The Future of Web/Health/Democracy

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Outline

- Context
- The Future of:
  - Web
  - Health
  - Democracy
- Implications

The Holy Trinity

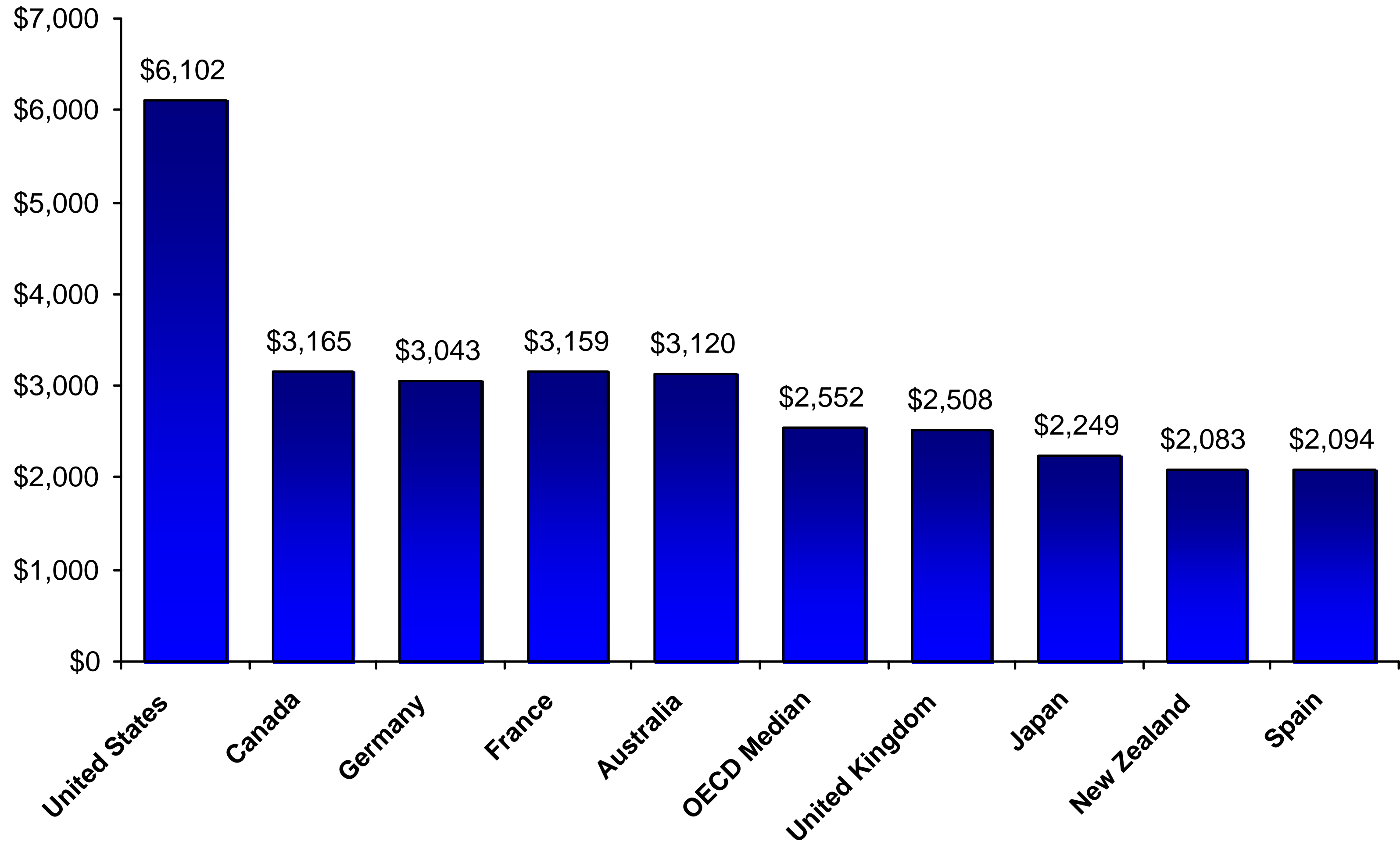
- Cost
- Quality
- Access
- (Security of Benefits)

Defining Value of Health Services

$$\text{Value} = \frac{(\text{Access}+\text{Quality}+\text{Security})}{\text{Cost}}$$

Strategic Health Perspectives

Health Care Spending per Capita in 2004
(Adjusted for Differences in the Cost of Living)



Source: OECD Health Data Published in Health Affairs Volume 26:5 2007

International Health Comparisons, 2004-05

Country	Health Care Spending ($ per Capita) 2004	Pop'n over 65 (percent) 2004	MRI per million	Female Life Exp (years)	Infant Mortality (per 000) 2005 est
USA	6,102	12.4	8.2	79.8	6.5
Canada	3,165	13.0	4.2	82.2	4.8
Germany	3,043	18.3	5.5	81.3	4.2
France	3,159	16.4	2.7	83.0	4.3
UK	2,508	15.7	4.0	80.4	5.2
Japan	2,249	19.0	35.3	85.2	3.3
Spain	2,094	17.6	6.2	83.1	4.4
Hungary	1,276	14.9	2.5	76.7	8.6
Korea	1,149	8.5	7.9	80.0	6.3
Turkey	580	6.6	3.0	70.9	41.0

Source: OECD 2002-2007

Strategic Health Perspectives

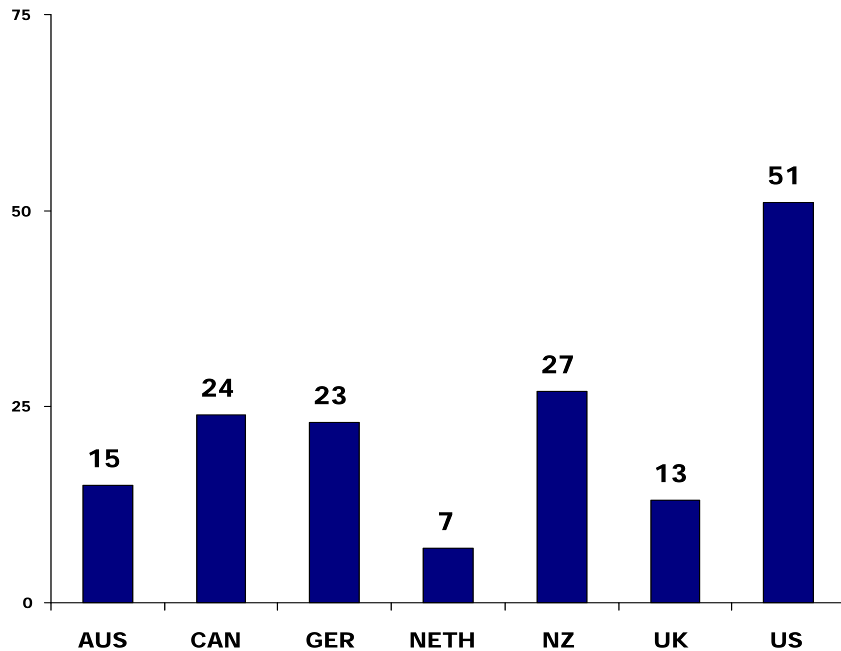
International Health Comparisons, 2004-05

Country	Practicing MDs per 1000	MD Visits per capita	Acute Care Bed Days per capita	Alcohol Consumption (liters per person aged 15 plus)	Tobacco Consumption (% pop daily smokers)	Overweight or obese (BMI > 25)
USA	2.4	3.9	0.7	8.4	17.0	66.3
Canada	2.1	6.1	1.0	7.9	15.0	57.5
Germany	3.4	n/a	1.8	10.1	24.3	49.2
France	3.4	6.7	1.0	14.0	23.0	34.6
UK	2.3	5.3	1.1	11.5	25.0	63.0
Japan	2.0	13.8	2.1	7.6	29.4	24.9
Spain	3.4	9.5	0.8	11.7	28.1	48.4
Hungary	3.3	12.6	1.7	13.2	30.4	52.8
Korea	1.6	10.6	n/a	8.3	n/a	n/a
Turkey	1.4	3.1	0.4	1.5	32.1	43.4

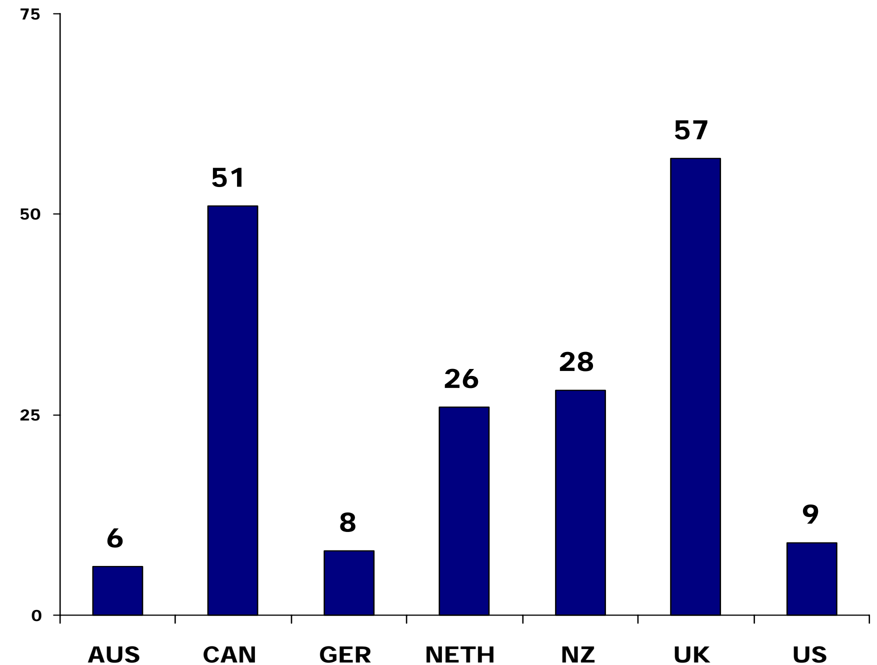
Source: OECD 2002-2007

Physicians' Perception of Patient Access

Patients Often Have Difficulty Paying for Medications



Patients Often Experience Long Waits for Diagnostic Tests



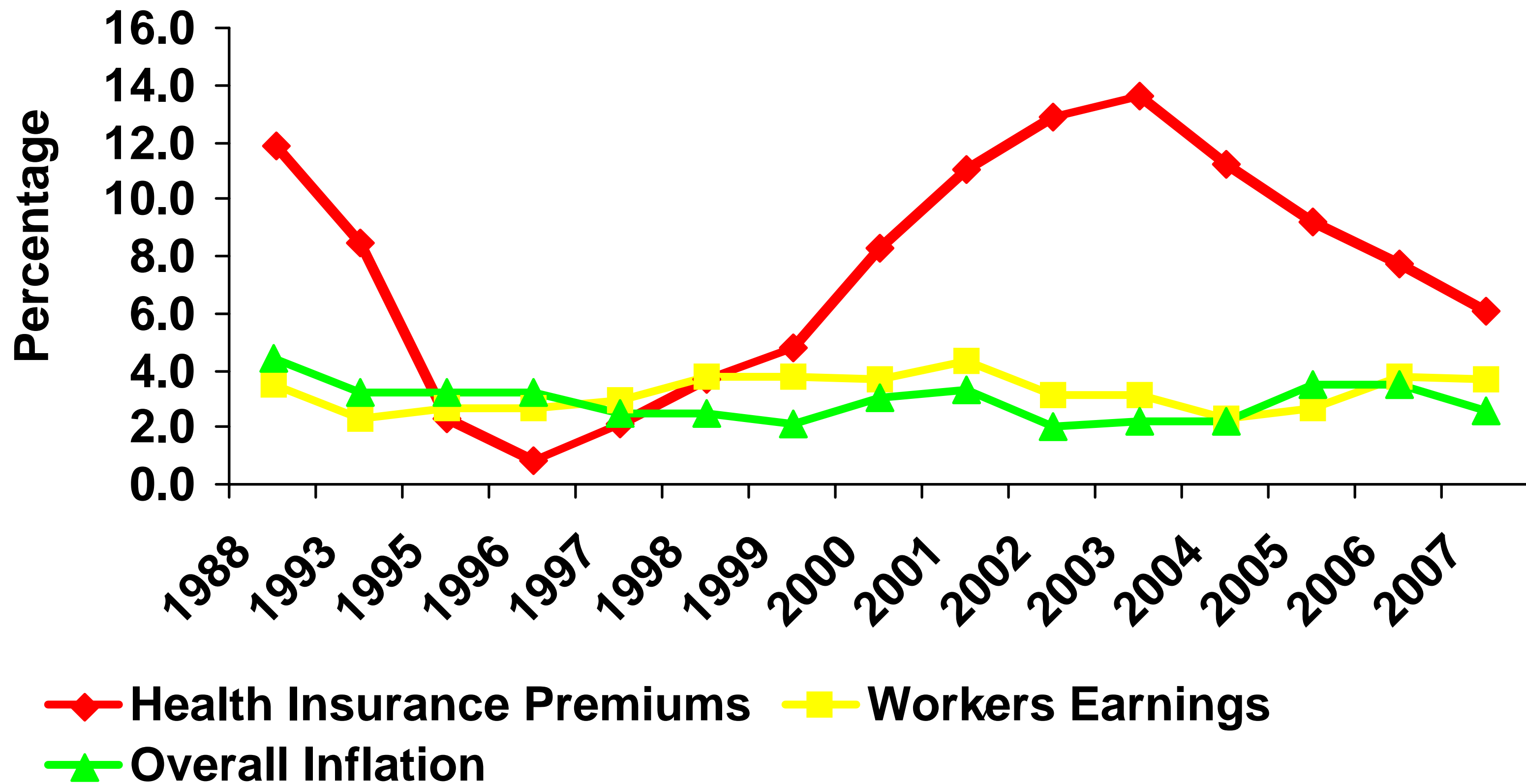
Source: 2006 Commonwealth Fund International Health Policy Survey of Primary Care Physicians.

