How to Fix America's Broken Health System (And Why It Hasn't Happened) | Vivian Lee

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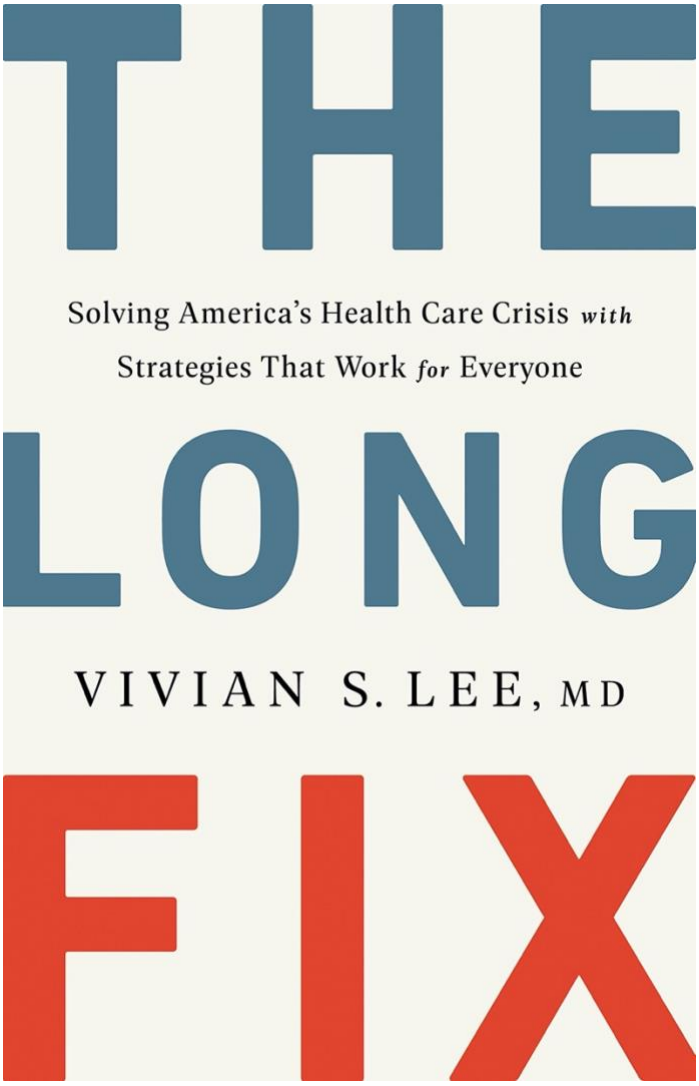
It's not who runs the system that matters, it's what they pay for that needs to change radically. — Vivian Lee, M.D.

INTRODUCTION

Vivian S. Lee, M.D., Ph.D., M.B.A, is President of Health Platforms at Verily Life Sciences, an Alphabet company whose mission is to apply digital solutions that enable people enjoy healthier lives. She is the former Dean, SVP and CEO of the University of Utah Health. As a leading healthcare executive, she is committed to the advancement of value-driven transformation in health care. As CEO, Lee led University of Utah Health to recognition for its health care delivery system innovations that enable higher quality at lower costs and with higher patient satisfaction, as well as successful strategies of faculty development and mentorship. Dr. Lee was elected to National Academy of Medicine (formerly, the Institute of Medicine) in 2015, and in 2019, she received the International Society for Magnetic Resonance in Medicine's highest award for scientific contributions and leadership, the Gold Medal. She served on the NIH Council of Councils advisory to the NIH Director and has authored over 200 peer-reviewed research publications.

Dr. Lee is magna cum laude graduate of Harvard-Radcliffe Colleges, received a doctorate in medical engineering from Oxford University as a Rhodes Scholar, earned her M.D. with honors from Harvard Medical School, and was valedictorian of her Executive MBA program at NYU's Stern School of Business.



WHY DO I CARE?

