Health Care Reform 2020 & Beyond

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Michael Fine, MD

Chief Health Strategist to Mayor James Diossa of Central Falls, Rhode Island; Senior Population Health and Clinical Services Officer, Blackstone Valley Community Health Care, Inc., Pawtucket, Rhode Island

Dr. Fine is a writer, community organizer, and family physician. Devoted to health care reform and the care of underserved populations, he has worked in New York's South Bronx as a VISTA community health organizer; in the mountains of East Tennessee as a National Health Service Corps (NHSC) scholar; at a hospital in rural Kenya; and in Liberia as a consultant to Medical Emergency Relief International (Merlin) and the Liberian Ministry of Health. Other past positions include director of the Rhode Island Department of Health (2011 to 2015); medical director of the Rhode Island Department of Corrections (2010 to 2011); physician-in-chief of Miriam Hospital (2003 to 2008) and Rhode Island Hospital (2001 to 2008); and physician operating officer of Hillside Avenue Family and Community Medicine, the largest family medicine practice in Rhode Island (1992 to 2008). He was also the founder and managing director of HealthAccessRI, the nation's first statewide direct primary care (DPC) organization, and practiced in urban and rural settings in Rhode Island for 16 years.

A past president of the Rhode Island Academy of Family Physicians, Dr. Fine was an Open Society Institute/George Soros Fellow in Medicine as a Profession from 2000 to 2002; was the 2017 recipient of the Barbara Starfield Primary Care Leadership Award; and has been the recipient of many statewide and national honors and awards. In addition, he is the author of four books, including The Nature of Health (2007) and Health Care Revolt (2018). Released in April 2019, his novel Abundance was a semi-finalist in the William Faulkner–William Wisdom Creative Writing Competition.

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Purva Rawal, PhD

- Principal, CapView Strategies, Washington, DC
- At CapView Strategies, Rawal works with health systems, life sciences companies, think tanks, and health care coalitions. She has particular expertise in payment and delivery reform, and health system sustainability and transformation issues. In January 2016, she published The Affordable Care Act: Examining the Facts, a book exploring the veracity of beliefs and claims about health care reform. She is also an adjunct assistant professor at Georgetown University, Washington, DC, where she teaches undergraduate classes including Politics of Health Care. In addition, she serves on the board of trustees for Woodley House, a mental health housing and support agency in Washington, DC.
- Rawal began her health policy career as a Christine Mirzayan Science and Technology Policy Fellow at the National Academy of Sciences (NAS)/Institute of Medicine (IOM). She began on Capitol Hill as a congressional fellow for the Society for Research in Child Development (SRCD) and the American Association for the Advancement of Science (AAAS). From 2005 to 2010, she was on staff in the U.S. Senate, where she worked on the Senate Budget Committee as a key adviser to Chairman Kent Conrad (D-ND) during the drafting and passage of the Patient Protection and Affordable Care Act (ACA). Prior to that, she was the health adviser to Sen. Joseph Lieberman (I-CT). After leaving Capitol Hill, she was a director of health insurance and reform practice at Avalere Health. She earned a bachelor's degree and doctorate from Northwestern University, Evanston, Illinois

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Nicole Fisher

Founder/President, Health & Human Rights Strategies, Washington, DC

Fisher is the founder and president of Health & Human Rights Strategies, an advising firm that focuses on health care and human rights. She is also a health policy advisor on Capitol Hill and an expert on health innovation, technology, and brain health. Fisher contributes to Forbes, contextualizing health and highlighting ideas, companies, and people changing the health landscape. In addition, she curates an international dinner series called "A Seat at the Table," bringing together thought leaders for off-the-record discussions about moving research policy and planning forward. Fisher co-runs the nonprofit Brain Treatment Foundation, and she is pursuing a doctoral degree at the University of North Carolina. Her writing has appeared in numerous journals and other publications, and her talks can be found on the United Nations website and various news and sports outlets. Before pursuing her doctorate, Fisher earned a master's degree in public policy from the University of Chicago and an undergraduate degree from the University of Missouri.

