2008 Ezekiel Emanuel, M. D., Chair, Department of Bioethics, The Clinical Center of the National Institutes of Health, *Beyond Band-Aids: How to Cure America's Sick*

Well, it's wonderful to be here. And this is actually only the second time I've been to the University of Michigan despite having grown up in the Midwest, in Chicago. And I will say I nevertheless feel a very close attachment to the institution. For one thing one of the most important mentors in my life at the Dana Farber Cancer Institute, Dan Hayes, is a faculty member here and a man from whom I learned a lot. The former dean here is a very close friend, Alan Lichter, who I constantly get sage advice from. And the medical school has been wise enough to accept three of the fellows from my department here. And they have thoroughly enjoyed the place so it has left me with a very soft spot for the institution and I appreciate your turning out.

One of the things that Doctor Margolis did not mention is that I do a lot of surveys in my research and despite not getting informed consent from you I am going to do a little bit of a survey here at the start of my lecture. The first question is considering all aspects how well do you think the American health care system functions? Who thinks it functions very well? No one? Maybe one. Moderately well? A fair number of people here. Fairly well? Maybe the majority at fairly well. Not well at all? All right. Second question, considering all aspects how happy are you personally with the

health care services you personally receive? Very happy? A lot of people there. Moderately happy? A few more. Fairly happy? Not too many. Not happy at all? None. This difference between the way you view the health care system and the way you view your own personal health care services is a very important data point. And it's actually an important barrier to health care reform which we're going to come back to at the end of the talk.

Now I think that this cartoon summarizes it pretty well. Between congratulations on your left and get well it says good luck with the American health care system. The American health care system has really combined two parts. One part is how we pay for care, how we actually pay doctors. And the other part is how we deliver care, seeing patients, admitting them to the hospital. And I want to submit to you that both parts, both the financing part and the delivery side, are broken. The financing part is inefficient, inequitable and increasingly fiscally unsustainable. And in a few seconds I'll review the data on that. The delivery system, again how we deliver care to our patients, is fragmented. It's not designed to care for chronic illness even though chronic illness accounts for 70 percent of the dollars we spend. It delivers haphazard and I would submit poor quality. And we have a very high use in this country of unproven and marginal therapies. And again,we'll discuss some of the evidence for each of these.

True health care reform must fix both the financing and the delivery side. I think this is a very good litmus test for any health care reform proposal you

happen to see. When a politician proposes a health care reform and you listen to it you ask yourself does it solve the financing problem, does it solve the delivery system problem? If it doesn't do both you can be sure it is not a going concern. It is not sustainable. The unfortunate fact is that in this political year and the debate about health care reform in America today we are focused on the financing side and trying to get to universal coverage. We say almost nothing about delivery system reform and that is a serious problem which we'll return to.

Now if I locked all of you in a room, gave you a sheet of paper and a pen and said what would you want a good health care system to achieve? You would fill up a page with lots of ideals that it should achieve. Now we can't talk about 30 or 40 different things. I can talk about seven and that's probably itself too many. The first three coverage, cost control and quality I don't think there's any disagreement on. The fourth one, choice. We live in a country where you can go to the supermarket and choose from 50 different jams, probably 75 or 100 cereals. It's going to be very difficult not to have choice built in to the health care system. We will not tolerate that. We also need a system that has fair fiscal responsibility where the rich pay their part and we subsidize the poor rather than having the poor subsidize the rich as we do today in our current system. If we want doctors to support a reform system we need malpractice reform. And last, we want a health care system

that helps the economy rather than dragging it down and creating problems for employment and businesses.

Well, how does the current system match up to these goals? And I'm not going to go through each one of them. You already know because everyone pummels you with it that 47 million Americans are uninsured. Probably what you don't know is that between two-thirds and three-quarters of those uninsured are either full-time workers or members of families with a full-time worker in it. That is completely, completely un-American. The rules of the game in this country are if you work hard, you play honestly, you're supposed to get the benefits of our society. Not getting health care insurance even though you pay taxes and therefore support health insurance for other people is not part of the American social contract. Worse even is the fact that 9 million children who couldn't possibly afford to provide themselves with health care insurance don't have coverage. We should be ashamed of that.

Cost control. In 2006 the last year for which we have reliable data we spent 2.1 trillion dollars on health care. No. I did not by mistake add three extra zeros there. That is what trillion looks like. That's one out of every six dollars in your wallet going to nothing else but health care. Now I'm at the University of Michigan and I know you guys are really smart but I would venture to wager you don't really understand how big a trillion is. So I am just going to help you here. How many seconds ago is a million seconds? Last week. How many seconds ago is a billion seconds? When Richard

Nixon resigned the White House. How many seconds ago was a trillion seconds? 30 thousand B.C., 15 thousand years before a human being stepped foot on the North American continent. And we are spending two of those each year on nothing but health care. I was pretty sure you didn't know how big a trillion was. It's so big we're spending two trillion dollars a year. It's bigger than the GDP of China. Everything they spend in China for 1.2 billion people is less than what we spend on health care. It's bigger than the GDPs of France and Spain put together. But it's not just how much we're spending today. It's what I call the tsunami of the future. This is health care spending as a percent of GDP long into the future. If we don't do anything by 2082 there is only health care. There's either patients and the health care people taking care of them, nothing else exists in the economy. That clearly can't go on, but that's what the curve looks like if we don't do anything.