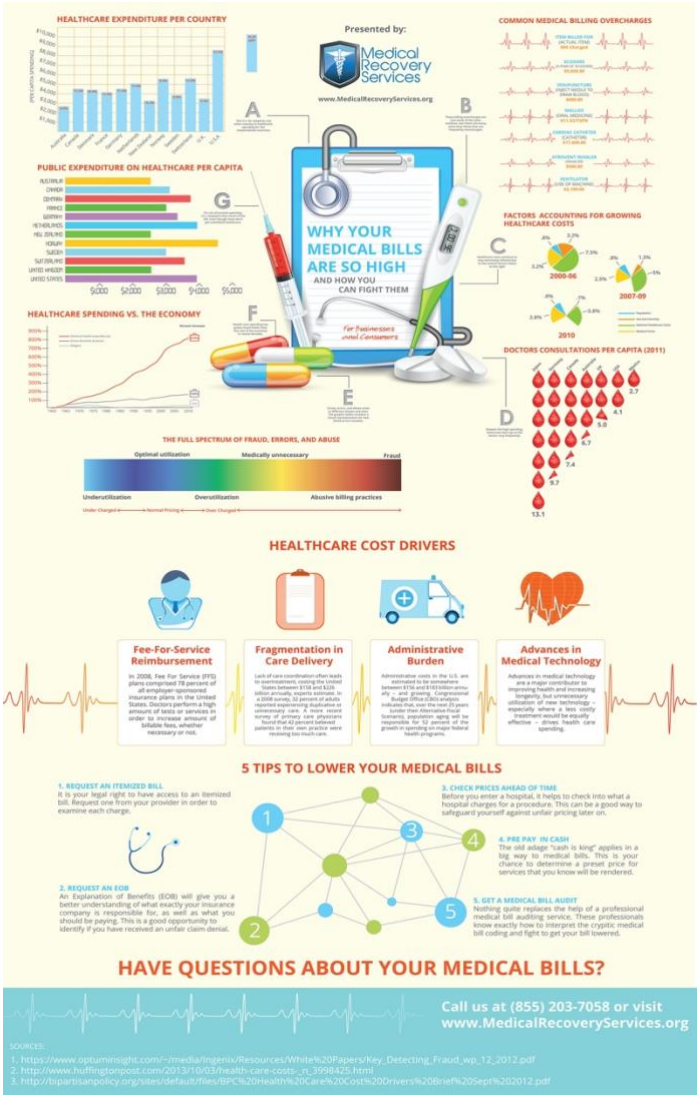
The costs we tend to associate with the debates around heath care are the medical ones, but the debates themselves represent a significant drain on the electorate's limited attention for matters of public policy. We have wasted untold amounts of time blabbering and yammering about America's "broken health care system," moralizing about the source of the problem and arguing over how to fix it. Why has it been *so difficult*?

My goal in this conversation is to first, (1) answer this seemingly simple question. Considering the multi-faceted nature of this debate, it's important for us to focus in on what we are actually talking about. Second, (2) I would like to drill into Dr. Lee's diagnosis of the problem, and lastly, (3) vet her proposed solutions.

It is difficult to make the case that our health is not the most vital thing that our dollars can buy. Whether we pay for it through better self-care, better treatment, or some combination of the two, the potential return on investment is greater for this product/service than for anything else in our economy. Considering the political implications associated with it, fixing healthcare may be the single biggest opportunity we face as a country.

According to an Institute of Medicine 2012 study, (1) we waste 30 cents of every dollar we spend on health care. That's over $1 trillion per year. Some of that is fraud and abuse, but most of it comes from failures to care for patients properly. (2) A substantial part of the waste is driven by overdiagnosis and overtreatment. In a 2016 survey, US physicians thought that about 20% of all medical care was unnecessary. This not only contributes to waste, but it also causes harm. In fact, (3) medical errors are the third-leading cause of death in the United States—over 250,000 deaths each ear. That's about 9.5% of all deaths, behind only heart disease and cancer. (4) Clinicians also make decisions without being fully informed about the latest science and without information about costs (to the patient, and overall), following recommended guidelines only one-half to two-thirds of the time. (***important to note that pioneers cannot follow guidelines). This despite having a system that is drowning in bureaucracy. (5) About 8% of healthcare spending in the United States is spent on administration costs. Among ten high-income OECD nations, this figure averaged only 3%.

