3. Tuberculosis
4. Acute nephritis and Bright's disease
5. Cancer
6. Cerebral hemorrhage and apoplexy
7. Diarrheal disease

Paying for healthcare

- Flexner report - 1910
- Private insurance began 1920's
- Veterans Health Administration 1946
- Private insurance expanded 1947
- Public assistance coverage 1950
- Kerr-Mills 1960 and Medicare 1965
- Medicaid 1965
- S-CHIPS 1997
- Medicare Part D 2005



Paying for Health Care

- Emphasis on maintaining “private practice” model
 - VA and IHS exceptions
- Emphasis on employer based coverage where possible
- Emphasis on consumer choice

Health Care System Today

- Government direct funds 45% through taxes
 - Direct payments
 - Direct payment through salaries
 - VA, Indian Health Service, CHC
 - Direct payment through insurance model
 - Medicare
 - Federal payments to states for care of poor, disabled
 - Medicare

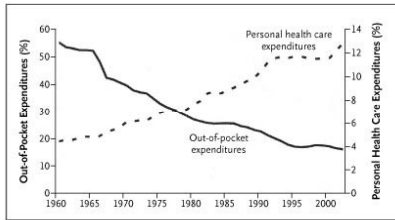
Health Care System Today

- Employer-sponsored health care
 - 160 million non-elderly
 - Government subsidy reduces cost by 50%
 - 15% of total healthcare costs
 - 43% of workers had a choice of plans in 2000

Health Care System Today

- Contribution of individuals
 - Out of pocket expenditures
 - 12% in 2007
 - Percent of income
 - Medicare-Medicaid eligible spent 35% of income
 - Medicare only below poverty line-50% of income

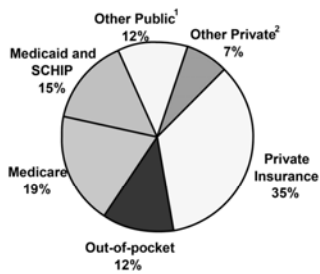
Percentage of Total Personal Health Care Expenditures Paid Out of Pocket and the Percentage of the Gross Domestic Product (GDP) Spent on Personal Health Care, 1960-2002



Blumenthal D. N Engl J Med 2006;355:82-88



The Nation's Health Dollar, Calendar Year 2007: Where it Came From



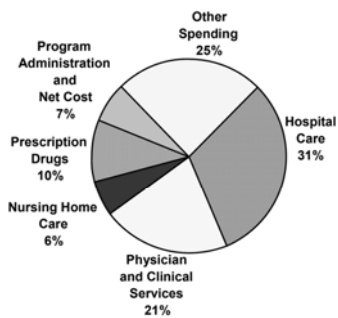
¹ Other Public includes programs such as workers' compensation, public health activity, Department of Defense, Department of Veterans Affairs, Indian Health Service, State and local hospital subsidies and school health.

² Other Private includes industrial in-plant, privately funded construction, and non-patient revenues, including philanthropy.

³ E: Numbers shown may not add to 100.0 because of rounding.

IRCE: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group.

The Nation's Health Dollar, Calendar Year 2007: Where it Went

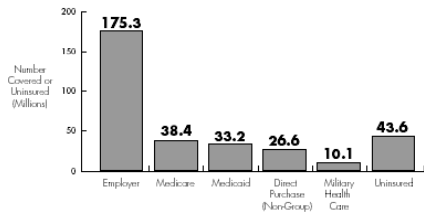


Other Spending includes dentist services, other professional services, home health, durable medical products, over-the-counter medicines and sundries, public health, other personal health care, research and structures and equipment.

Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group.

Funding the healthcare system

5. HOW THOSE IN THE U.S. GET HEALTH COVERAGE



The uninsured (45 M)

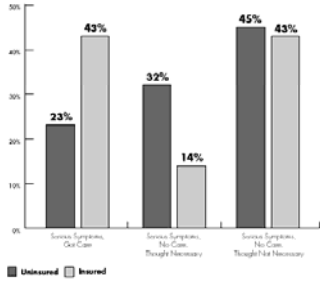
- Most are working families with no access to employer-sponsored insurance
- Although most have low-income, most are not Medicaid eligible
- Most avoid preventive and chronic disease care

Children without insurance

- 1/3 of children had no coverage at some point in 2007
- 91% of these come from households with employed parents
- Associated with less preventive care and care for chronic conditions

Why worry?

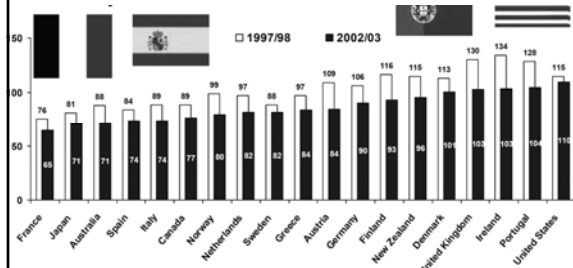
2. UNINSURED LESS LIKELY TO GET CARE, EVEN FOR SERIOUS SYMPTOMS



Underinsured

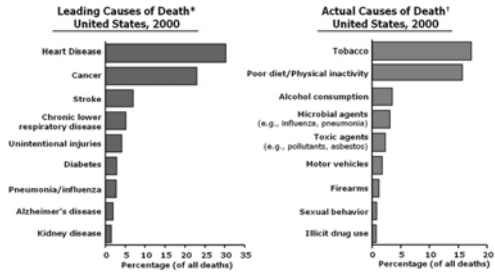
- Refers to medical needs not covered by health plans
- Out of pocket amount increasing
- Patients on Medicare and Medicaid have more stable doctor-patient relationships

Cost and Quality Today



Countries' age-standardized death rates, list of conditions considered amenable to health care
 Source: E. Nolte and C. M. McKee, Measuring the Health of Nations: Updating an Earlier Analysis, Health Affairs, January/February 2008, 27(1):58-71

Causes of death 2008



* Morita JM, Arias E, Kochanek KD, Murphy SL, Smith BL. Deaths: final data for 2000. National Vital Statistics Reports 2002; 50(15): 1-120.
 † Milledjian AP, Marks JL, Stroup DF, Berending J. Actual causes of death in the United States, 2000. JAMA. 2004;291(10):1239-1246.