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Learning Objectives

1. Overview of the strengths and weaknesses of our current health care system.

2. Discuss major reformproposals being considered.

3. Compare the United States system to other countries.

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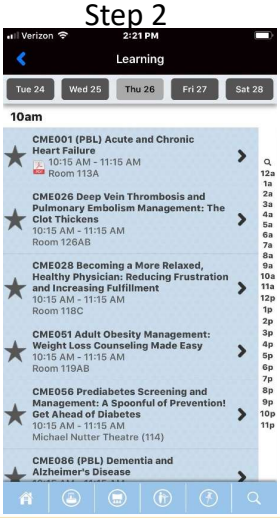
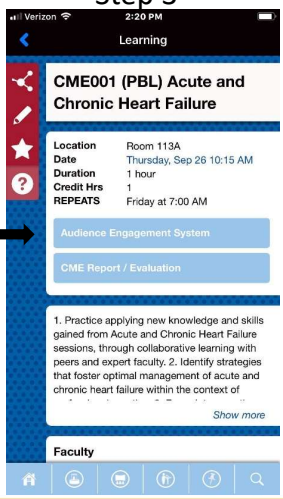
Audience Engagement System

Step 1

Step 2



Step 3



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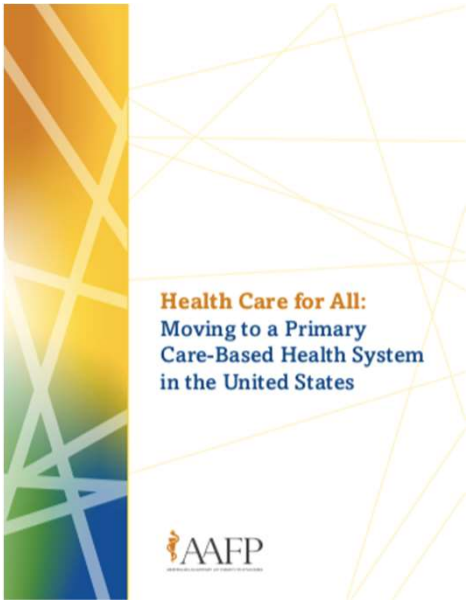


Health Care for All:

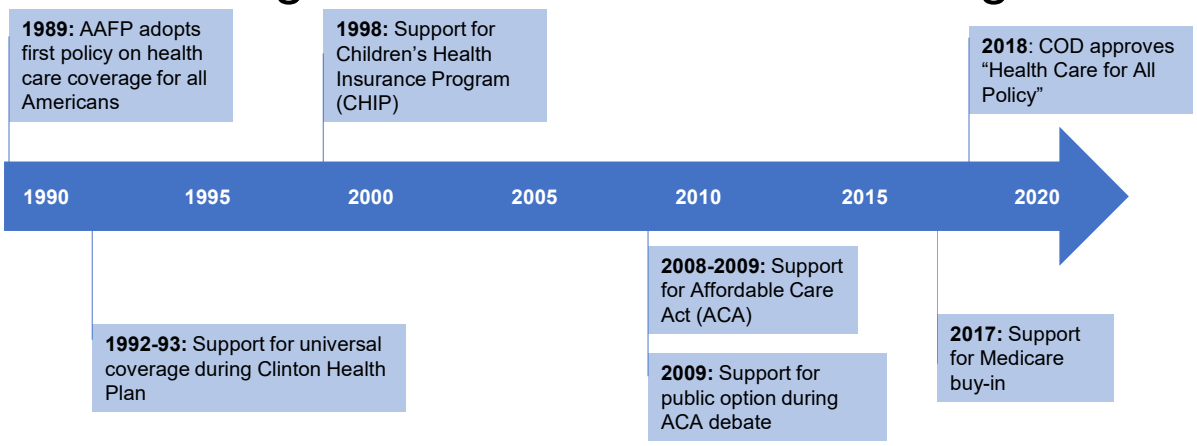
Moving to a Primary Care-Based Health System in the U.S.

Executive Summary

- The American Academy of Family Physicians' (AAFP) vision is to "…transform health care to achieve optimal health for everyone."
- Policymakers and the public are looking for ways to address coverage, quality, and cost challenges within the U.S. health care system
- In 2018, the AAFP Congress of Delegates (COD) approved the "Health Care for All" policy—outlining seven principles and considerations for health reform
- The "Health Care for All" policy considered commissioned research on international health systems, historical policy positions, and feedback from chapters to support affordable, primary-care based health care for all