Now if you think about controlling costs there are two aspects to it. One is the waste in the current system. And I want to focus just a bit on the administrative waste which is mainly related to administrative waste with insurance from underwriting, sales, marketing, broker's commissions, billings. And then there is the long-term upward slope which is 50 percent of that slope is related to technology, the development of new technologies and the diffusion of existing technologies to patients with less and less indication for it and therefore less and less impact. Well, let's just talk about administrative costs for the moment. This is a quote from two economists

from Stanford, “The need for more than 850 insurance companies to see and contract with millions of employers, underwriting each one, adds greatly to administrative cost.” Typically administrative costs are on the order of 11 percent of premium. And this does not include the cost to employers to purchase and manage that health care spending. To understand how this could be different consider that Kaiser Permanente signs only one annual contract for the coverage of more than 400 thousand employees independent with CalPERS. That’s a California Public Employees Retirement Plan. And the administrative costs are on the order of 0.5 percent of premium. That 10.5 percent difference between 11 percent and 0.5 percent is pure administrative cost with no health benefit. That is a result of a defective, broken health care insurance market. It’s because you have to sell to each employer individually rather than to the whole country.

Let’s talk about quality for a second. We have a terribly fragmented, nineteenth century, horse and buggy delivery system. Last year there were one billion office visits in the outpatient setting to doctors. A third of them were to solo practitioners operating alone. Another third were to doctors in groups of four or less. It’s really hard to provide high quality care in those kind of small groups, hard to provide the infrastructure of computers, hard to coordinate care. The typical Medicare beneficiary sees seven different doctors in a year including five specialists. And if you have two chronic conditions in Medicare you see 15 doctors. Is that likely to get you good

medicine? The WRAN study, many of you may be familiar with this published in the New England Journal about four years ago, looked at Medicare patients discharged from hospitals. And they assessed the quality of care they got on nine very simple measures. We're not talking about complicated chemotherapy, complicated surgical procedures. We're talking: was blood pressure measured and if it was high were patients put on the right medication to get it under control? Was cholesterol measured and if it was high were they put on the right medications to get it under control? Did they get a NUMA vaccine before discharge? Well, the chance of Medicare patients getting those nine proven procedures about 55 percent, flipping a coin essentially. And if you're a child on other measures the WRAN study found only 46 percent of the time you get proven measures, simple things again. We are not providing high quality care.

And then there is a lot of unproven costly therapies. So you may know that over 210 thousand American men will get diagnosed with prostate cancer this year. And you have a choice of three different therapies. There's watchful waiting. There's surgery, a prostatectomy. There's radiation therapy. And inside radiation therapy there are four flavors of treatment. You can get 3D conformal radiation guided by CT scans. You can get breaking therapy which is little radiation seeds implanted into the prostate. And then there's IMRT, Intensely Modulated Radiation Therapy. And then there's Proton B, not giving electrons but giving protons. These machines

cost upwards of a hundred million dollars, have to be housed in football field sized buildings. And you can see the price difference here. Those are the Medicare reimbursement prices except for Proton B which is what Lul Melinda charges out in California. Eight full price differences. Now you might want to ask what's the difference for eight full price difference? I can't tell you. No one can tell you. There's never been a head to head comparison of these four treatments. I will tell you one thing. No one in this country believes that there is a survival difference and that includes the three thousand radiation oncologists in this country. Because last year at this time I went to their annual meeting, gave the plan of recession, showed this slide and I asked, "One person just get up and tell me I'm wrong." Not one of them did. At best based on single institution studies there is probably a 10 percent absolute difference in side effects. Now is that difference in impotence and proctitis worth 70 thousand dollars? I ask you.

Well, you also heard that I'm a breast cancer oncologist. I just picked on the radiation oncologists. Now I'll pick on the urological oncologists. A recent study in the Journal of Clinical Oncology showed that among men 66 years and older with low or moderate grade prostate cancer not receiving radiation or prostate surgery a third of them received castration, either chemical castration or actual surgical castration. This despite the fact that there's no evidence it improves longevity and we know it makes the quality of life a lot worse because they end up impotent. It's not recommended on any of the

major guidelines either the AUA guidelines or the NCCN guidelines and yet a third of the time urologists are doing this. And the worst piece of information, in my humble opinion, academic urologists are not much better than private practitioners.

Drag on the economy. The average cost of employment based coverage for a family is 12 thousand dollars a year. To translate that for you when the University of Michigan gives you health insurance for you and your family that's like hiring another worker at minimum wage for the whole year. To give you health insurance it's hiring two workers. That is a serious drag. The way we've structured our health care system we link health insurance to employment and this has created a whole series of problems. First, over the last decade almost every strike has been linked to health benefits. The only strike that's not linked to health benefits was the Hollywood Writer's strike and no one knows what the h** that was about. Linking employment and health care insurance creates this problem of portability especially if you've had an illness. It encourages companies to outsource and off shore jobs as you well know in Michigan. And it actually leads to suppression of wages. Money that goes to buy the insurance doesn't go actually to wage increases.

