



## Code Red and Blue — Safely Limiting Health Care's GDP Footprint

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Public and private policymakers from red and blue states are converging on three conclusions that portend a momentous choice for physicians accustomed to benefiting from health care's growing

share of the gross domestic product (GDP).

First, if the average health gain per dollar spent ("value") were brought to the level of the highest-value U.S. health care providers or of national health systems in other wealthy countries, our per capita spending would decrease by 15 to 30%.<sup>1,2</sup>

Second, the annual gap of 2 to 3 percentage points between health spending growth and GDP growth saps broader economic vitality.<sup>3</sup> Warren Buffett likens our health system to a tapeworm inside the U.S. economy that drags down our global competitiveness and suffocates funding for K–12 education, basic research, infrastructure maintenance, and

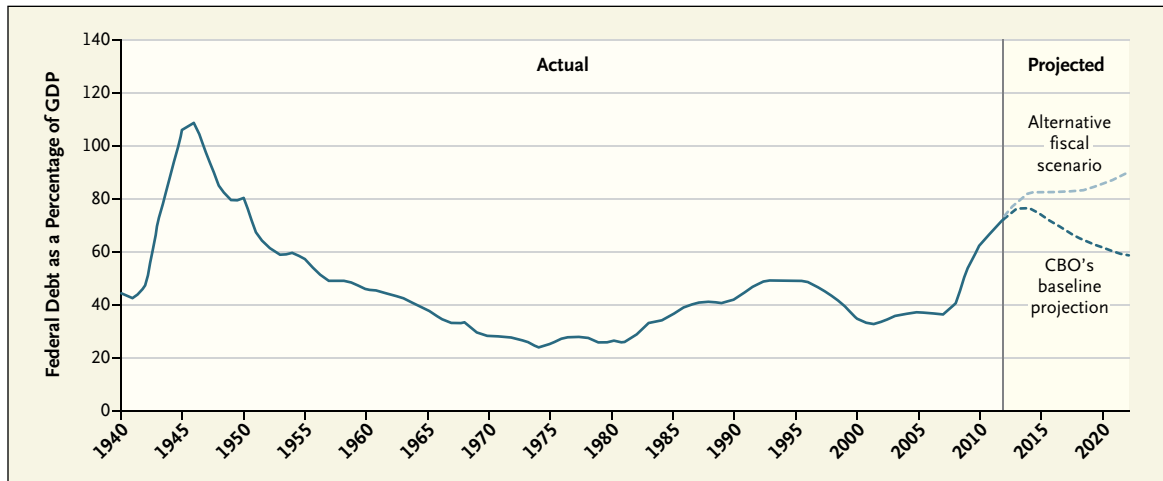
other public goods. Politicians struggle with the gap's effect on government debt and creditworthiness, because the gap steadily increases the proportion of Americans requiring public funding to afford access to good care, especially among seniors whose need for health care has been extended by medical progress.

Third, U.S. health care needs to adopt new work methods, outlined in the Institute of Medicine's vision for a learning health system.<sup>4</sup> Such methods would enable clinicians and health care managers to more rapidly improve value by continuously examining current clinical workflows, management tools from other service industries, burgeoning databases,

and advances in applied sciences (especially health psychology and information, communication, and materials technologies). They could then use the insights gained to design and test innovations for better fulfilling patients' health goals with less spending and rapidly scaling successful innovations.

Whether a learning health system could improve value fast enough to perpetually neutralize the annual gap of 2 to 3 percentage points remains unknown: better care sometimes adds costly but useful clinical services and prolongs later life stages requiring greater resource use, but exemplars of value such as Kaiser Permanente, Intermountain Health-care, and CareMore continue to improve.

Politicians are motivated to foster learning health systems that may close the gap. They fear voter backlash if an increasing



### Federal Debt as a Percentage of GDP, Historically and as Projected by the Congressional Budget Office (CBO).

The alternative fiscal scenario incorporates the assumptions that all expiring tax provisions (other than the payroll tax reduction), including those that expired at the end of December 2011, are instead extended; that the alternative minimum tax is indexed for inflation after 2011 (starting at the 2011 exemption amount); that Medicare's payment rates for physicians' services are held constant at their current level; and that the automatic enforcement procedures specified by the Budget Control Act of 2011 do not take effect. The budgetary effects under the alternative fiscal scenario also include the incremental interest costs associated with projected additional borrowing.