Why the Big Difference?

- The Fallacy of Excellence
- The 6 Point Spread
  - Everyone makes more money: Not just doctors, higher prices and incomes for everyone
  - Administrative Waste Motion: 25%-30% Price of Pluralism
  - Intensive and Expensive Use of Technology
    - End of Life Care: 30% of Medicare
    - Intensive use of Diagnostics, procedures, and high-tech interventions
    - Primary versus Specialty Care Balance
- Is it fixable?
  - Some is culture: Values, expectations, and attitudes
  - Some is population differences: Way too much is made of this e.g. The Natural Experiment Paper
  - Most is policy, management and payment system

Strategic Health Perspectives

Premium Increases Compared to Other Indicators, 1988-2007



Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2006; KPMG Survey of Employer-Sponsored Health Benefits: 1988, 1993, 1996, 1998; Bureau of Labor Statistics, 2000.

Strategic Health Perspectives

Quality Shortfalls: Getting it Right 50% of the Time

Adherence to Quality Indicators

Condition	Percentage of Recommended Care Received
Breast Cancer	75.7%
Prenatal Care	73.0%
Low Back Pain	68.5%
Coronary Artery Disease	68.0%
Hypertension	64.7%
Congestive Heart Failure	63.9%
Depression	57.7%
Orthopedic Conditions	57.2%
Colorectal Cancer	53.9%
Asthma	53.5%
Benign Prostatic Hyperplasia	53.0%
Hyperlipidemia	48.6%
Diabetes Mellitus	45.4%
Headache	45.2%
Urinary Tract Infection	40.7%
Ulcers	32.7%
Hip Fracture	22.8%
Alcohol Dependence	10.5%

0% 20% 40% 60% 80% 100%

■ Percentage of Recommended Care Received

Adults receive about half of recommended care

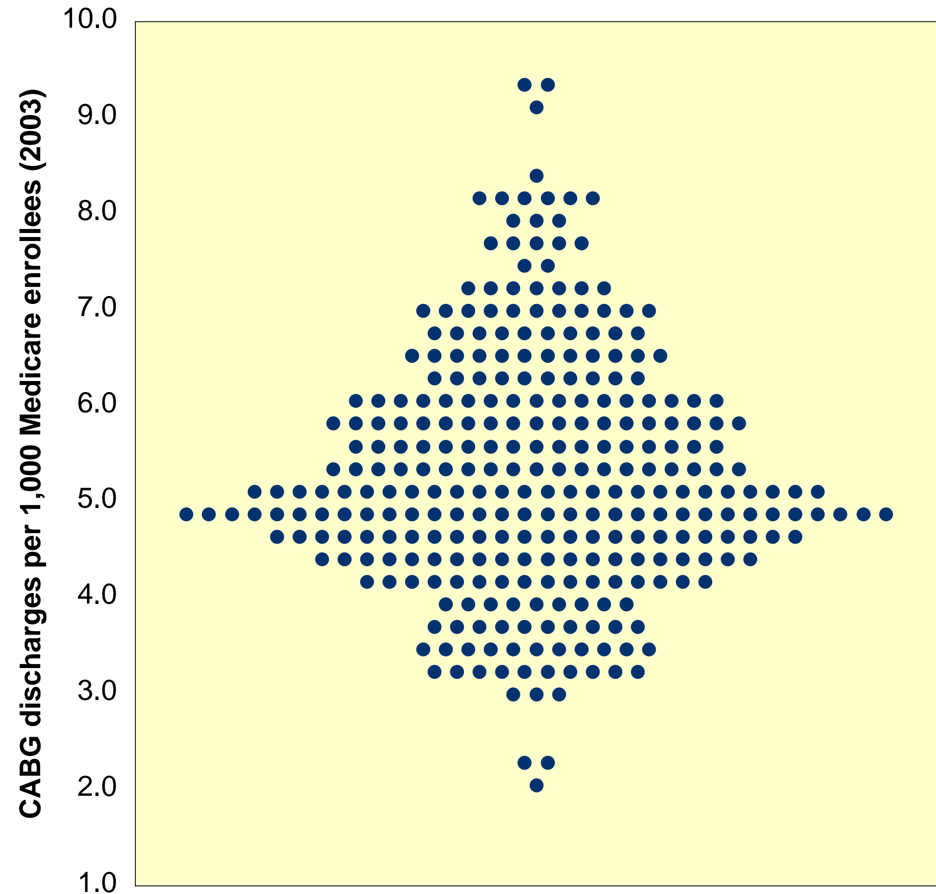
- ***54.9% = Overall care***
- ***54.9% = Preventive care***
- ***53.5% = Acute care***
- ***56.1% = Chronic care***

Source: McGlynn EA, et al., "The Quality of Health Care Delivered to Adults in the United States," New England Journal of Medicine, Vol. 348, No. 26, June 26, 2003, pp. 2635-2645

Enormous Variations in Practice and Spending

Coronary Artery Bypass Graft Surgery

Age-sex-race adjusted rate per 1000 enrollees in 2003



Source: Dartmouthatlas.org courtesy Elliot Fisher MD

The Progressive Transformation Story

- Cost and Quality are correlated inversely
- Utilization is not based on need and doesn't create outcomes
- Measurement matters
- Transparency on cost and quality will:
  - Embarrass providers to improve
  - Motivate payers to differentially pay
  - Motivate consumers to change providers
  - Steer business to the high performance providers
  - Do all of the above given enough time
- Re-engineering of delivery system will ensue
- Value gains will make healthcare more affordable and of much higher reliability and quality

Quality and Efficiency Vary Widely By State

EXHIBIT 1
Relationship Between Quality And Medicare Spending, As Expressed By Overall Quality Ranking, 2000–2001

Health Affairs
April 7, 2004

Overall quality ranking

1
11
21
31
41
51

NH, VT, ME, ND, UT, IA, CO, WI, CT, MN, OR, NE, MT, DE, MA, HI, RI, VA, WA, SD, WY, ID, NC, NY, MD, MI, IN, MO, Az, KS, PA, SC, AK, WV, NV, NM, OH, TN, KY, FL, AL, NJ, CA, OK, IL, GA, AR, TX, MS, LA

3,000 4,000 5,000 6,000 7,000 8,000
Annual Medicare spending per beneficiary (dollars)

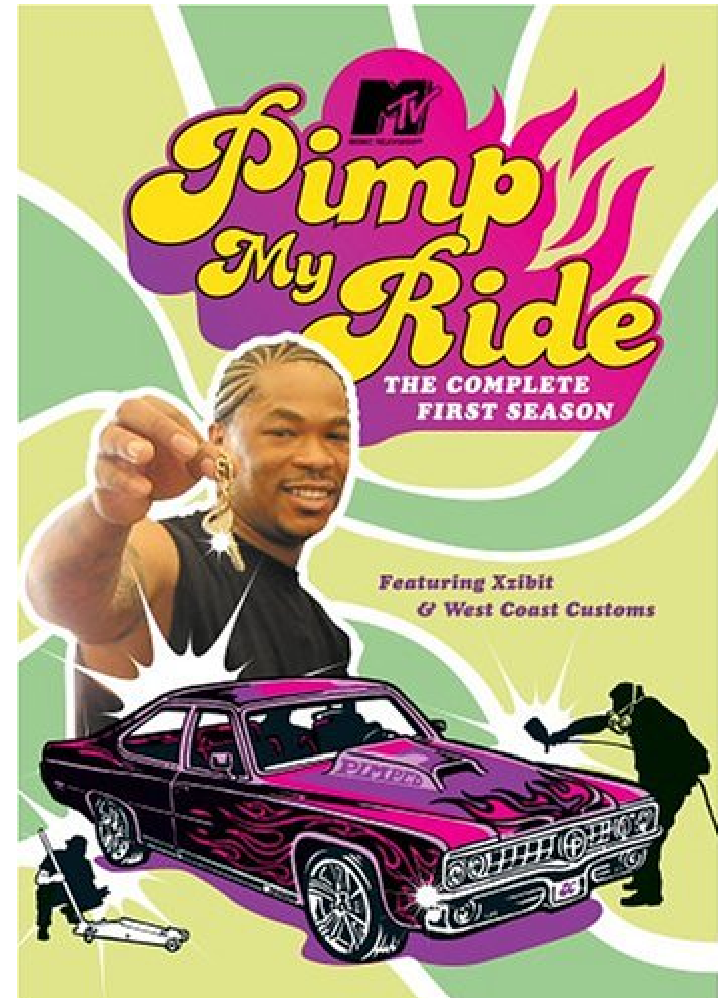
SOURCES: Medicare claims data; and S.F. Jencks et al., "Change in the Quality of Care Delivered to Medicare Beneficiaries, 1998–1999 to 2000–2001," *Journal of the American Medical Association* 289, no. 3 (2003): 305–312.
NOTE: For quality ranking, smaller values equal higher quality.

The Battle for Quality: IOM versus “Pimp My Ride”

The IOM Vision of Quality:

Charles Schwab meets Nordstrom meets the Mayo Clinic

The Prevailing Vision of Quality in American Healthcare:
“Pimp My Ride”

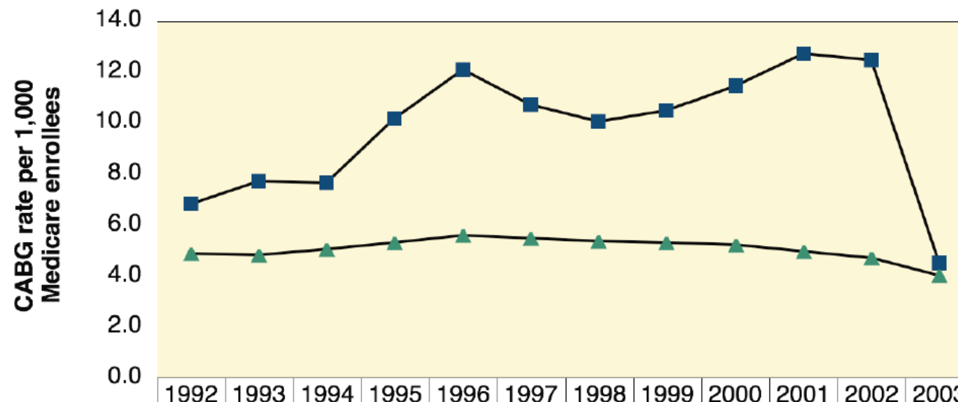


The Battle for Quality: IOM versus “Pimp My Ride”

- Really Bad Chassis
- Unbelievable amounts of high technology on a frame that is tired, old and ineffective
- Huge expense on buildings, machines, drugs, devices, and people at West Coast Custom Healthcare
- People who own the rides are very grateful because they don’t have to pay for it in a high deductible catastrophic coverage world
- It all looks great, has a fantastic sound system, and nice seats but it will break down if you try and drive it anywhere

Pimp My Ride in Redding

- Fee-for-service payment rewards:
  - Volume
  - Fragmentation
  - High margin services
  - Growth



	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Redding HRR	6.8	7.7	7.7	10.2	12.1	10.7	10.1	10.5	11.5	12.8	12.5	4.5
California average	4.9	4.8	5.1	5.3	5.6	5.5	5.4	5.3	5.2	5.0	4.7	4.0
Number of procedures in excess of CA average	81	123	111	209	278	223	200	227	277	349	352	22
U.S rank in year	27	5	10	1	1	2	2	2	2	1	1	227

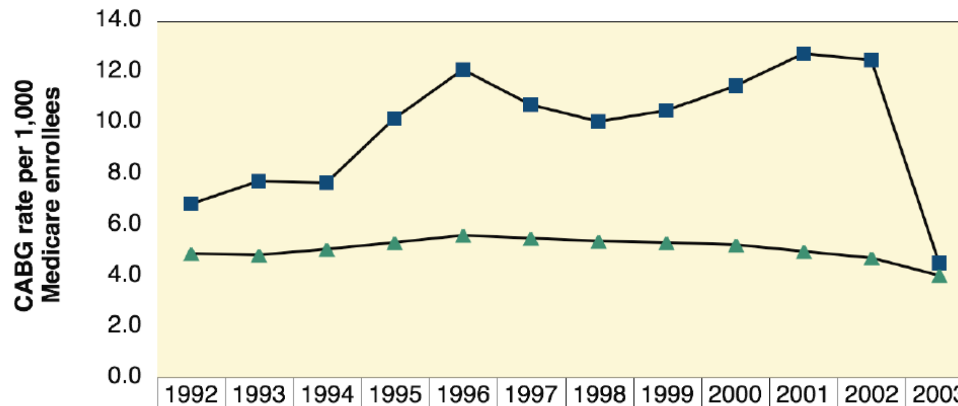
Source: Dartmouthatlas.org courtesy Elliot Fisher MD