So the real question is what should be done. What should we do? Well, you did hear that I work for the U.S. Government and the NIH and I'm required to say these are not the official views of the U.S. government or the NIH, the Department of Health and Human Services. But I will use this slide for a

little civics test. You all know the guy in the middle. The guy on the left, Secretary Michael Leavitt. About one to two percent of audiences even at very educated places know that. Interestingly he controls more money in the federal government than anyone else, about a trillion dollars a year and we don't know who he is. The guy on the right? Zirhouni, right. You know him more interestingly and he only controls 28 billion dollars and only for one more day because he's resigned effective Friday. Not that late in the afternoon ladies and gentlemen.

Well, if you go around and ask what should be done in Washington you can come across literally hundreds of health care reform proposals and I am not joking, hundreds of them. As a matter of fact some of you may have heard of the Center for American Progress which is a left leaning think tank in Washington run by John Podesta who's a former chief of staff of Bill Clinton, a very smart guy. And they have actually in the last 18 months issued three health care reform proposals. That's not because one has been adopted. It's because you want to get attention you release another health care proposal. But you don't need to think about hundreds of health care reform proposals or even ten. All health care reform proposals can really be boiled down to one of four flavors. The Guaranteed Health Care Access Plan which is our plan which is similar to the Wyden Bennett bill, incrementalism, individual and/or employer mandates, what they're doing in Massachusetts, or single-payer. So what I propose to do is to explain our

plan and then like Fox news give a fair and balanced rendition of everyone else's.

So the Guaranteed Health Care Access Plan has ten planks to it. First, every American receives a certificate or voucher to receive a standard benefits package through an insurance company or a health plan. There's an insurance exchange set up and you get to choose which company you want to go with. The standards benefits plan is modeled on the program. It's essentially the health insurance that federal workers as well as congressmen and senators get. It's better than what about 85 percent of Americans currently have. The health plans have to guarantee issue and they cannot exclude anyone or coverage for any preexisting condition. In exchange for that everyone's included so there's no selection on that basis. And they get a risk adjusted premium which means they get paid more to cover people with emphysema or COPD or cancer or diabetes and less to cover the healthy 20-year-old University of Michigan students.

Second, Americans who get their certificate have free choice of any qualified plan which has to enroll them at no premium and no deductible. Typical people would have a selection of five to eight plans. In rural areas it might be only one. Americans who don't enroll are randomly assigned to a health plan by their regional health board. There are no cracks in this system. You cannot be excluded. You don't have to pay anything. No requirement for a mandate.

Certificates are funded by a dedicated value added tax. What do I mean by dedicated? All the money from the value added tax goes to health care, no general revenue. And the value added tax can't be siphoned off for other things whether it's social security, education, the environment, defense.

Fourth, people have freedom to purchase more services than the standard benefits package with their own after tax dollars. You want a wider selection of doctors, you want more brand name drugs, you want complimentary and alternative medicine, you want a better mental health package, you want concierge medicine and have a doctor come to your house you can buy all those services with your own money.

Fifth, the private sector organizes and delivers care and is accountable for it.

Sixth, the tax exemption for employment-based insurance is eliminated. So right now when the University of Michigan provides you health insurance you pay no income tax and no payroll tax on it. This is a huge incentive and a huge reason we have employment-based coverage. We get rid of that. Right now that tax deduction, single largest tax deduction in the American tax code, worth more than 210 billion dollars.

Seven, we phase out Medicare, Medicaid, SCHIP and all government programs. What does that mean? No person on those programs is thrown off but no new enrollees go on. So if you're 65 or you turn 65 in our plan the

Guaranteed Health Care Access Plan you don't go on traditional Medicaid/Medicare you just stay in our plan.

Administration and oversight are by a national health board and 12 regional boards modeled on the Federal Reserve System. So people are appointed to the boards for long staggered terms nominated by the president, confirmed by the Senate, can't be removed for political reasons or making unpopular choices. They have their own funding stream because of the value added tax. They're responsible for setting the standard benefits package and adjusting it based upon the available money as well we changes in technology. They oversee the insurance exchanges that compete for people. They regulate the health plans and collect data from them. And they report to Congress.

Nine, we create an institute for technology and outcomes assessment to do two things. First, to evaluate new interventions, see why they're clinically effective, cost effective and compared to other things. And it collects patient outcome data from the various health plans and evaluates them and distributes that information to the public.

Finally, each regional health plan has a Center for Dispute Resolution and Patient Safety to do two things again. One is to adjudicate claims of patient injury. So they evaluate the claims and see whether in fact an injury has occurred and whether they should compensate them. And secondly, more importantly, they have responsibility, authority and financial resources to

promote proven patient safety measures that are not widely implemented now because there's no champion and no resources for them. This prevents, we hope, a lot of malpractice.