proportion of Americans cannot afford good care. Two factors now constrain politicians' ability to fund required consumer subsidies with government debt. The 2008 financial meltdown, 2001 tax cut, and two wars have pushed federal debt as a percentage of GDP to twice the level it had generally maintained since recovering from the fiscal aftermath of World War II levels (see graph), and a growing fraction of U.S. creditors are not American. Unconstrained by patriotism and unnerved by devaluation in several European governments' bonds, foreign creditors will demand higher interest rates if U.S. debt continues to increase as a percentage of GDP. Higher interest rates increase debt and suppress the economic growth needed to reduce it. Perpetually raising taxes to offset the annual gap's effect on debt isn't feasible, especially when the economy is weak. Alternatives include increasing the informal rationing that al-

ready occurs in states where many physicians won't treat Medicaid patients and improving health system efficiency by 2 to 3 percentage points annually, as has been done in several other U.S. service industries.<sup>5</sup>

Most approaches to persuading the health industry to create robust learning health systems strengthen incentives for improving value. Provider-directed incentives improve payments to health care providers that attain more health gain per dollar spent than they have in the past or than their peers do. Examples include Medicare's chronic illness and bundled-payment demonstrations, pay-for-performance programs launched over the past decade, and newer approaches such as accountable care organizations, bundled payments, medical homes, and hospital value-based purchasing. Some physicians will be more directly affected in January 2013, when they will receive

reports from Medicare comparing them with their peers. By 2017, these comparisons will be used to modify all physicians' Medicare fees. Patient-directed incentives link the fraction of health care costs paid by patients to the extent to which they select higher-value health care providers and treatment options, including self-care.

Both approaches have been tested by non-Medicare health care purchasers. Safeway Stores, Unite Here Health (a health-benefits trust), the employee health plans of some states and cities (California, Massachusetts, and Minnesota and the city of Los Angeles), and some options offered by health insurers all use patient communications and strong patient incentives to move market share to higher-value providers; others use provider-payment methods instead. Their effectiveness depends on better harmonizing the way that all payers assess and

reward physicians and other health industry participants. Modest forms of harmonization are illustrated by the Bush administration's Chartered Value Exchanges and support for the National Quality Forum and by the Affordable Care Act's provision that the Independent Payment Advisory Board recommend policies affecting all payers.

The split in the debt-trend line forecast by the Congressional Budget Office (CBO) — downward toward solvency, upward toward “fiscal Armageddon” — mostly reflects uncertainty not about whether stronger incentives to improve value will succeed, but about whether Congress can withstand the health industry's pressure to preserve its revenue. Perpetual growth in health spending in excess of GDP will negate any non-continuous fiscal fix, such as postponing Medicare eligibility. Since physicians powerfully influence the use of health care resources and public opinion about health policies, Congress needs their support to legislate sufficiently compelling multipayer incentives for health care providers to close the gap permanently and safely.

However, demand for most physicians' services would probably decrease in response to stronger incentives for value. Such incentives would eliminate service use that is safely preventable, inappropriate, or unwanted by well-informed patients and trigger reassignment of physicians' work that could be performed by less costly workers or by automating some diagnosis and treatment. Medical specialists remember substantially decreased demand during the heyday of managed care. Primary care phy-

sicians realize that larger numbers of patients are being well cared for by peers who use e-mail contacts with patients, nurse call centers, and team-based visits.

Physicians can successfully resist policies that threaten their incomes. Their opposition to managed care contributed to its decline and faster subsequent growth in health care spending. Physicians neutralized Medicare's full implementation of fee reductions under the formula for a sustainable growth rate.

Some physician leaders believe that preserving physicians' income may be unnecessary for enlisting physicians as stewards of patients' pooled health insurance dollars, which comprise income that their patients forgo or taxes they pay. Most physician specialty societies have committed their members to such stewardship by endorsing the Physician Charter. If they are wrong, can physicians succeed in such stewardship without substantially lowering their incomes?

Physicians could lobby to slow policies limiting overall health care spending. However, broadly targeted postponement won't satisfy foreign creditors. Physicians could lobby to protect their incomes but not those of others in the health care industry. Or they could enhance their incomes by exporting their expertise through telecommunication to rapidly developing countries facing physician shortages. Progress has been swift in high-fidelity telecommunication and instant language translation for services that don't require manual examinations or procedures or that can be performed by less expensive health workers with remote physician supervision.

The CBO's diverging trend lines present physicians with an urgent choice. One path leads to a gain of 2 to 3% in annual efficiency, robust federal creditworthiness, and thereby equitable access to good care, the other to better protection of physicians' incomes and traditional roles but wider informal rationing of health care services. Osler anticipated today's code red and blue when he wrote, “Medical care must be provided with the utmost efficiency. To do less is a disservice to those we treat, and an injustice to those we might have treated.” Which path will physicians choose?

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