Where money is spent on healthcare professionals, their time is used very inefficiently. (6) The average US generalist physician makes about $218,000, while specialists average $316,000, and yet, these very expensive and highly trained professionals waste an enormous amount of their time on frustrating administrative tasks like computer data entry and disputing with insurance companies instead of caring for patients. (7) We push expensive new technologies and treatments even if they aren't any better than cheaper (or generic) alternatives. We spend double to triple what Canada and some European countries do on pharmaceuticals, mostly due to high-cost branded drugs and the overprescription of antibiotics and other medications. (8) With about 8.5% of the population uninsured, we often wait until it's too late to treat patients. By the time the health system sees them, it has missed the chance at prevention. And yet, (9) how can we expect to insure a population that we actively encourage to consume poisonous diets? As a nation, we seem to favor sugar and high-fructose corn syrup-laden sweets and drinks (spending $4 billion on them annually), deep-fried food ($200 billion for fast food), tobacco ($130 billion), and sedentary lifestyles with plenty of screen time and video gaming ($43 billion) over healthier alternatives. Primary care providers often do not have enough time with patients in order to diagnose, let alone meaningfully influence these habits. Lastly, (10) we deny the wishes of the dying by putting people into hospitals who would be better off at home, allocating costly resources to caring for people at the very end of life, when they would be better off at home, under some form of hospice or palliative care.



Vivian's main argument in "The Long Fix," is that our incentives in healthcare are, for lack of a better term "out of whack." "The root cause of this crisis," according to Dr. Lee, "is that we pay for each pill, echocardiogram, laboratory test, and operation, regardless of whether it makes people healthier. Our fee-for-service system rewards

action, not better health outcomes. It encourages overtreatment and specialty care at the expense of prevention and primary care. Every headache or backache warrants an MRI in a fee-for-service world, and every episode of chest pain justifies a coronary angiogram (even if it's indigestion). This is the fundamental flaw of American health care."

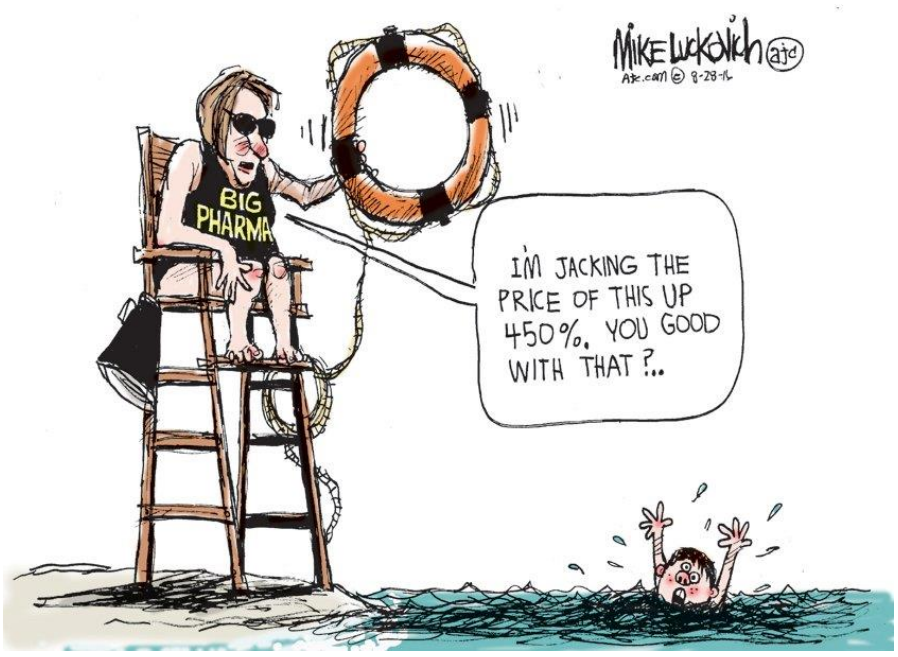
But there is also the issue of how we pay for healthcare. Most Americans don't really "buy" health care or pay for it directly. They pay for it indirectly by buying health insurance. With the exception of elective procedures like cosmetic operations, for example, the only people who actually pay up-front for healthcare are the ones who can't afford it in the first place. This incentive structure often puts insurers and doctors at odds with patients' interests. Insurers who pay doctors and hospitals for care are incentivized to spend as little as possible on a patient's health. The less they pay out, the more profit they make. Conversely, in a pay-for-action model, most doctors and hospitals are incentivized to spend as much as possible. This means patients (or more precisely, their premiums) are the rope in an annual trillion-dollar tug of war. Doctors and hospitals pull by ordering more tests and operations; insurers yank back by denying those services or adding restrictions like "prior authorization" paperwork for expensive medication and tests. When hospitals or doctors charge more than insurers are willing to pay, patients can get caught in the middle and be asked to pay the difference, leading to those so-called "surprise bills" that we all love so much.