Well, how does the Guaranteed Health Care Access Plan stack up against the seven goals I mentioned at the start of the talk? Guaranteed coverage, all, one hundred percent of Americans are covered regardless of income, age, job, health status or any other condition you can think of. There is no crack in the system. There's no employment-based coverage, Medicare, Medicaid and maybe a crack between someone falls through if they don't qualify for those. Everyone qualifies. There's no premium barrier. There's no deductibility barrier. And if you don't sign up, you're assigned. You cannot be left out of this system.

Controlling costs, we eliminate or reduce costs from insurance underwriting sales and marketing. Incoming subsidies, right now in Medicaid to decide whether someone's eligible the state has to decide what their income is. And investigate whether they fulfill other eligibility requirements. That is very expensive. That's completely eliminated in our system. No subsidies so you don't need even to look at what someone earns. And business no longer has to buy health insurance, saving money. You will see human resource departments at businesses shrink dramatically.

What about quality health care? Health plans that will receive the certificate and provide the coverage will provide an infrastructure, information and incentives for integrated care and coordinated care. If they have to report outcomes to the national health board and the regional boards that'll be a huge incentive for computerization and infrastructure changes to bring doctors and hospitals and home health care agencies and pharmacies together to provide better care at the right location. Providing a standard benefits for a fixed premium, we'll provide them a big incentive to cover only interventions that pass technology assessment and to figure out how to get rid of duplicative testing. Finally, because individual consumers, you, rather than your company or the government will chose the health plan there will be a big incentive to provide good customer service and high quality, persuading people that you are a high quality provider.

Freedom of choice, Americans will have the complete freedom of choice, which plan they want to go with, which doctor they want to follow, which hospital they want to go to and whether they want to buy additional services with their own money. We have financial responsibility. Everyone pays a VAT. You can't evade it if you buy something. And the more you consume the more you pay. The average American family where the median income in our country is now 50 thousand dollars will pay 45 hundred or less under our plan and get a benefit of 12 thousand dollars. That's a hallmark of progressivity.

Now practice reform I already mentioned, the two aspects of the Center for Dispute Resolution. And helping the economy, under our plan business no longer pays for health care. This eliminates the incentive for outsourcing and promotes the hiring of more workers because you no longer have to consider their fringe benefit so carefully. It will reduce labor management conflict and it will provide you as a worker complete portability. Further it will reduce a lot of taxes. Yes, we add on a value added tax but you have to understand how we pay for health care today. A third of the budgets across this country of states are devoted to health care through ensuring state workers, Medicaid, SCHIP. Under our plan that goes away so state taxes can be dropped by a third. Now it may be true that governors won't give you every penny back. They might want to invest some of that in say the University of Michigan or K through 12 education, but you will see a huge drop in taxes. In addition, Medicare payroll taxes will be dropping over time as fewer and fewer people are on Medicare. And right now the federal government contributes about 150 billion dollars a year of general revenue into supporting Medicare and Medicaid and that will decline as well.

Well, you might be sitting there and wondering well, it sounds a little too good to be true. What's the price tag? That's a very legitimate question. Any health care reform has to pass the fundamental test of economic feasibility. On this slide I've shown you what we're paying for health care today excluding the Medicare population. So everyone under 65 what are we

paying? I assume we can fold in the Medicare population dollar for dollar. Well, employment-based coverage, what employers pay and what workers contribute in premium in 2006, the last year for which we have reliable data, was 723 billion dollars. Medicaid and SCHIP were an additional 269 billion dollars when we exclude nursing home coverage. So that doesn't count the nursing. And then other safety net programs whether it's payment for pregnant women and children or other programs comes to at least 10 and some people think as much as 50 billion dollars. You add all that up and using government figures it's about one trillion dollars.

So one question is can the Guaranteed Access Health Care Plan provide coverage to all Americans for that one trillion dollars? Well, on the next slide I show you the answer is, of course, yes. Otherwise I wouldn't have put this one up, right? I'm not that stupid. So what you have here is the population under 65 of individuals who aren't in households and families in households, 258 million Americans not covered by Medicare. Here under annual premium you have the 2006 premiums for the high end, PPO Blue Cross and Blue Shield plan provided by the Federal Employee Health Benefits Plan. It's actually the Illinois version. It's the one I have. You can see individuals they have to pay five thousand plus dollars and for families it's eleven thousand, two hundred, two years ago. You multiply these numbers together and you get 944 billion dollars to cover 258 million Americans. Now I presume in the audience and I'm just going to take a

guess there are one or two public health students who say, aha, but that is a distorted number because being a federal employee is a very good test of your health. And if we include the Medicaid population and the uninsured they actually are likely to use more services. One of the reasons they're on Medicaid is they can't work because of their illness. And that's absolutely right. So we know that Medicaid especially, not so much the uninsured, will use a lot more services. I could show you the calculations. It's around about 50 billion dollars a year of additional services they're likely to use. So add that and you come up with 994 billion dollars, round it off after all I'm a government employee, a trillion dollars. The same that we're spending today and not covering 47 million people and not giving most Americans as good a health package as the Federal Employee Health Benefits Plan. How is that possible? Well, for one thing we got rid of those 70 billion dollars, that 11 percent of premium. We get rid of most of that, so worth about 70 billion dollars. And that's almost enough to cover all Americans in the plan and give them a very good health plan. We rationalize the insurance market.