Pimp My Ride in Redding

- Fee-for-service payment rewards:
  - Volume
  - Fragmentation
  - High margin services
  - Growth

Clinical Intervention

The FBI Arrived



	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Redding HRR	6.8	7.7	7.7	10.2	12.1	10.7	10.1	10.5	11.5	12.8	12.5	4.5
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U.S rank in year	27	5	10	1	1	2	2	2	2	1	1	227

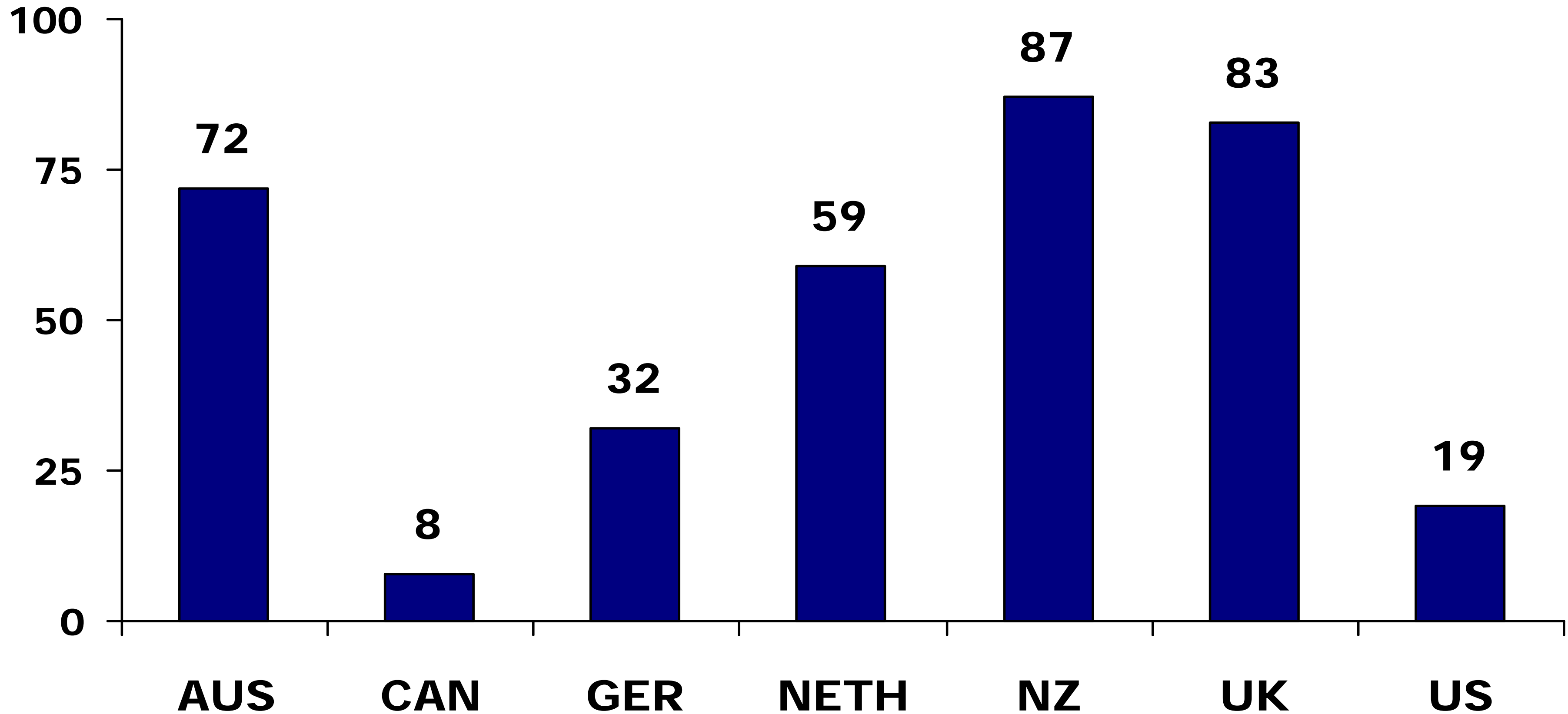
Source: Dartmouthatlas.org courtesy Elliot Fisher MD

The Future of the Health Web

- Healthcare still predominantly uses 17th century information technology
- Amara's Law
- Toxic incentives for coordinating technology
- Health 2.0 has considerable momentum
- Microsoft and Google matter
- Just Looking
- Three Powerful forces:
  - Money: Hospitals continue to spend on HIT outreach and maybe Obama will too
  - Consumer Demand: We want help in navigation, transactions, coordination and social support
  - Enabling technology: The tools will improve and the business models will emerge

Strategic Health Perspectives

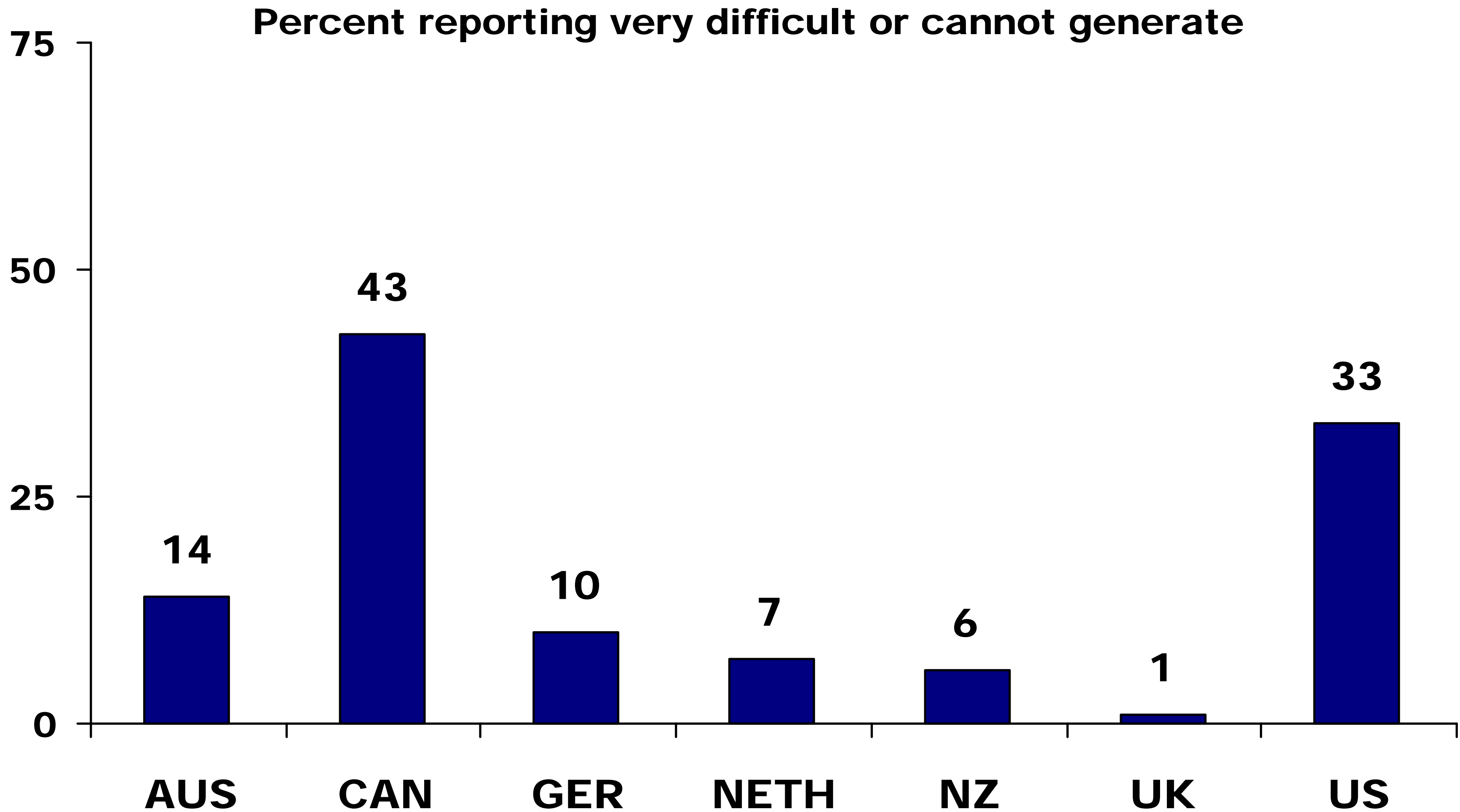
Primary Care Practices with Advanced Information Capacity



* Count of 14: EMR, EMR access other doctors, outside office, patient; routine use electronic ordering tests, prescriptions, access test results, access hospital records; computer for reminders, Rx alerts, prompt tests results; easy to list diagnosis, medications, patients due for care.

Source: 2006 Commonwealth Fund International Health Policy Survey of Primary Care Physicians.

Capacity to Generate List of Patients by Diagnosis



Source: 2006 Commonwealth Fund International Health Policy Survey of Primary Care Physicians.

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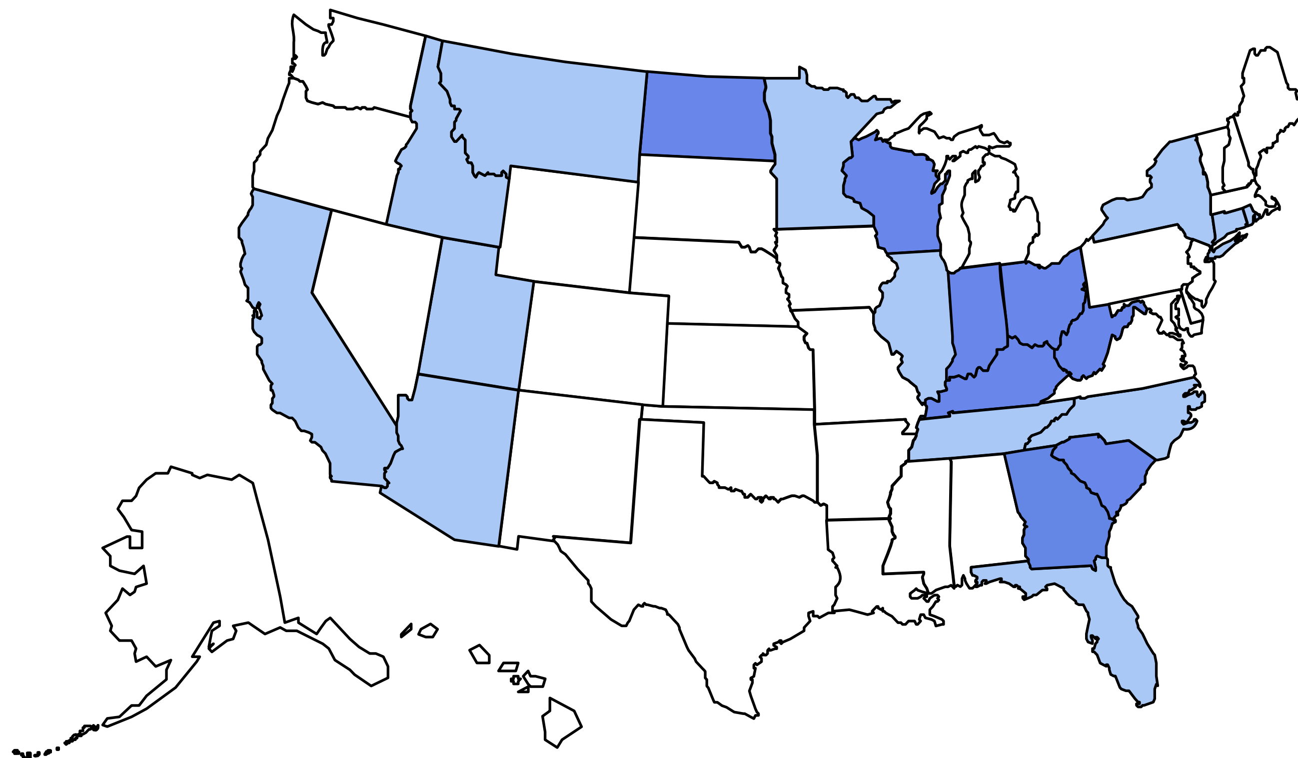
The Future of Health

- Health behaviors matter…… 75% of health care costs for chronic conditions that are preventable
- The Triple Tsunami
- Obesity rising everywhere, although recent US data shows plateauing of rates in men and kids
- Reinvigorated interest in Corporate Wellness
- Significant minority (20%) actively practicing integrative medicine