Normally, we could expect market forces to drive costs down in such a highly inefficient system, but here again, the model of buying insurance as opposed to paying for the actual service means not only that customers are price inelastic, but that they are actually incentivized to consume as many services as possible, since they have already paid for them in the form of a monthly premium.

So how do we go about solving this problem? Do we just ban insurance altogether? That would certainly drive costs down dramatically, but it would also put healthcare out of reach for most Americans and isn't practical or ideal for many reasons. And as noted earlier, insurance is not the primary driver of high-costs. The overall incentive structure of health care is broken; insurance is only part of that.

According to Dr. Lee, in order to reform our healthcare system, (1) we first need to start paying for results instead of action. The best investments in health engage people and keep them healthy (prevention), at home and independent, and recognize the vital roles that families and communities play. Within hospitals and clinics, paying for health instead of action creates the opportunity for health insurers and physicians to work together (instead of at odds with each other) to keep people healthier. Second, (2) we need to start running health care delivery systems like businesses that compete to deliver better health outcomes at lower costs. This starts with making health care *safer*. Reducing medical mistakes by adapting better management models from other industries is one way to do this, but so is improving the quality of care by making it easier to learn from experience. Building tools that measure the costs of care and treating patients a bit more like customers can also help drive costs down dramatically. Third, (3) we need to look at other components of the health care ecosystem like pharmaceuticals and device manufacturers. Entities like Medicare, who represent millions of patients, should be able to negotiate drug prices, armed with data about their effectiveness. Patients' electronic medical records should be used for the benefit of their health and to help doctors and hospitals improve the delivery of care. Unfortunately, these systems have too often felt like a burden to doctors who spend untold hours entering data on spreadsheets when they should be busy seeing patients and helping to save and improve lives.

Vivian believes that there are things we can learn from the success of employer-driven & government-run health systems, but that ultimately, we need to implement an action plan that builds on the roles that everyone needs to play in radically redesigning our health system for better outcomes. This includes a set of guiding principles that Dr. Lee puts forward at the end of the book. The first is that (1) healthcare is a problem that requires bipartisan solutions. Much of the political rhetoric about health care gets tangled in two contentious points. First, should everyone in the United States be entitled to health care? Second, what is the government's role versus the private sector's role in providing that healthcare? It may help to know whether if universal coverage would improve the health of Americans in any significant way (the data seems to indicate that it would). At the same time, expecting healthier Americans to subsidize the health of the unhealthier cannot happen without demanding that everyone take responsibility for his or her behavior.



DIAGNOSIS

"First we're going to run some tests to help pay off the machine."

What's the Problem? — I've been listening to the debate on healthcare since as long as I can remember. I still haven't quite figured out what we are arguing about or what the problem is. **Q:** What is the problem that we are trying to solve? **Q:** How does this problem relate to the national debate we have been having for so many years?

Inaccessibility & Unequal Distribution — Q: Is the problem that there are still people who are not insured or can't access health care at a cost that is affordable? **Q:** Is the problem that some people have access to better care than others?