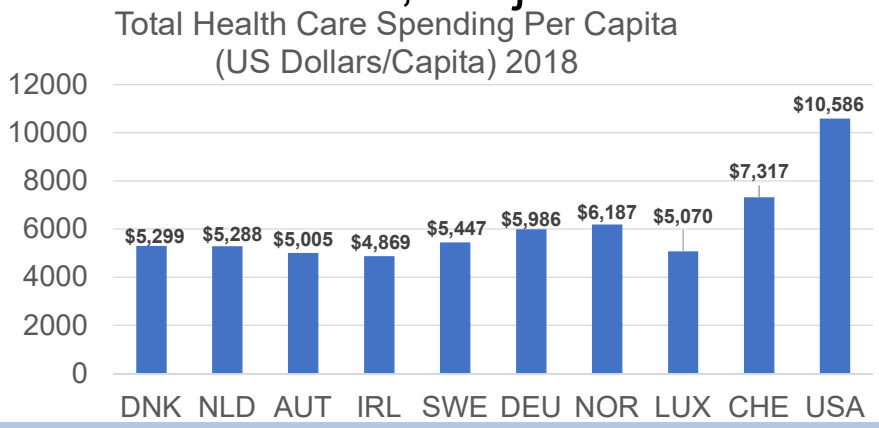
"Health Care for All" policy will guide AAFP's assessment of and engagement on health reform proposals at the Federal and state levels and with the public.

AAFP Has a 30-Year Commitment to Ensuring All Americans Have Coverage



U.S. Health System Challenges

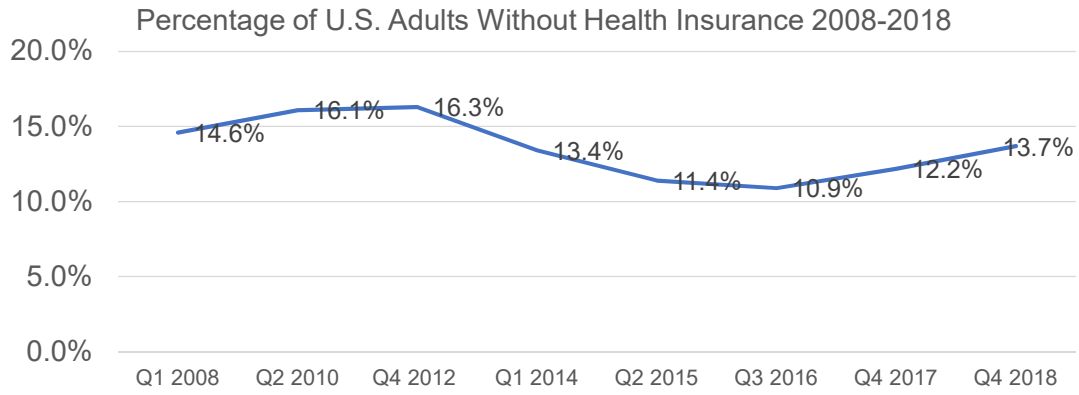
U.S. Health Care Spending Outpaces Most Other Countries, Projected to Grow



Health share of GDP in the U.S. was 17.9% in 2017 and is projected to increase to 19.4% by 2027. Health spending is expected to rise from $3.6 T in 2018 to almost $6 T by 2027

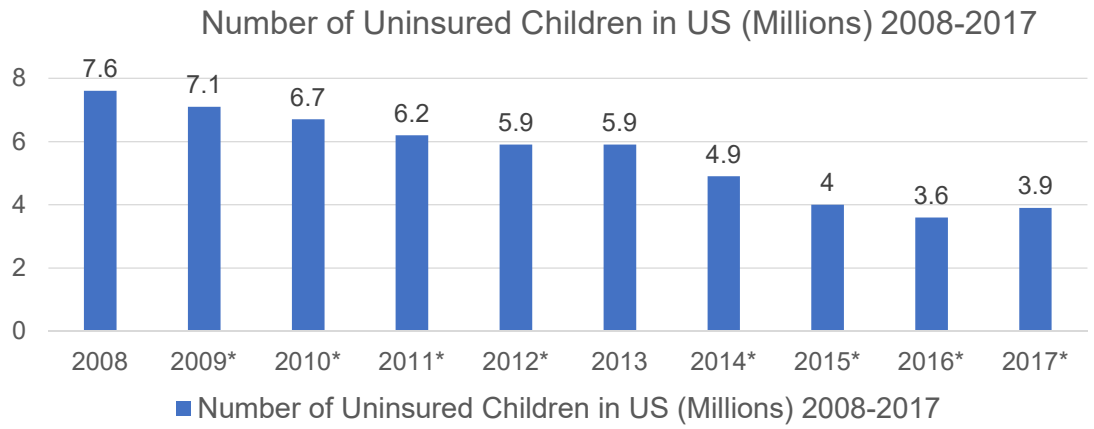
Source: OECD, Health spending: total, government/compulsory, voluntary; US dollars/capita; 2018 or latest data available.