Obesity Trends* Among U.S. Adults
BRFSS, 1985

(*BMI ≥30, or ~ 30 lbs. overweight for 5' 4" person)



No Data | <10% | 10%–14%

Strategic Health Perspectives

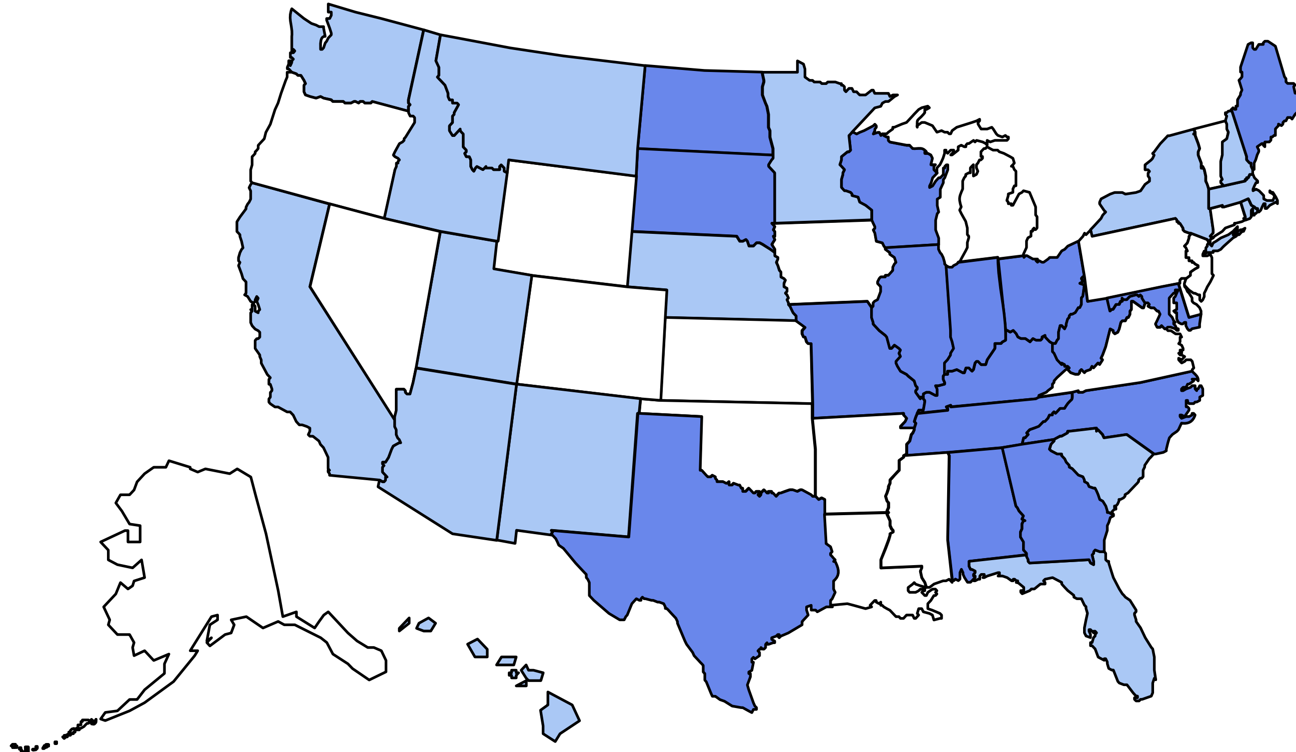
Obesity Trends* Among U.S. Adults
BRFSS, 1986

(*BMI ≥30, or ~ 30 lbs. overweight for 5’ 4” person)

No Data | <10% | 10%–14%

Obesity Trends* Among U.S. Adults
BRFSS, 1987

(*BMI ≥30, or ~ 30 lbs. overweight for 5’ 4” person)



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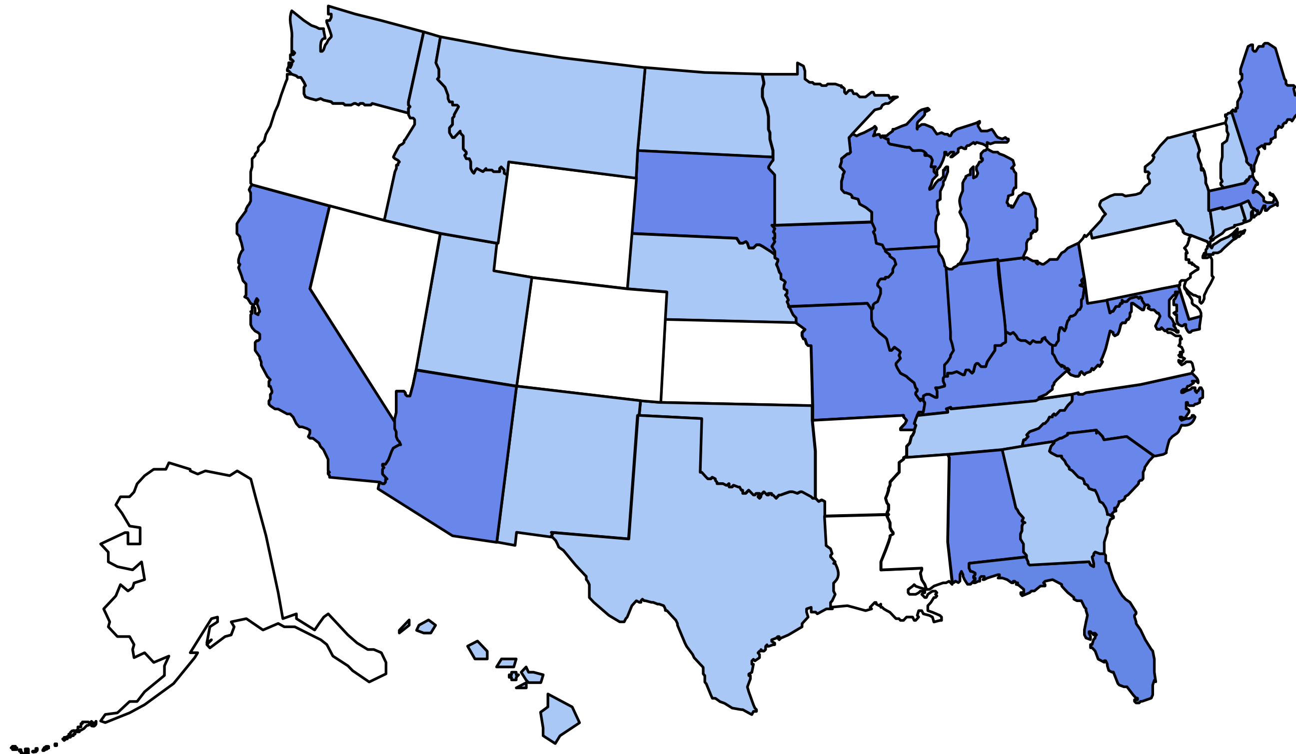
Obesity Trends* Among U.S. Adults
BRFSS, 1988

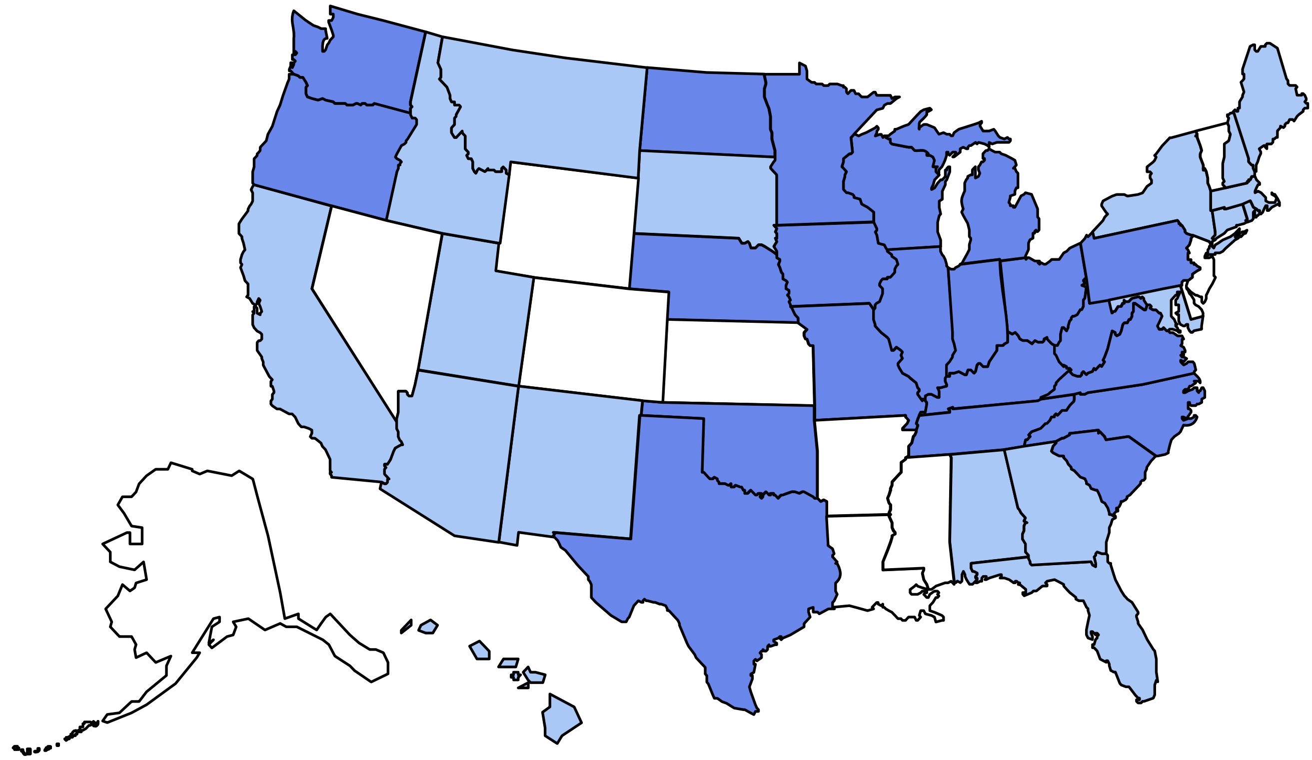
(*BMI ≥30, or ~ 30 lbs. overweight for 5′ 4″ person)



No Data <10% 10%–14%

Obesity Trends* Among U.S. Adults
BRFSS, 1989

(*BMI ≥30, or ~ 30 lbs. overweight for 5' 4" person)

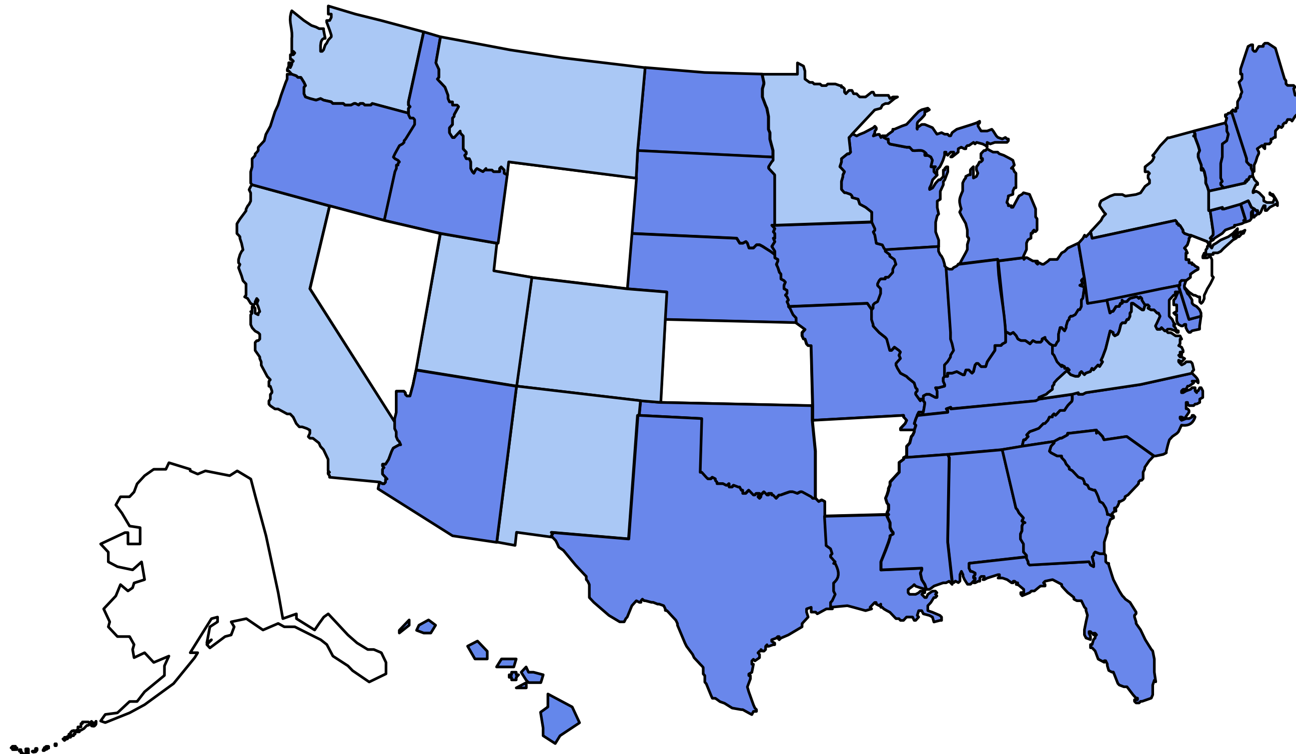


No Data <10% 10%–14%

Strategic Health Perspectives

Obesity Trends* Among U.S. Adults
BRFSS, 1990

(*BMI ≥30, or ~ 30 lbs. overweight for 5′ 4″ person)