But economic feasibility is more than just covering everyone at current dollars. It's also long term cost control. What does the Guaranteed Health Care Access Plan do for long term cost control? Well, it has multiple cost control mechanisms. Because we don't believe that only one cost control method is going to be effective. We need all the horses pulling in the same direction.

First, there is what I like to call the reistat based upon the dedicated value added tax. Any increase in benefits, if Americans want more benefits they're going to have to pay for it through and increase in the VAT rate. This should provide a hard backstop limiting how much we spend and increased year to year. I assume given how much Americans love to pay taxes it'll be a little difficult for congress to raise that VAT rate too much too fast. This will provide some breaks on the system and some incentive for efficiencies.

Second, by requiring people to provide additional services with after tax dollars they're going to look very carefully for quality and again, this will keep increases down. Competition among health plans [inaudible] a heavy emphasis on cost effective care, care that actually improves health at a reasonable rate. If you are skeptical of this role of competition let me just draw your attention to Medicare Part D. The new premiums are out and they're about 26 percent lower than anticipated at the start of the program because the big eight plans that cover 85 percent of the population, are competing pretty heavily to enroll people and have gotten remarkable efficiencies.

But the most important cost control is systemic technology and outcomes assessment. It will do two things for cost control. First, it will give us information about what's effective and what isn't effective that can be implemented and covered by the health plans. But more importantly it will send a signal upstream to those people who are developing technologies and

drugs about what will be acceptable under the system. After all the big pharmaceutical companies are working on innovations and drugs today that'll be on market 10 years from now. They have to make determinations. How much will be paid for? What will the competition be? What is that playing field going to be like? The technology and outcome assessment sends them a signal. We develop a cancer chemo-therapeutic drug for 55 thousand dollars that improves life expectancy one month, two months, it's unlikely to be covered or paid for. That will change what they invest their money in.

Well, that's the Guaranteed Health Care Access Plan. Now in an objective way let's consider the three other proposals. One is incremental reform and there are a variety of flavors of this. We could expand SCHIP to all children. We could have electronic medical records in all physician offices and hospitals and pharmacies. We could have medical savings accounts with catastrophic insurance over five thousand. McCain's health plan is based on three planks.

First, he proposes to eliminate the tax exclusion for employer-based insurance. I mentioned that to you already and he agrees that we should get rid of that and so you would have to pay taxes on the University of Michigan's contribution to health care for you. Instead he would offer people a tax credit, five thousand dollars to a family and twenty-five hundred dollars to individuals for however they got insurance, whether their

employer provided or whether they had to go into the individual market and get it. And then he would allow interstate purchase of insurance in a more unregulated market. So you in Michigan could buy coverage from say Nevada or Arizona or an insurance company in Oregon or wherever.

Then he's got this whole sort of motherhood and apple pie list of things, everybody agrees to these: electronic medical records, pricing transparency when you go in, you know what your cat scan is going to cost, you know what your cabbage will cost and it can't be hidden, re-importation of drugs so we give Canadians a reason to come across the border for us, a little disease management, and then state insurance pools for people with pre-existing conditions. Senator McCain's proposal is incrementalism quintessential. It is a classic case of incrementalism.

Now the main appeal of incremental reform is not the quality or the adequacy of the reform, but it's supposed political feasibility. It is the triumph of politics over policy. No one says it's going to really fix the system because it doesn't fix any one of the goals. It certainly doesn't get the universal coverage. It doesn't have cost control. And it doesn't lead to an improved quality of the delivery system. It is not meant to achieve any one of those seven goals. Its single virtue is supposedly it can actually be enacted, given how easy it was to enact SCHIP reform or SCHIP expansion in this country I have real doubts about that political feasibility to begin with.

The Lewin group, a non-partisan health policy consulting group in Washington, did an evaluation of the McCain and Obama plans and they said that McCain's health plan would reduce the uninsured by 21 million, roughly 45 percent of the uninsured would get coverage and that's mostly by the tax credit. It reduces employer coverage by nearly 10 million so a lot of young people are likely to leave employment-based coverage because they can get a better deal with that tax credit outside. And its cost, two trillion dollars over 10 years so roughly two hundred billion dollars a year. So keep in mind 21 million people covered at a cost of two hundred billion dollars a year because I'm going to come back to that number in a second.

In addition, when individuals buy coverage in the individual market as opposed to their insurers they typically get less generous health benefits, a smaller package with higher deductibles and more co pays. And if you don't like red tape and paperwork this is a terrible plan because if you go into the individual market the insurers have to underwrite you and evaluate your risk. That is very administratively intensive and a lot of administrative cost. And finally, there is significantly worse protection for people with pre-existing conditions under Senator McCain's plan.