2018 Adult Uninsured Rate Was Highest Since ACA Went Into Effect



Source: Gallup National health and Wellbeing Index. Witters D. U.S. uninsured rate rises to four-year high. January 23, 2019.

Number of Uninsured U.S. Children Increasing



* Change in coverage relative to previous year is significant at 90% confidence level.

Source: Alker J, Pham O. Nation's progress on children's health coverage reverses course. Washington, DC: Georgetown University Health Policy Institute, Center for Children & Families; 2018. Based on 2008 to 2017 U.S. Census Bureau American Community Survey (ACS) data

U.S. Underperforms on Population Health Compared to Other High-Income Countries

	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
OVERALL RANKING	2	9	10	8	3	4	4	6	6	1	11
Care Process	2	6	9	8	4	3	10	11	7	1	5
Access	4	10	9	2	1	7	5	6	8	3	11
Admin. Efficiency	1	6	11	6	9	2	4	5	8	3	10
Equity	7	9	10	6	2	8	5	3	4	1	11

Source: Schneider EC, Sarnak DO, Squires D, Shah A, Doty MM. Mirror, mirror 2017: international comparison reflects flaws and opportunities for better U.S. health care. July 2017.

Research Shows Access to Primary Care has Positive Impact on Spending, Quality, Outcomes

- Research has shown that states that rely more on primary care physicians to manage chronic illness are associated with:
  - Lower Medicare spending
  - Lower utilization of some services (e.g. physician visits, days in hospital and ICU)
  - Better quality of care

- Study analyzing the impact of having a regular source of primary care on quality and patient experience found:
  - Those with primary care were more likely to have had a routine preventative visit and fill more prescriptions over past year, received more high-value care, and reported better access and experience with care

- Study found that greater supply of primary care physicians was associated with longer life expectancy
  - Also associated with reduced mortality due to cardiovascular, respiratory diseases

- **However, a 2019 study estimated that only 2-5 percent of Medicare spending is on primary care**

Sources: Dartmouth Medical School Center for the Evaluative Clinical Sciences, The care of patients with severe chronic illness: an online report on the Medicare program by the Dartmouth Atlas Project. The Dartmouth Atlas of Health Care 2006; Levine DM, Landon BE, Linder JA. Quality and experience of outpatient care in the United States for adults with or without primary care. *JAMA Intern Med.* 2019;179(3):363-372; Basu, S., Berkowitz, S., Phillips, R. et al. (2019). Association of Primary Care Physician Supply with Population Mortality in the United States, 2005-2015. JAMA Internal Medicine; R. Reid, C. Damberg, M. Friedberg. Primary Care Spending in the Fee-for-Service Medicare Population. April 2019.

Review of International Models with Foundational Primary Care

International Health Systems Discussion Paper Examined Approaches to Enhance U.S. System

- In 2016, the AAFP Board of Directors commissioned a "Discussion Paper on Health Care Coverage and Financing Models"
  - Discussion paper was not adopted as AAFP policy, but supported development of the 2018 "Health Care for All" policy
- Analysis looked at international health systems and their impact on select system and population health indicators
  - Healthcare Coverage and Access
  - The Family and Primary Care Physician Workforce
  - Health Care Spending, and
  - Population Health

The Board examined the discussion paper and AAFP member feedback – and found that the most optimal system may be a combination of features from reviewed models that can address the unique needs of the U.S.

Comparison of Health Care Coverage & Access Across Health Systems

Model	Percent of Population Covered	Percent Experiencing Cost Barriers	Percent Waiting 2+ Months for Specialist
Bismarck Model	Coverage likely to increase	Unknown	Unknown, but some opt-out of statutory system for private coverage
Public Option	Coverage levels could increase	Unknown	Unknown
Single Payer Model	Coverage likely to increase	Access barriers likely to be reduced	Wait times may increase modestly

Countries with single payer or Bismarck models have universal coverage and more limited cost barriers to access, but may have longer wait times for specialty care.