No Data | <10% | 10%–14%

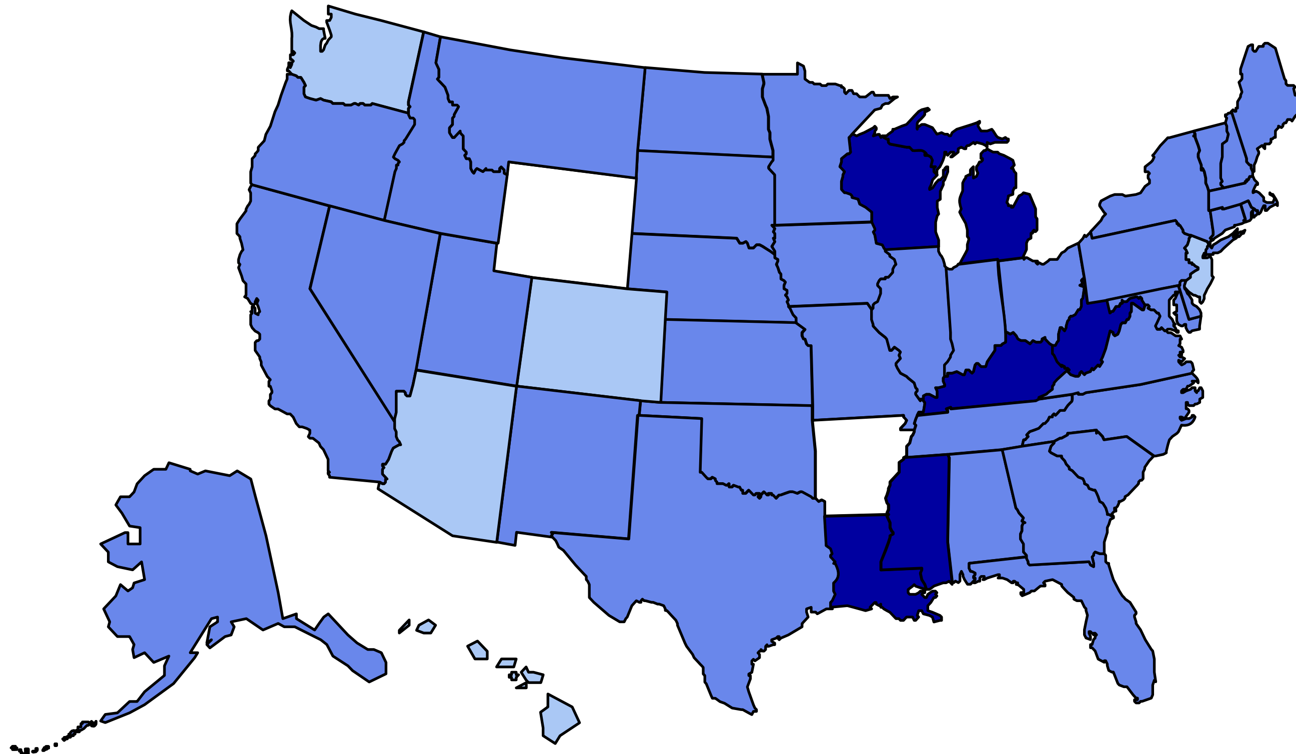
Obesity Trends* Among U.S. Adults
BRFSS, 1991

(*BMI ≥30, or ~ 30 lbs. overweight for 5’ 4” person)

No Data | <10% | 10%–14% | 15%–19%

Obesity Trends* Among U.S. Adults
BRFSS, 1992

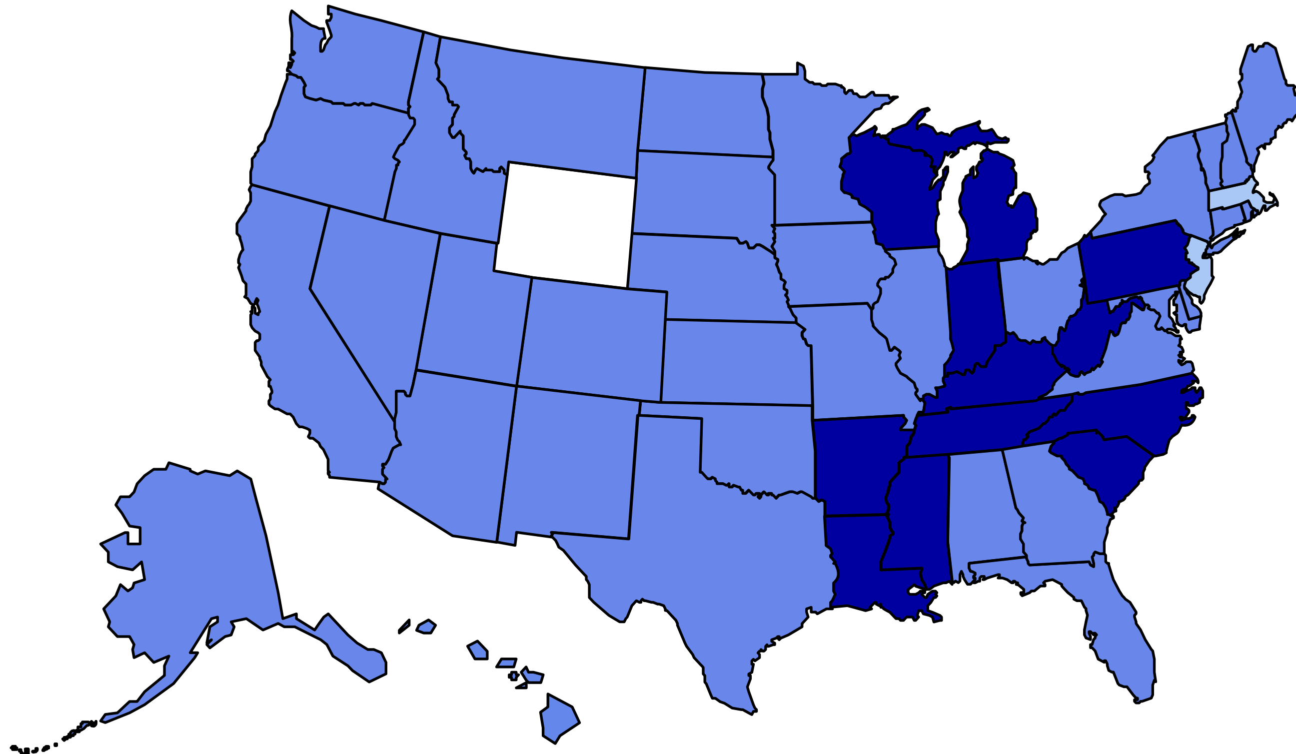
(*BMI ≥30, or ~ 30 lbs. overweight for 5' 4" person)



No Data | <10% | 10%–14% | 15%–19%

Obesity Trends* Among U.S. Adults
BRFSS, 1993

(*BMI ≥30, or ~ 30 lbs. overweight for 5' 4" person)



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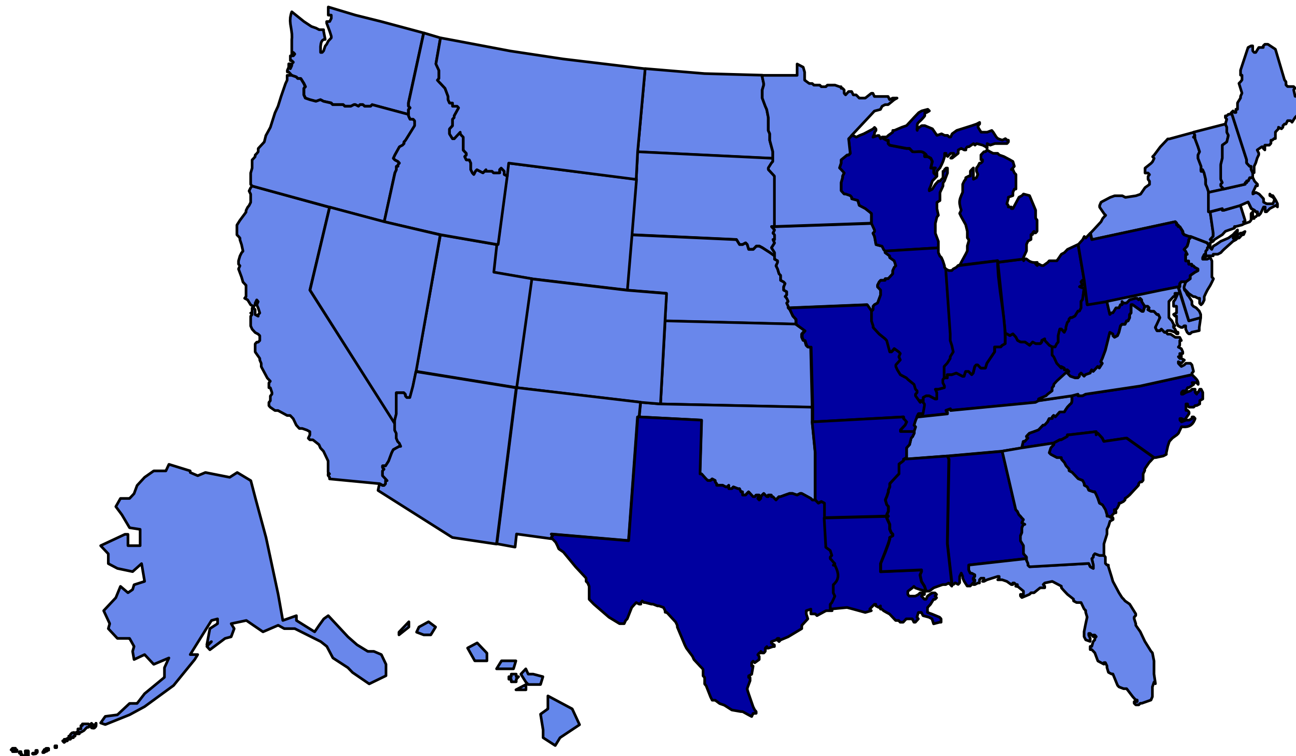
Obesity Trends* Among U.S. Adults
BRFSS, 1994

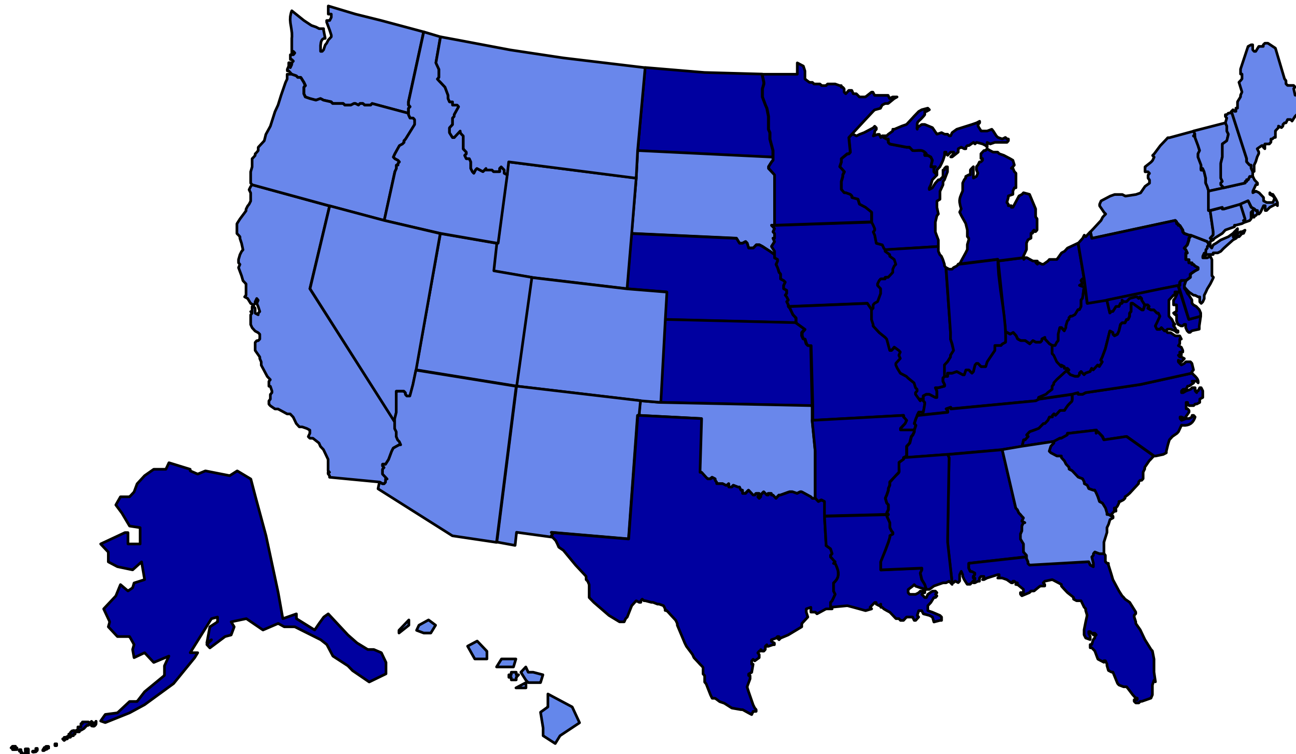
(*BMI ≥30, or ~ 30 lbs. overweight for 5′ 4″ person)