What about the other alternatives? Mandates. This is what they're doing in Massachusetts. It rests on three pillars. First, there is this mandate. You require individuals and their employers to buy health insurance even if only catastrophic coverage with a high deductible health plan. Second, you set up

insurance exchanges. And again, this is where all the insurance companies have to offer the same package. And people can choose typically in the mandate proposal it's for the uninsured, the self-insured small businesses. It provides them lower rates and more selection. And last, if you can require people to get coverage you have to subsidize them. And the typical plan is to subsidize lower income people, usually up to 300 percent of poverty or 60 thousand dollars a year and/or subsidize small businesses for providing coverage to their workers.

The Obama plan is a version of mandates. The mandate in his plan is cover all children. All children have to get insurance through their families. And large employers have to do what's called pay or play. That is they have to provide coverage to their workers or they have to pay a penalty. And some of you may have seen recently an article in the *New York Times* where one of Obama's advisors would say, well, we didn't figure out what constitutes large employer. We didn't figure out what the penalty was. We just decided not to do that. They also would have an insurance exchange, a national exchange where all health plans, all insurance companies would have to offer the same benefit package and allow people to buy coverage. They'd have a competing national health plan run by the government open to everyone who couldn't get coverage through their employer or a public program. Again they would have a standard benefits package based on the federal employee benefit program like we do with guaranteed issue and no

pre-existing condition exclusions. And finally, it has subsidies, 50 percent tax credit to small businesses to provide health insurance for people. And income links up to these for people to buy into the national health plan if they can't get coverage any other way. Then it's got, as I said, motherhood and apple pie. The same set of provisions that McCain has, electronic medical records, pricing transparency, re-importation of drugs, yadda, yadda.

Well, you might think of mandates as a fill in the cracks reform. It relies on the current system and tries to make as few changes as possible to the current system to get you as close as possible to universal coverage. Now given that I told you I was going to be fair and balanced you might think those are my words. They're not. They're actually the words of Jonathan Gruber, the MIT economist who developed the Massachusetts Plan. He and I were debating for John Edwards when Edwards was considering what his health plan ought to be and this is the way Gruber characterized his own plan, a fill in the cracks plan.

Coverage? Never gets beyond 97 percent and maybe not even that close. Why? Because while it provides subsidies to people up to 300 percent of poverty. There are people between 300 percent and 400 percent of poverty or 60 to 80 thousand dollars in annual income. Those people are not poor in American society. They are not poor and yet we're going to ask them to buy

a 12 thousand dollar health insurance plan? A lot of them aren't going to be able to afford it and they're going to be excluded from the mandate.

Controlling cost? There's really no cost control in this plan at all. And the experience of Massachusetts confirmed these worries. Before they started they marked 620 thousand uninsured in Massachusetts, 11 percent of the population. According to an article recently more than 200 thousand previously uninsured residents have enrolled in the health plan but state officials estimate that at least that number and perhaps twice as many have not. The current estimate is at about 93, 94, 95 percent coverage, somewhere in that range.

But the real problem is cost control, making it unaffordable in the long term. Rising costs of health care will mean that employers will pay a penalty rather than provide insurance and allow their workers to get coverage through the state plan. States therefore are going to have to provide great subsidies. Now just imagine what's going happen in the next couple of years. We're going to go to eight, nine, ten percent unemployment so you're going to have a lot more people who need to get Medicaid because they're unemployed and have no employer. The recession is going to put a lot of pressure on employers and they're going to have to choose between keeping workers or getting rid of health insurance. This is going to create a dilemma for the state government. Either they increase taxes to pay the increased subsidies or they declare more people exempt from the mandate. Now if

you're a governor sitting in a recession with 10 percent unemployment in your state what do you think you're going to do? Raise taxes or declare more people exempt? You don't have to ask me. Massachusetts insurers plan to raise 10 to 12 percent next year in 2008, twice this year's national average. If we continue with double digit inflation I don't think health care reform is sustainable. That's the guy running the Massachusetts health care insurance exchange, just listen to him. He tells you if we can't get cost control we cannot continue with this health care reform. And yet the plan doesn't have cost control.

Then there are the other problems, no real reform to improve quality of care. Freedom of choice might be better for the uninsured and the insurance exchange but not for people covered by their employer. Fair fiscal responsibility? Depends how you fund it. If you fund this health care reform by a payroll tax that is a very regressive tax. And helping the economy? Let me just say the following, if your economic plan is jobs mandating employers cover people is not consistent with that plan. It's an oxymoron. So you got to think about that. As I mentioned Obama's health plan is thought of as mandates -like because it doesn't have a mandate for adults.

The Lewin Group did an estimate. It suggested that it would improve coverage by 27 million Americans so 57 percent of the uninsured would get coverage, not close to the hundred percent. It would increase employer coverage by about 5 million and the cost would come in at 1.2 trillion over

10 years, round about 120 billion a year. So it in fact, covers more people than McCain at a lower price, but it doesn't cover a hundred percent at no price increase the way our plan does.