Comparison of Health Systems on Family and Primary Care Physicians

Model	Admin. Burden	Payment	Workforce	Caseload	Physician Satisfaction and Burnout	Auton-omy
Bismarck Model	Likely to decline	Unknown	May not change	Unknown	May not change	May decline
Public Option	Could increase	Unknown	Unknown	Unknown	No change	No change
Single Payer Model	Likely to decline	May be reduced - depends on payment levels and structure	Ratio of primary care physicians to specialists could increase	Unlikely to change	Likely to improve	Unknown

Counties with single-payer and Bismarck models generally have stronger, primary-care based health systems with higher ratios of primary care physicians to specialists and rates of physician satisfaction, and lower administrative burden.

Comparison of Health Spending Across Systems

Model	Total Expenditures	Personal & Government Expenditures	Variability in Spending
Bismarck Model	Lower	Variable	Out-of-pocket expenditures increasing
Public Option	Unknown	Unknown	Unknown
Single Payer Model	Lower	Personal – Unclear, Gov. – Increase	Greater emphasis on primary care, increase spending towards practice-based primary care

Impacts of models on total health expenditures difficult to distinguish. However, single-payer and Bismarck models have lower levels of health care spending as a percentage of GDP compared to the U.S.

Comparison of Health System Impact on Population Health

Model	Population Health
Bismarck Model	Likely to improve
Public Option	Likely to improve
Single Payer model	Likely to improve

Population health is likely to improve under all models.
Generally, health outcomes in both single-payer and Bismarckian countries are better than in the U.S. —likely due to focus on prevention and potentially greater investment in social programs.

Policy Priorities & Guardrails to Guide Engagement on Health Reform

Moving Towards the Goals of Coverage for All and a System Foundational in Primary Care

AAFP's Principles for Health Reform Proposals

- ✓ Coverage
- ✓ Primary Care-Based Health System
- ✓ Insurance Reforms
- ✓ Primary Care Payment
- ✓ Workforce
- ✓ Reduced Barriers for Primary Care
- ✓ Patient and Physician Choice

Guardrails for Assessing Reform Proposals

- Alignment With AAFP's Policy Priorities and Strategic Objectives
- Environmental Considerations (e.g., bipartisan, public support)
- Political and Economic Conditions (e.g., political and fiscal viability)
- Achievement of Changes Consistent With AAFP's Mission

Support for Health Reform

Support for health system reform that aligns with AAFP's principles, is feasible within the context of guardrails, and that results in coverage for all and a system for which primary care is foundational

Standing Together

What States Can Do

How Family Physicians Can Organize Ourselves, Our Colleagues and Our Communities To Build The Health Care System America Needs and Perhaps Preserve Democracy in the Process -- Block By Block, Neighborhood by Neighborhood, and Town by Town.

Health Care in the US is an expensive failure

- WE SPEND
  $3.65 Trillion
  Almost three times what nations with the best health outcomes spend

HEALTH REVOLT CARE

But compared to other advanced countries we get poor health outcomes

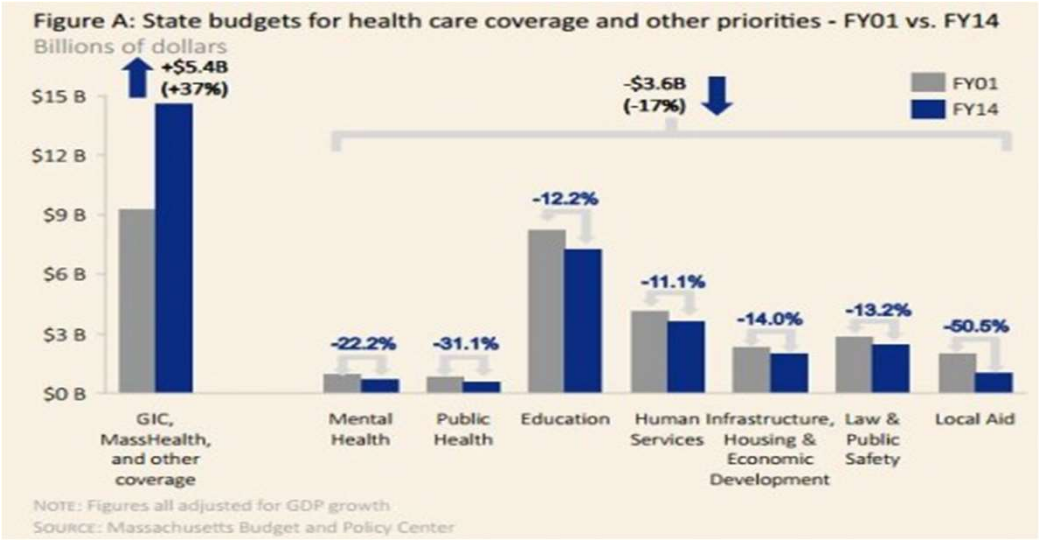
- Their costs: 50 percent less
- Their outcomes:
  Infant morality rates a third of ours.
  Life expectancy 4 years longer
  - (our life expectancy is falling. We now rank 64th in the world)