No Data <10% 10%–14% 15%–19%

Obesity Trends* Among U.S. Adults
BRFSS, 1995

(*BMI ≥30, or ~ 30 lbs. overweight for 5' 4" person)



No Data | <10% | 10%–14% | 15%–19%

Strategic Health Perspectives

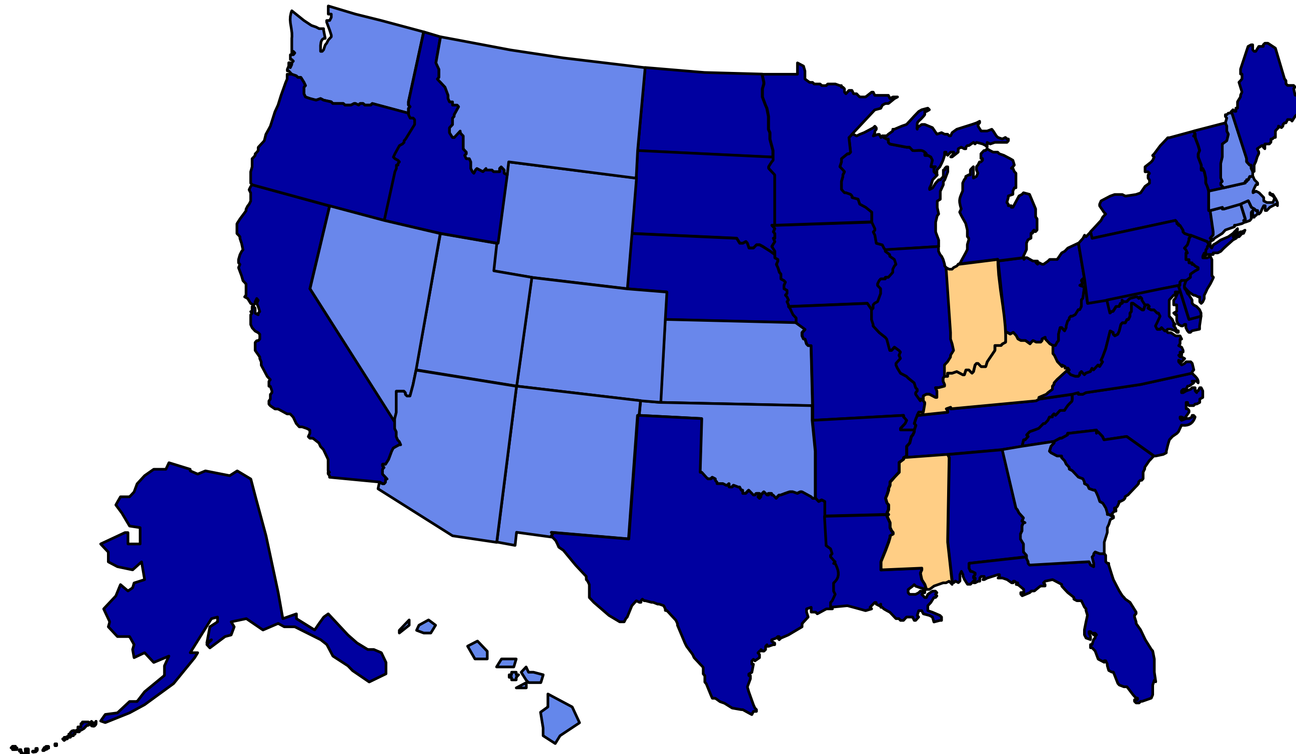
Obesity Trends* Among U.S. Adults
BRFSS, 1996

(*BMI ≥30, or ~ 30 lbs. overweight for 5′ 4″ person)

No Data | <10% | 10%–14% | 15%–19%

Obesity Trends* Among U.S. Adults
BRFSS, 1997

(*BMI ≥30, or ~ 30 lbs. overweight for 5′ 4″ person)



No Data <10% 10%–14% 15%–19% ≥20%

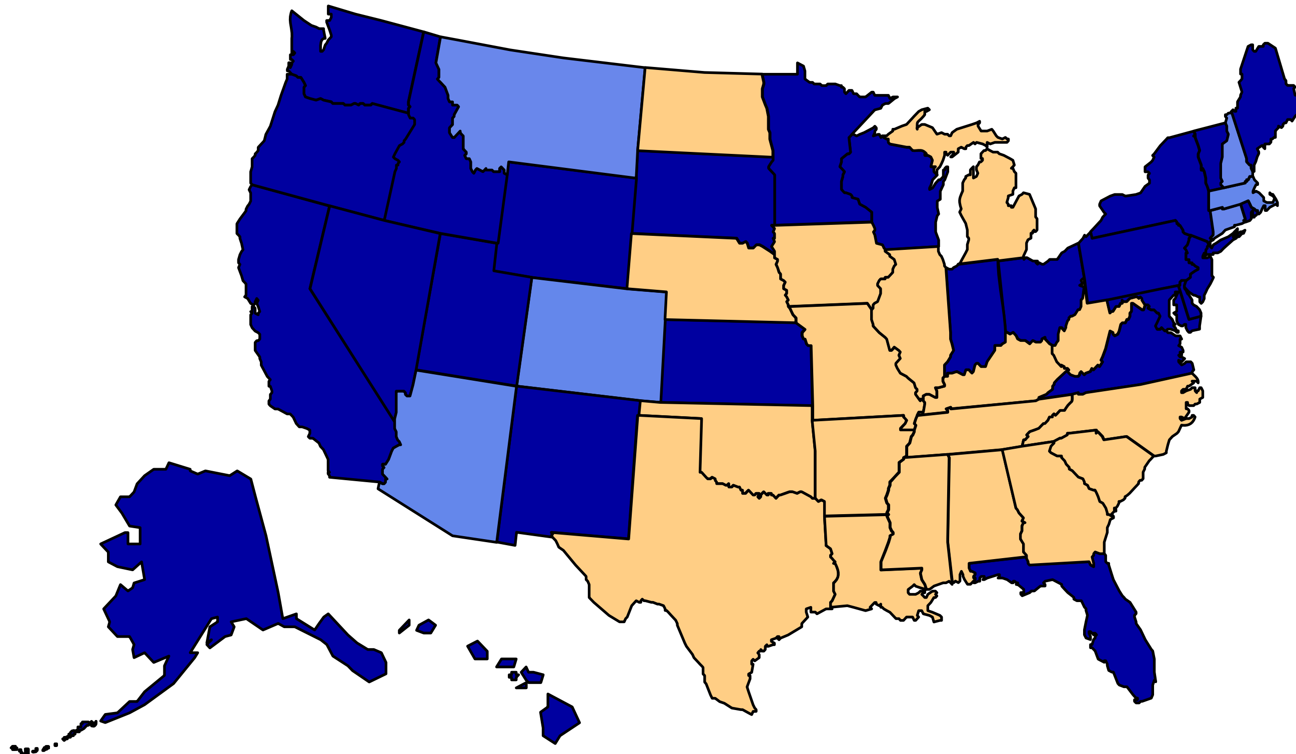
Obesity Trends* Among U.S. Adults
BRFSS, 1998

(*BMI ≥30, or ~ 30 lbs. overweight for 5’ 4” person)

No Data | <10% | 10%–14% | 15%–19% | ≥20%

Obesity Trends* Among U.S. Adults
BRFSS, 1999

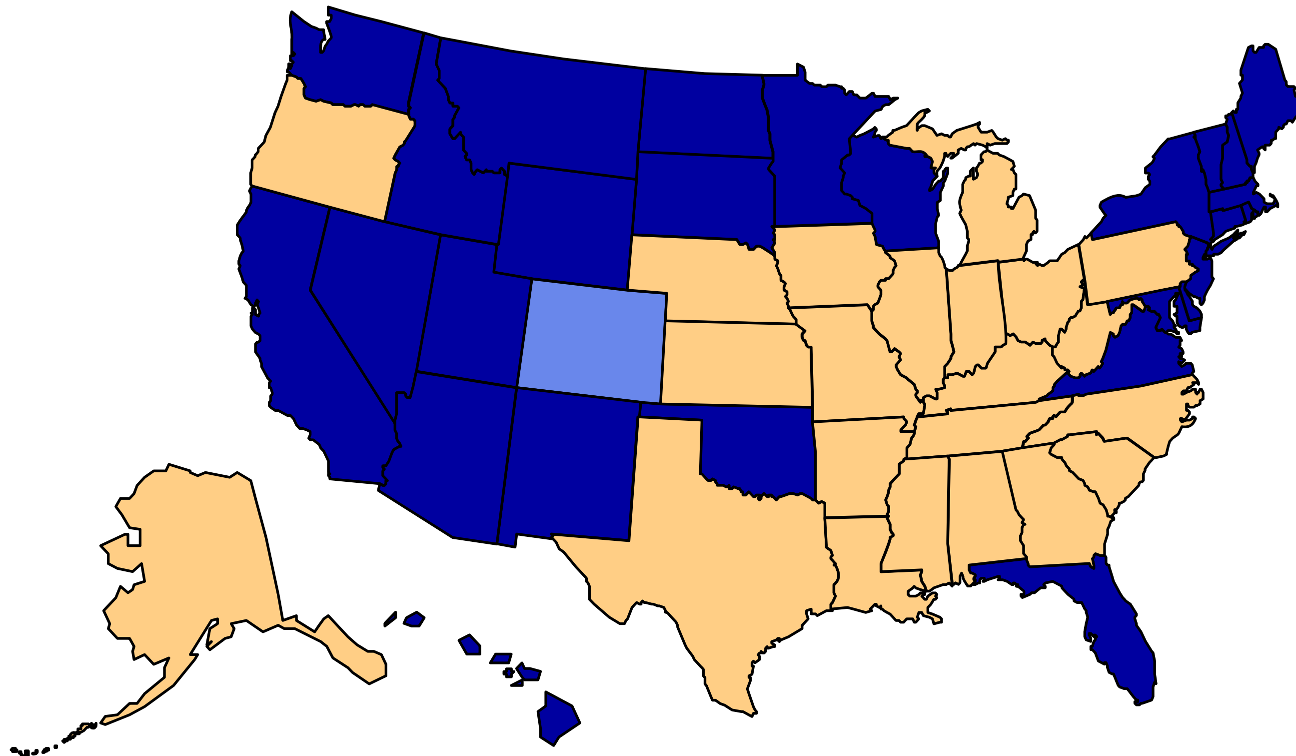
(*BMI ≥30, or ~ 30 lbs. overweight for 5’ 4” person)



No Data | <10% | 10%–14% | 15%–19% | ≥20%

Obesity Trends* Among U.S. Adults
BRFSS, 2000

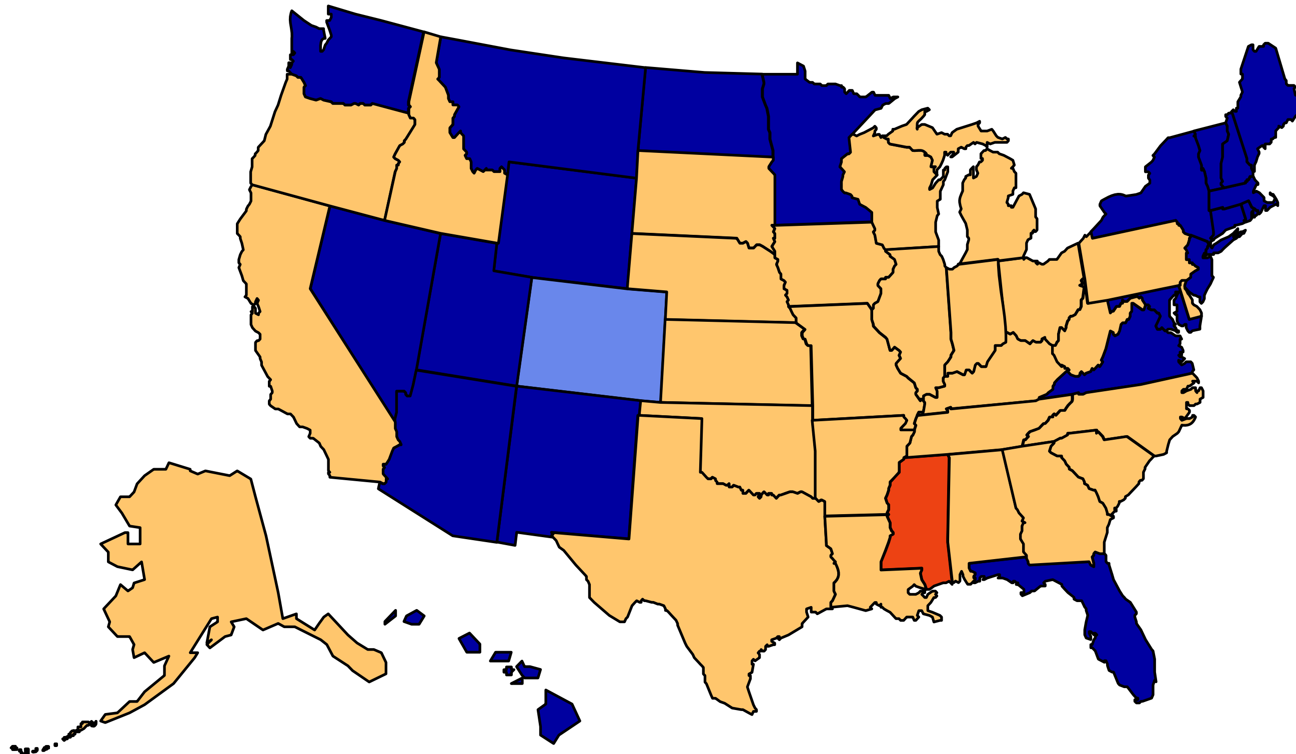
(*BMI ≥30, or ~ 30 lbs. overweight for 5' 4" person)