Paying for Health Care

- Why so expensive
 - All nations spend more on healthcare as they prosper but US spends more than predicted
 - Consumerism and lack of primary care oversight
 - Physicians better paid
 - Hospital care is more expensive
 - Technology diffuses more rapidly

Health Care Reform (again)



Presidents who have attempted health care reform



More recently...

"I'm absolutely opposed to a national health care plan. I don't want the federal government making decisions for consumers or for providers. I remember what the administration tried to do in 1993. They tried to have a national health care plan, and fortunately it failed. I trust people; I don't trust the federal government. I don't want the federal government making decisions on behalf of everybody."

George W Bush, 2000

George W Bush's Health Care Legacy

- Began expansion of community health centers (2002)
- International AIDS relief (2003)
- Medicare Part D (2004)
- Hurricane Katrina (2005)
- Walter Reed scandal (2007)
- Immigration "crack-down" (2007)

Candidate Obama

- Providing affordable, comprehensive and portable health coverage for every American;
- Modernizing the U.S. health care system to contain spiraling health care costs and improve the quality of patient care; and
- Promoting prevention and strengthening public health, to prevent disease and protect against natural and man-made disasters.

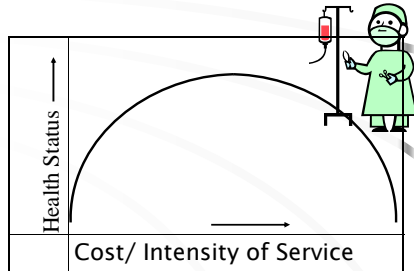
Is something different this time?



Drivers of “unnecessary” demand

- Poor physician performance due to an oversupply of physicians in a geographical area; the complexities of current treatment modalities and the inability of individual physicians to sort through them competently enough to understand which test or treatment is appropriate;
- Advertisements targeted toward the public that in turn induce patients to demand services from their physicians
- The financial pressure on facilities
- outright greed of a small minority in the medical profession
- the ongoing medical liability crisis and the resultant practice of “defensive medicine”; a financing/reimbursement system that gives incentives to provide services without regard to outcomes.

There is a relationship between cost and health status improvement:

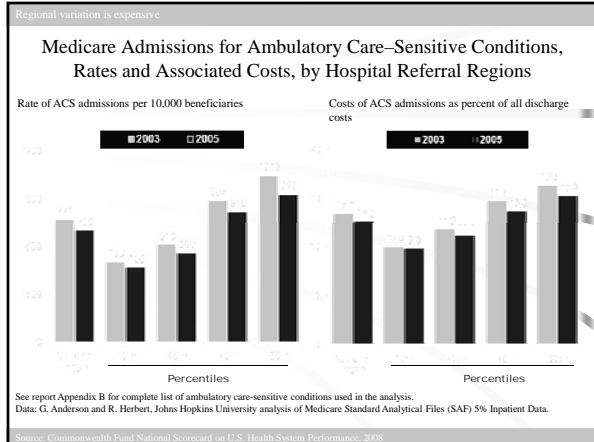


Regional variation is expensive

Table 2. Average Number of Physicians (Full-Time Equivalents) Caring for Chronically Ill Medicare Beneficiaries in the Last 6 Months of Life at Five Top U.S. Hospitals, 1999–2003.*

Variable	Johns Hopkins	Mayo Clinic	UCLA Medical Center	Cleveland Clinic	Massachusetts General Hospital
Rank according to U.S. News and World Report	1	2	3	4	5
No. of clinical physicians (full-time equivalents) per 1000 patients					
Total	12.2	8.9	16.9	12.7	15.3
Primary care	5.0	3.0	3.5	4.3	6.3
Medical specialists	3.9	3.9	10.1	5.5	5.5
Surgical specialists	1.1	0.8	1.4	1.5	1.1
Hospital-based specialists	1.4	1.0	1.5	1.2	1.7
No. of days in the hospital	17.1	12.9	19.2	14.6	17.7
No. of days in intensive care	4.3	3.9	11.4	3.5	2.8

* Hospitals were ranked "top honor roll hospitals" by U.S. News and World Report.



What has been accomplished?

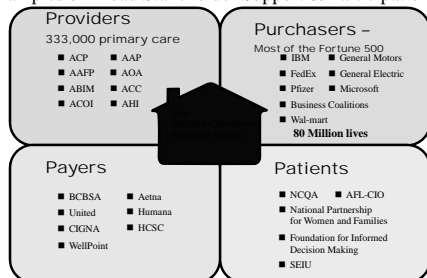
- Expansion of coverage leading to universal access (S-CHIPS already passed)
- Expand Indian Health Service (Stimulus package)
- Expand Veteran's and active duty coverage (Stimulus package)
- Expand primary care training (Stimulus package)
- Expand National Institutes of Health (Stimulus package)
- Expansion of safety net primary care system (Stimulus package)
- Health information technology development (Stimulus package)
- Expand efficacy evaluation ability (Stimulus package)

What has yet to be accomplished

- Structural changes
 - Future of Family Medicine
 - Lessons from Massachusetts
 - Input of business leaders
 - Efficacy of existing system

The Patient-Centered Primary Care Collaborative

Examples of Broad Stakeholder Support & Participation



36