  Huge health disparities

One third to half of what we spend is unnecessary or wasted

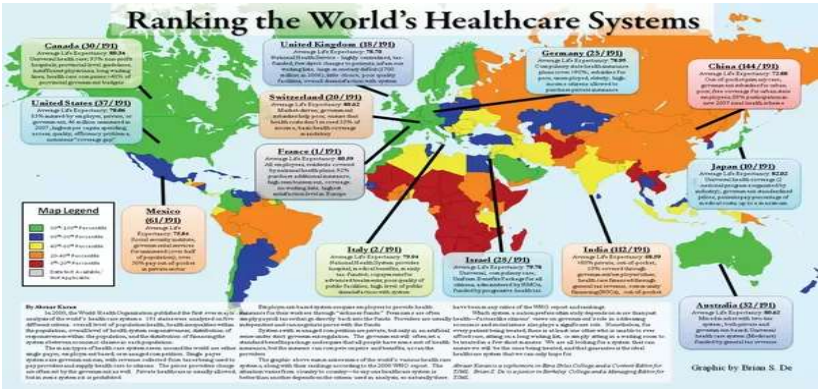
- We *waste* $1.7 to $1.8 trillion a year, most of which is profit for someone

The money we waste is money we aren't investing in social programs that actually improve health



Most advanced countries provide primary care to everyone

- Finland
- Denmark
- Israel
- Cuba
- Spain
- The United Kingdom



Most advanced nations provide primary care to everyone

- They spend *three times* what we spend on primary care (20% vs 6%)
- *Half* of all their doctors are primary care doctors
- They provide primary care *to everyone*, in *every* neighborhood and community

HEALTH REVOLT CARE

But in the US, little primary care: we haven't seen what primary care can do

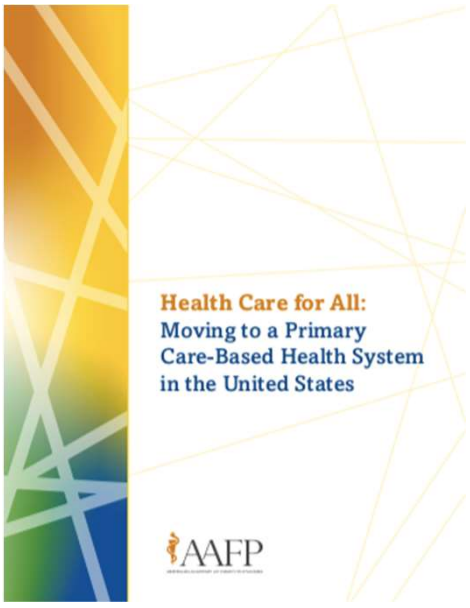
- 43 percent of Americans had any primary care visit in the last year
- Only 52 to 54 percent of insured Rhode Islanders had a preventive examination in the last two years
  - That includes kids (so the proportion of adults is likely much higher)
- 45 percent of millennials can not identify a primary care clinician at all

You don't change a $3.6 Trillion industry by just *asking* it to change

You change a $3.6 trillion dollar industry by building a national movement to change it

Five Things States Can Do

- Teach clinicians to talk about health care cost and outcomes ***in the exam room***
- Primary care spend legislation/regulation
- Make Medicaid and Public Employee Direct Primary Care
- Red States: Medicaid and Public Employee Insurance via **HSA**
- Blue States: Primary Care Trusts



Questions?

www.aafp.org/hcdelivery

Questions

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