No Data | <10% | 10%–14% | 15%–19% | ≥20%

Obesity Trends* Among U.S. Adults
BRFSS, 2001

(*BMI ≥30, or ~ 30 lbs. overweight for 5’ 4” person)



No Data | <10% | 10%–14% | 15%–19% | 20%–24% | ≥25%

Strategic Health Perspectives

Obesity Trends* Among U.S. Adults
BRFSS, 2002

(*BMI ≥30, or ~ 30 lbs. overweight for 5′ 4″ person)

No Data | <10% | 10%–14% | 15%–19% | 20%–24% | ≥25%

Obesity Trends* Among U.S. Adults
BRFSS, 2003

(*BMI ≥30, or ~ 30 lbs. overweight for 5' 4" person)

No Data | <10% | 10%–14% | 15%–19% | 20%–24% | ≥25%

Obesity Trends* Among U.S. Adults
BRFSS, 2004

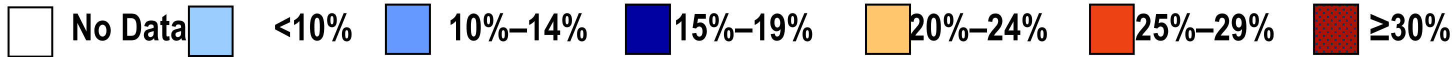
(*BMI ≥30, or ~ 30 lbs. overweight for 5' 4" person)

No Data | <10% | 10%–14% | 15%–19% | 20%–24% | ≥25%

Strategic Health Perspectives

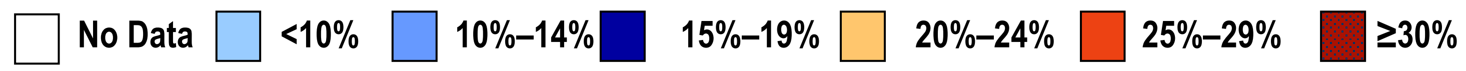
Obesity Trends* Among U.S. Adults
BRFSS, 2005

(*BMI ≥30, or ~ 30 lbs. overweight for 5' 4" person)



Obesity Trends* Among U.S. Adults
BRFSS, 2006

(*BMI ≥30, or ~ 30 lbs. overweight for 5′ 4″ person)



Strategic
Health
Perspectives

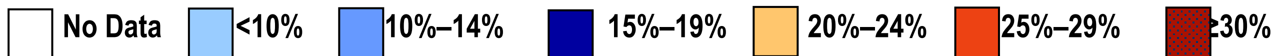
Obesity Trends* Among U.S. Adults
BRFSS, 1990, 1998, 2006

(*BMI ≥30, or about 30 lbs. overweight for 5’4” person)

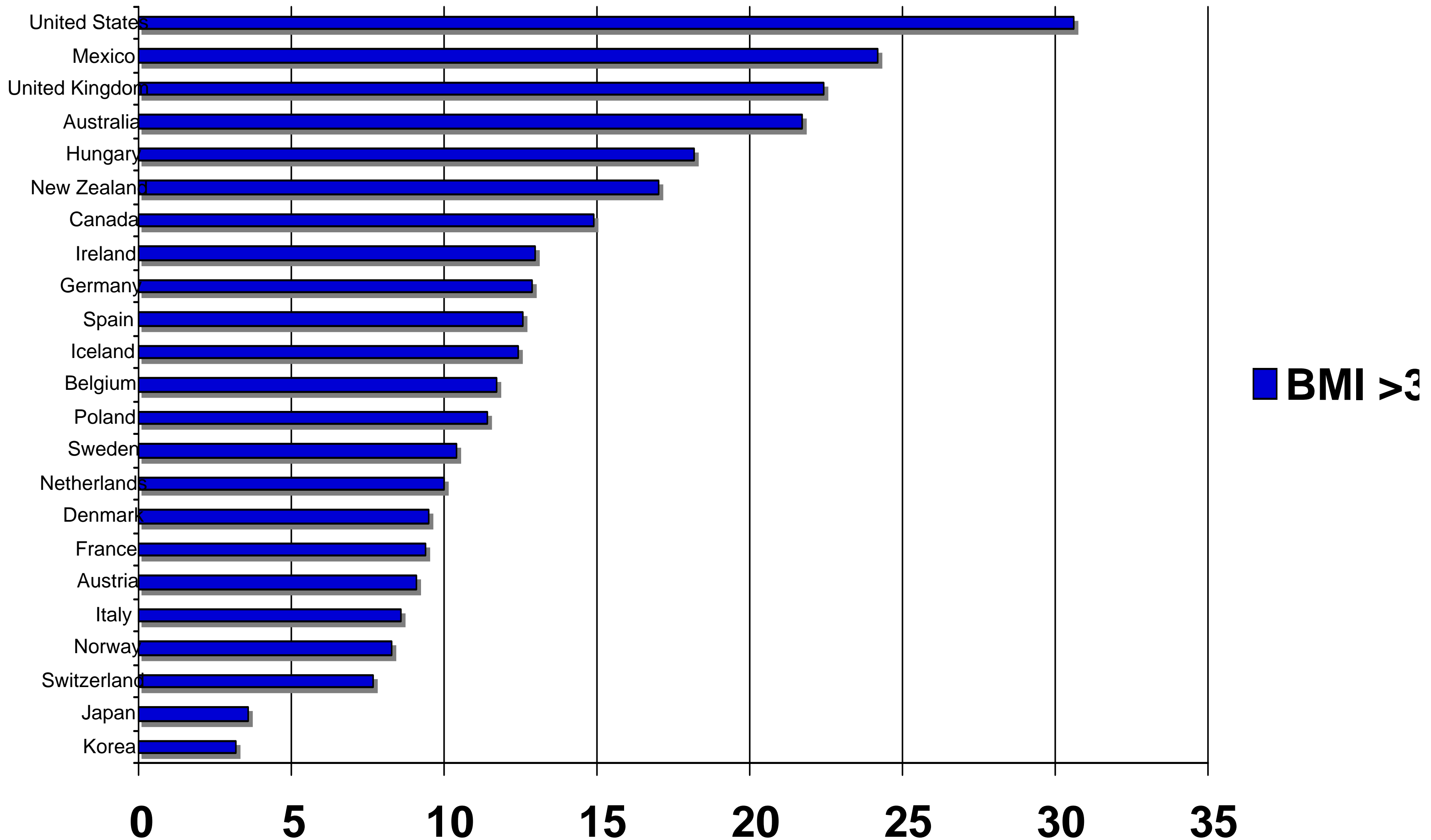
1990

1998

2006



International Obesity 2003
Percent of Population over 15 with BMI >30



Source: OECD, 2005

Obesity Drivers

- We are eating more (duh!)
- We are eating out more (In 1970 34% of the food budget was consumed outside the home in late 1990s it was 47%)
- Everything is supersized at home and at McDonalds
- We stopped smoking
- We are all working too much especially women
- We don't exercise enough because we are all working too much
- The only people who are exercising and eating right are people who were thin in the first place or bulimic celebrities or rich people who don't work or French

Don't Look Down on Him: Middle Age Americans are not as Healthy as the English

- US White population in late middle-age is less healthy than the equivalent English population for, diabetes, hypertension, heart disease, MI, stroke and cancer
- Steep gradient by SES in both countries: It's good to be rich
- But, the poorest third of Brits are healthier than richest third of Americans for diabetes, hypertension, all heart disease, and cancer

Source: Banks, J. et al. JAMA 2006;295:2037-2045.

HONDAS

- Hypertensive
- Obese
- Non-Compliant
- Diabetic
- Alcoholic or All Systems Failing or both

Source: Connie Blackstone MD, Primary Care Physician, Greenville, SC

Fat People meet Skinny Benefits

The Future of Democracy

- Health reform on the agenda
- Political and Economic context
- Prospects for change

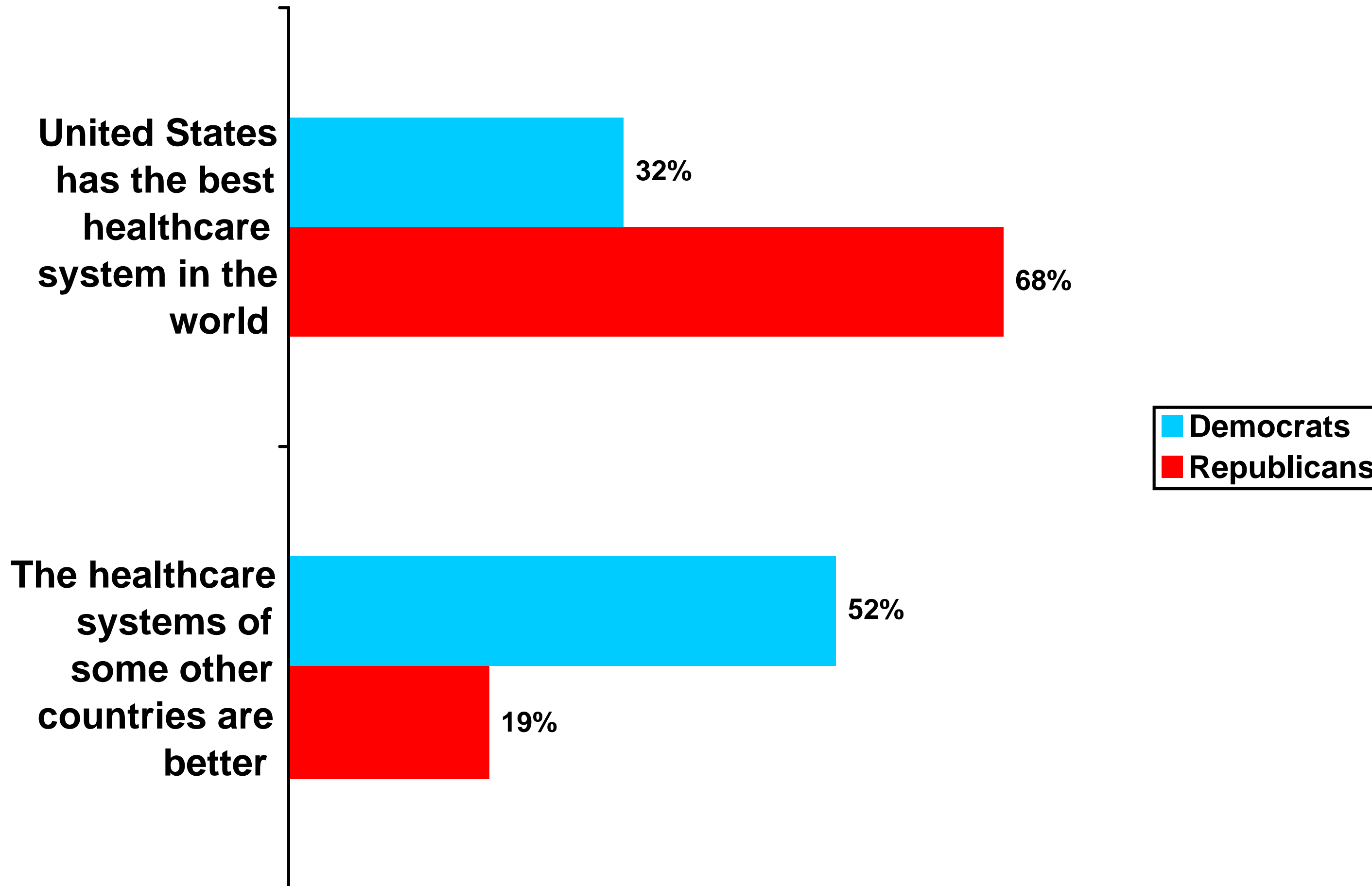
What We Have to Change….
Not Much Except………