Finally, there's Medicare for all or Physicians Working Group for Single-Payer National Health Insurance, the single-payer option. It, too, rests on three major principles. The first is there's a single national health plan, a single public plan covering all Americans. We get rid of the insurance companies. We have one national plan. It would reduce administrative costs because instead of that 11 percent of costs that I mentioned about insurers you would have the 3 or 4 supposed percent that Medicare pays. You'd eliminate all those administrative costs of insurers. And, finally, the main cost control mechanism is negotiated fees and payments to doctors, controlling their prices, to hospitals, controlling their prices and you'd negotiate the price with drug companies, device manufacturers, medical equipment providers, etc. to keep costs under control. Well, I think the best way of thinking about single-payer plans is as a radical reform of the financing of health care tied to our current nineteenth century horse and buggy crafts model delivery system.

Coverage? It's certainly true that single-payer provides a hundred percent coverage with no gaps. Everyone's in the system. A hundred percent freedom of choice and it will certainly remove employers although I'm not sure help the economy. The key problems are no improvement in the quality

of care, as a matter of fact institutionalization of our current system. No real cost control mechanism or really a failed cost control mechanism and worse the politicization of decision making.

As I mentioned if you want to get high quality care in America we have to have a new coordinated health care system. We need an infrastructure that brings doctors together with hospitals, home health care agencies, hospices, and the rest. We need information systems, electronic medical records so that they all have the same information in caring for patients. And it's real time with reminders, with safety measures built in. And we know that those things don't happen spontaneously because in the current system we don't have that infrastructure and we don't have those information systems by in large. So we need incentives to make that happen, right? Most doctors are willing to be team members as long as they're the captain. And to persuade them to coordinate and work with other doctors and hospitals and others requires incentives. I don't care what you call it but that organization that structure is going to give you the information systems, the infrastructure and the incentives. It's going to look an awful lot like an insurance company. You can call it some other name, but it is going to be an insurance company. And yet single-payer advocates are completely against that kind of intermediate organization.

Worse yet in my opinion, single-payer plans at least as currently advocated, institutionalize fee for service delivery system which we know does not

encourage integration and coordination of care. It encourages the very fragmentation we have. The fragmentation didn't happen spontaneously. It happened because 80 percent of the health care system is paid fee for service. And this reform institutionalizes it. The main mechanism of cost control is setting prices for physicians and the rest of it. We know this is a failed cost control regime. We've seen that in Medicare.

And then there is the problem of decision making. If you ask single-payer advocates, well just imagine who's going to run the system, how are you going to have this administered. They think this guy is going to be the guy who runs it. But as we've learned you can't rely on a person. Because you might end up with this guy running the system and that wouldn't be good either. Hal Luft, a health economist formally of University of California San Francisco and now the Palo Alto Medical Clinic wrote in *JAMA* a couple of years ago. "Medicare which provides near universal coverage to U.S. residents 65 years and older is the prototypical single-payer model and routinely exhibits the problem of that model. Although permitted to arbitrarily set fees Medicare has found it difficult to do so effectively. Across the board fee changes elicit broad-based political reaction, narrowly focus changes to a sub rows of special interest lobbying. Patient advocacy groups often supported by industry and specialty societies encourage coverage for their specific service. Rather than market discipline Medicare is subject to political manipulation and bureaucratic rigidity. Single-payer

advocates envisioning an equitable and efficient health care systems idealistically disregard the example of Medicare and the ethos of the U.S. political system. They are so focused on the evils of the insurance company and the evils of the drug company very little thought is given to how to actually run a system with minimal political interference that would strive for efficiency and high quality."

I want to end this talk in thinking about the politics of health care reform because we could have a million proposals but if we haven't thought through the politics we will not get it. There are many, many barriers to change. And let me mention just a few. The first is the rule of satisfaction, what you so wonderfully demonstrated at the start of this lecture. Most Americans want health care reform but they also say don't touch what I have. Well, it's very difficult to have health care reform and not touch your personal policy or your personal relationship. To the extent that 85 percent of Americans are covered and more importantly 93 percent of voters have insurance. This rule of satisfaction is a real barrier.

The second barrier is what I like to call is the James Madison rule of government. James Madison wrote the constitution and he had one objective in mind, prevent tyranny. And he made it very difficult to make big changes. So if someone got into the White House who wanted to be a tyrant it would be virtually impossible. That's why we have a system where you have to pass a bill in one committee of the house and pass a bill in a committee of

the Senate, have the House vote on it, have the Senate vote on it. And of course they're not the same bill so you have to have a conference committee, then you have to go back and vote and send the bill to many, many places to torpedo legislation. We have gridlock in Washington. James Madison would've been proud. That's what he wanted. Then there's my favorite, Machiavelli's Rule of Reform. He wrote to the Prince, "There is nothing more difficult to carry out, nor more doubtful of success, nor more dangerous to handle than to initiate a new order of things for the reformer has enemies and all those who profit by the old order and only lukewarm defenders and all those who would profit by the new order." After all if you're in the old order you know what you're going to lose, that nice salary, that ability to charge a lot of money. But if you're going to benefit from the new order it's a little hypothetical, abstract, maybe it won't work out exactly that way, not sure.