Ethical Considerations — Q: Is the problem that we can't agree on fundamental questions of fairness? (i.e. is it unfair that some people don't have access to health care or is it unfair that some people would have to pay for the care of others)

******* We have the most expensive healthcare system in the world per capita, per diagnosis, and per level of health of its population as a whole. We have the best infrastructure and excellent expertise if not the best in the world and are able to solve the toughest problems and cure people who come here because they could not have a successful treatment in their country; of course, only the rich can do so from other countries. We have the highest utilization of drugs; Americans have been nurtured to demand the best medication that will treat their condition yesterday. They demand the best brand names so long as their insurance will pay for it. Our system has the highest utilization of office visits and "demand" for testing when our insurance pays for it.

Quality & Costs — Q: Is the problem that we have skyrocketing costs for a system that provides worse outcomes than more affordable competitors in other countries for *most people*?

How Did We Get Here —

Q: How did we get here? (i.e. what is the origin of our broken, fee-for-service model?)

Q: What 's the role of insurance in driving up the costs of healthcare?

Fee-For-Service vs. Pay-For-Value — Q: What is the difference between a fee-for-service model & a pay-for-value model of health care? **Q:** What are some examples of these two different systems? **Q:** What are the pro's & con's? **Q:** What are some of the challenges and roadblocks to implementation of a pay-for-value model?

Measurement Problem — Q: How do we measure the success of any

"There's no easy way I can tell you this, so I'm sending you to someone who can."

given outcome when each patient is so unique? (i.e. one may have received the best possible care and yet, his/her body suffered a serious complication. **Q:** How do we measure outcome quality in malpractice lawsuits and how does this compare to what is used in the pay-for-value model? **Q:** Wouldn't pay-for-value models drive down the measurable quality of outcomes for the best physicians/hospitals, because the most difficult cases would tend to accumulate their over time?

"Your medical problems are more complicated than I thought. I am going to refer you to another doctor, who has more medical insurance than I have."

Defensive Medicine — Americans are very litigious. Since doctors are required to have malpractice insurance, patients feel more entitled than they otherwise would to go after insurance companies for any medical issues that can be plausibly linked to the treatment they received while under a doctor's care or while in the hospital. A report by the American Medical Association from 2016 showed that 34 percent of doctors have had a claim filed against them while in practice. The chances of getting sued increase with age, with almost 50% of physicians over the age of 55 having been sued. Likewise, the insurance companies are incentivized to settle cases out of court. This often leaves doctors on the hook whenever a case is settled that should have been taken to trial. It also leads to much higher premiums for the doctor's insurance. It also increases the risk that the doctor becomes uninsurable, therefore effectively becoming unable to practice medicine. (There is wide variation across the country in what physicians pay for medical liability insurance. For example, in 2017, OB/GYNs faced premiums that ranged from a low of $49,804 in some areas of California to a high of $214,999 in Nassau and Suffolk counties in New York.) All of this incentivizes doctors to minimize the risk of litigation by ordering a barrage of specialty tests, consultations, etc., for something that may be easily treated with an aspirin or some bed rest. It also perpetuates a level of distrust between patient and doctor that negatively impacts the patient's experience. **Q:** What is the total financial cost of medical malpractice insurance to doctors every year? **Q:** What are the non-financial costs of our highly litigious healthcare system?

End-of-Life — Almost 80% of the cost of health care is spent in the last three months of a person's life. Instead of allowing this person to die in peace at home and among his/her families members, he/she is kept under life support for months at a cost of $10,000-$20,000 per day. **Q:** How important is reforming our end-of-life care in making our overall system more affordable?

Independent Physician — One of the things I often hear from doctors is that our 21st century health care system has turned doctors into employees or factory workers. **Q:** How has the role of the physician in health care changed over the decades? **Q:** Why has it become harder for independent physicians to practice medicine? **Q:** Does this matter?

TREATMENT

Mandatory Insurance — Dr. Lee thinks that universal coverage makes sense if a healthier nation is the goal, although it will be more expensive in the short term. In a pay-for-action world, coverage would be unaffordable. **Q:** Should health insurance be mandatory for all?