Finally, there's what Stuart Altman a health policy expert at Brandeis says the rule of second best. Now I assume in this audience there are die hard single-payer advocates. Maybe some of you are for mandates. Maybe I've even convinced one or two of you to Guaranteed Health Care Access Plan. I hope there are no incrementalists. But we all have a second best, do nothing. For me, I'm not passing yours. This is a real problem in America and we saw it play out in California with Governor Schwartzenegger's proposal. But I am not pessimistic.

Now a great political scientist, great I say in this audience but I actually say it in all audiences, because he used to be a professor here at the University of Michigan in the political science department, John Kingdon, wrote that to get major change in America you need four things. Actually he wrote three things and I was uppity enough to think I could add a fourth. If you want major change in America four things have to come together at one point in time. First, you need widespread recognition of the problem. Second, you need a proposal that is agreed upon by the major actors. Third, and this is my emendation, you need a major actor or set of actors that are going to champion that proposal through thick and thin and over years. And last, you need a transforming political event to create what he called an open policy window to enact the agreed upon change.

Well, problem. I think we have widespread awareness of the health care problem. Actually when I talk to senators and congressmen, when I talk to their aides, if you even go to the McCain website and read his material on the health care you realize people really understand the problem. They understand the fact that we're getting more volume rather than quality, the fact that we're mispaying in the system, the fact that it's really broken. I don't think the problem is poorly understood. Of course we can educate Americans more about the problem, but I don't think that's the issue.

Policy? At the moment we don't have consensus on a policy. We have Senator McCain's proposal. We have Obama's proposal. We have our

proposal. We have single-payer. Importantly many key stakeholders haven't gotten off the fence. You are in Michigan. The big three are complaining about the health care system. They complain bitterly about it. But tell me what they're for. You don't know. They have not come off the fence and told you what they're for. There's a difference between whining and making a positive proposal. Even the head of Wal-Mart whines about the system but that is not the same as saying we want the following five elements in a health care reform plan. So business is one group that hasn't gotten off the fence. Governors are another group. I have no idea why governors are so passive in the current system. They are handcuffed by the 32 percent of their budget going to health care, preventing them from doing something about education or the environment or whatever else they want to do. But they have not said we need leadership from Washington in unison and we want the following parts to the plan. And finally, there are patient advocates. So the champions we need I think are those three groups.

And finally, we need a transforming political event. That transforming political even by definition is unpredictable, not only unpredictable to you and I who are not politicians but unpredictable to politicians. There's actually been some really interesting studies about how well politicians understand when a moment of change is going to happen and which bill will be passed. They're worse than you and I at predicting that actually. But I

think the financial crisis we're in may be that transforming political event. And let me give you six separate reasons for that.

Reason one, when you bail out the banks and Freddie and Fannie and AIG with hundreds of billions of dollars who's going to talk about socialized medicine anymore? When you socialize Wall Street no one can credibly talk about socialized medicine as an epithet of negativity. You just will not hear it. So we might actually get an intelligent discussion about health care reform without slinging this nonsense of phrases.

Second, when you spend seven hundred billion dollars maybe, maybe not to fix the economy suddenly spending two hundred billion dollars doesn't look so expensive. It's chump change. Everything is a matter of perspective.

Third, in this very uncertain fiscal time a lot of American families are going to worry about being unemployed, having their employer cut off their insurance. They're going to look for a safe harbor and having a guarantee of insurance may be a very important safe harbor that they want from the government.

Fourth, that fiscal insecurity might also make Americans willing to compromise instead of the gold-plated Cadillac coverage they might be willing to accept a more basic coverage but as long as it's guaranteed through thick and thin.

Fifth, there are employers. They may not be able to afford health care insurance. They may want to get it off their books. They may want to compete without it. And the recession that's coming may induce them to be more active on this.

Finally, sixth, you remember I said remember the figures for McCain and Obama. McCain covered 21 million people at a cost of 2 trillion dollars over 10 years. Obama covered 27 million people at a cost of 1.2 trillion dollars over 10 years. And I showed you that we could do it for zero. Well, let me tell you the Lewen Group hasn't assessed our plan, but it's assessed the Wyden Bennett bill. And that bill which covers all Americans gets rid of employers, very similar to our bill, Lewen estimated that they get a hundred percent coverage, costs zero. As a matter of fact it saves 1.4 trillion dollars over 10 years. So what you have is the very important phenomenon that more comprehensive health care reform is actually cheaper in the long term. Given the debt pressure of the fiscal crisis and the need to spend seven hundred billion dollars to bail out Wall Street this may induce congress to actually do more. Now I have to admit until two months ago I was talking about health care reform in 2013, not in 2009. But I think this fiscal crisis may have changed the landscape. I can tell you all the negative reasons I just offer that as an idea at the end here.

So for those of you who are politically engaged and want to learn more about Health Care Guaranteed you can look at that website. It's not run by

me; it's run by two guys out of Seattle who are active in this. If you want to look at details like technology and outcome assessment or the taxes or independent administration or how you have competition you can go to freshthinking.org. I'm really meaning if you want a good paper that will put you to sleep like that, freshthinking.org.

Finally, one of the things that happens when you become an author is you become completely shameless. So we have published a book that summarizes and expands on the things I've mentioned today and it is available as Phil mentioned. Thank you very much and I look forward to your questions.