Government-Run Benefits — Q: Will there still be special groups who receive government-run health benefits and get care in government-run medical facilities? **Q:** Should these programs be expanded?

Administration & Lessons — **Q:** Outside of government-run programs like the veterans' administration, how should health insurance be administered? **Q:** What lessons can we take from how other countries tackle this problem? (e.g. the Swiss distinguish between basic health pans and supplemental insurance; basic health plans are universal in this case)

Delivery & Payment Method — **Q:** How should we pay for and deliver health care?

Protocols — The patient-doctor relationship is multidimensional. It is a highly complex, physical *and* emotional relationship and the emotional charge can often times be the most impactful. No two patients are going to act and react alike, no matter how similar their health care problems are. **Q:** How and where can protocols be effectively applied given the complexities inherent in navigating the patient-doctor relationship?

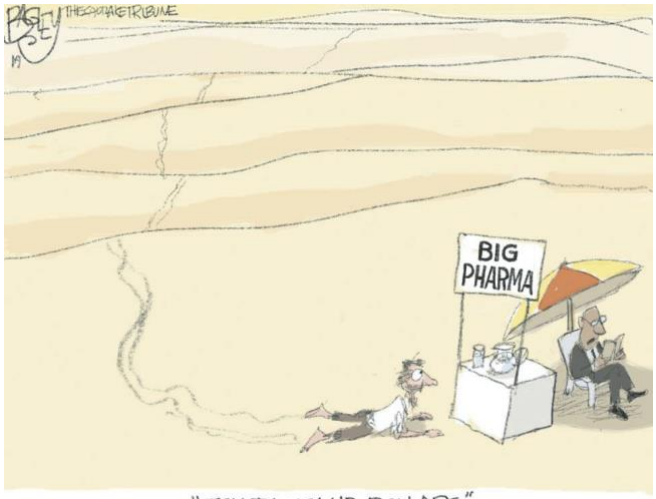
Tort Reform — **Q:** How can we reform our medical malpractice industry so as to reduce costs and increase patient-doctor satisfaction? **Q:** Is part of the problem that we aren't being honest to ourselves and to patients about what it means to "practice" medicine? (i.e. the practice of medicine from diagnosis to intervention is wrought with uncertainty)

Segmenting the Marketplace — **Q:** What is the best way to think about or segment the marketplace for health care (e.g. elective vs. schedulable services/procedures)?

Information Marketplace — **Q:** What can we do to increase information about products and services and their associated costs?

Expanding Competition & Choice — **Q:** What can we do to ensure that the market has enough different hospitals, medical groups, and insurers to choose from and that can compete with one another?

Insurance Overutilization — **Q:** How do we disincentive the insured from overutilizing care?



"TEN THOUSAND DOLLARS."

Big Pharma — We have the most expensive drugs in the world by a factor of 10 to 15 times and some cases, even more. This is not only in brand name drugs but also in generic drugs. A patient who has insurance and pays out of pocket for his/her Rx can often times pay *less* than if he/she paid using health insurance (which requires a copay). The copay is often times the same as the total out of pocket cost, and sometimes (maybe most of the time) 2x or even 3x the out of pocket costs. **Q:** Why are drug costs so much more expensive in America than they are in other countries? **Q:** Is it true that the government is legally prevented from negotiating prices with drug distributors, and if so, how is this the case? **Q:** How do we ensure that pharmaceutical companies have to compete on value by improving health at the lowest possible cost?

Incentivizing Healthy Behavior & Personal Responsibility — **Q:** Of all the factors driving the cost of our health care system, how important is personal responsibility and health habits? **Q:** How do we incentivize people to take every measure to be healthy be incentivizing healthy behaviors? **Q:** How do we break this mindset that health is about "fixing" a problem rather than preventing it?

Fixing Electronic Health Records — Patients' electronic medical records should be used for the benefit of their health and to help doctors and hospitals improve the delivery of care. Unfortunately, these systems have too often felt like a burden to doctors who spend untold hours entering data on spreadsheets when they should be busy seeing patients and helping to save and improve lives. **Q:** How do we fix the electronic health record system so that it functions better for the patients and the doctors?