- Our values
- Our Strategic Focus: From Pimp my Ride to Primary Care and Prevention
- Our Reimbursement System
- Our Delivery System
- Our Individual and Collective Behavior
- Our Expectations
- Our Business Models
- Our electronic infrastructure to support it all

Key Driving Forces: Political

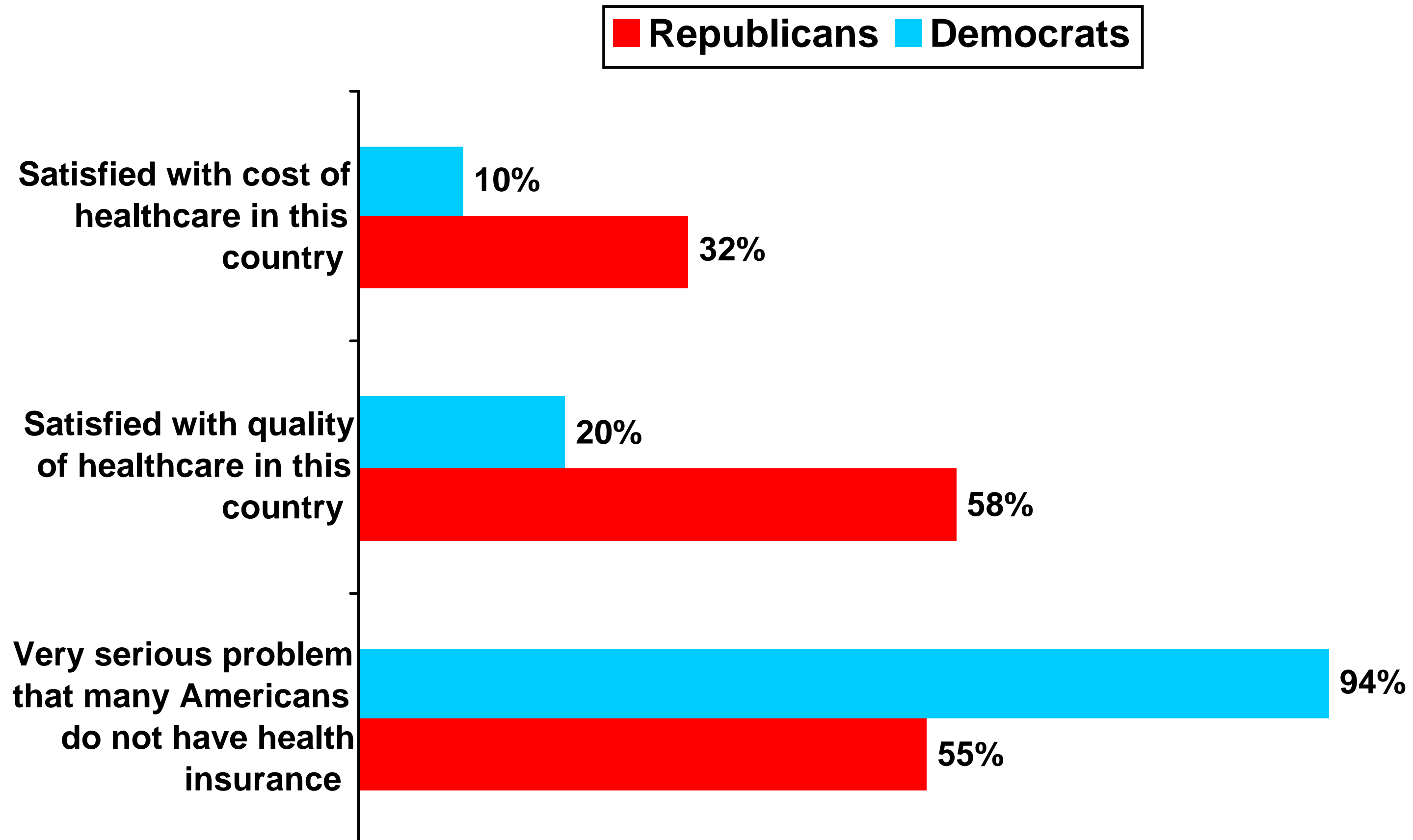
- Presidential Election Year Where Candidates Are Focusing on Change
- Many Republican Incumbents in House and Senate Not Seeking Re-election
- Possible Big Turnout of Youth: The Echo Boom Can't Drink Yet, but They Can Vote
- Health Care Is the Number Two Domestic Issue (Behind the Economy) Among Democrats and Independents
- Growing Sense of Anti Corporatism Even Among Republican Candidates (Huckabee and McCain)
- Possibility of a Large Democratic Victory

Republican and Democratic Attitudes about Who Has the Best Health Care System



Debating Health: Election 2008, Harvard School of Public Health/Harris Interactive. March 5-8, 2008

Republican and Democratic Beliefs about the State of Healthcare



NEJM, "Health Care in the 2008 Presidential Primaries," January 2008.

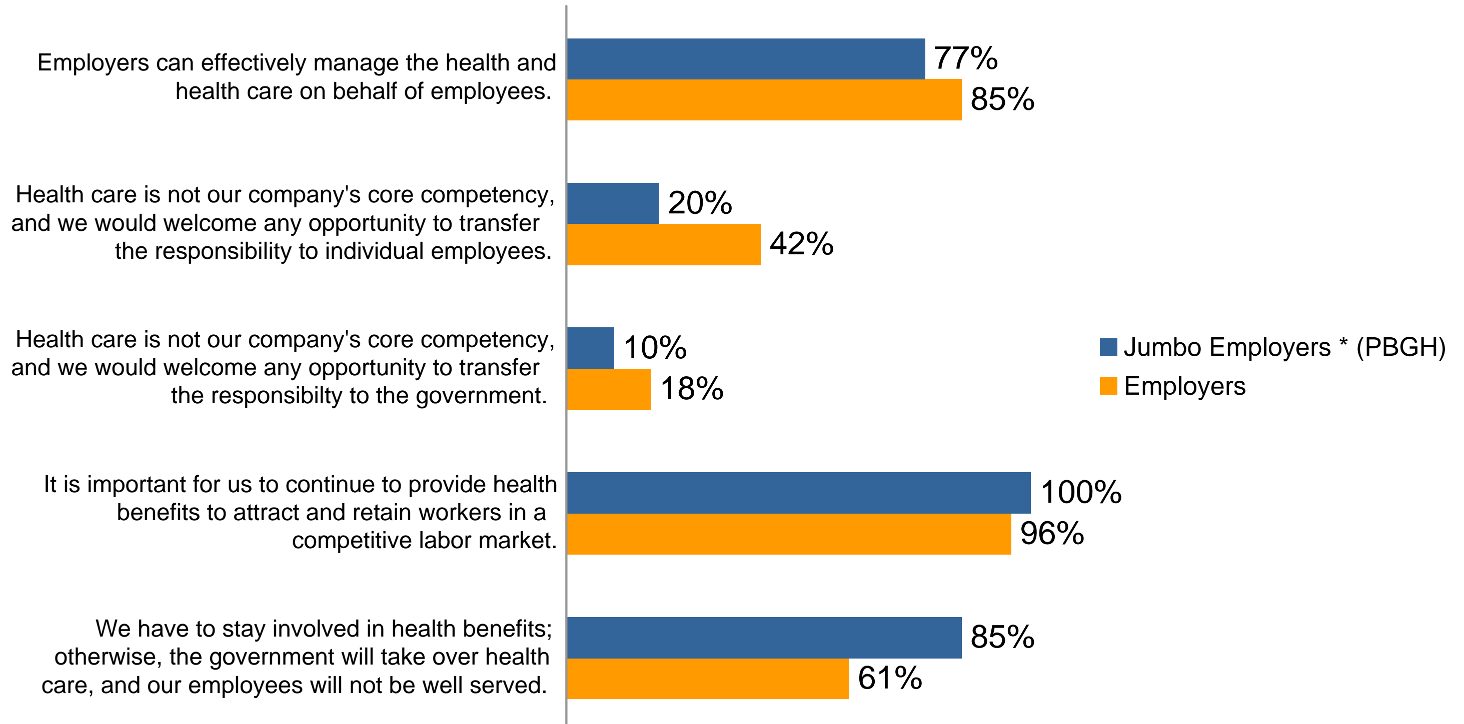
Key Driving Forces: Economic

- Economic slowdown in 2008-2009 seems likely to continue
- Continued involvement in iraq short term means big government deficits
- Little government opportunity for big expansion in short run
- Sub-prime mess lingers and perhaps worsens, declining consumer confidence, weakening dollar, continued high energy prices
- Business sees profit squeeze after long run-up and high performance expectations from investors

Key Driving Forces: Health Reform

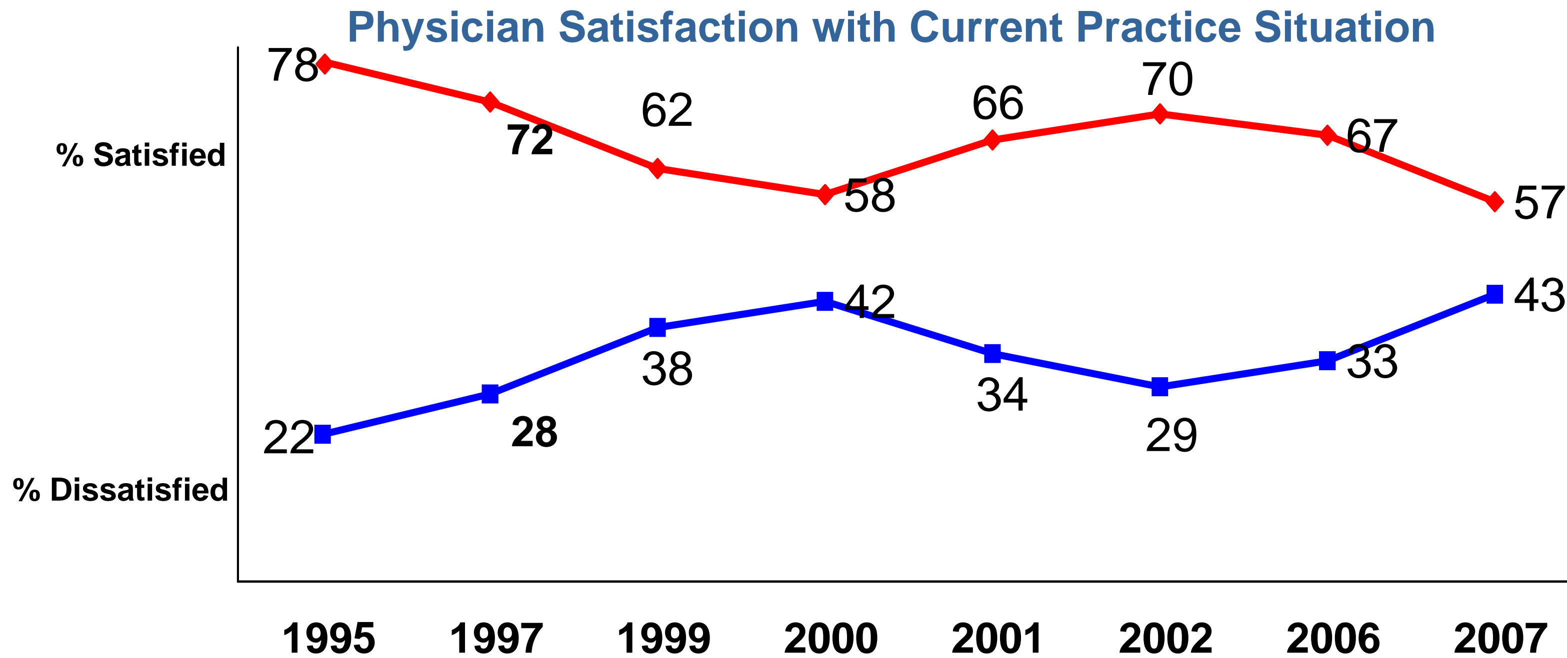
- Health reform options are in a narrow range (democrats' positions are right of Richard Nixon's)
- New American Compromise of shared sacrifice and incremental expansion of coverage is favored by both democratic presidential candidates and some republicans at state level
- Focus is on coverage expansion for an anxious middle class; not wholesale transformation of health care, but …
- Health care glitterati honing in on elements of a compromise (Commonwealth Fund 15 is a good starting list of cost containment options)
- Unlikely coalitions are forming; e.g., SEIU, Wal-Mart
- Big actors are staking positions near and around the New American Compromise; for example, the AHA, AHIP, Mayo Clinic, Committee on Economic Development and others
- Big business not as ready to bail out of health care as some pundits think
- Seniors are satisfied with medicare (including part d) and are not pressing for health reform of medicare yet, but how will part d play in 2008?
- Doctors are cranky and depressed

Most Employers are Ideologically Opposed to Massive Exit in a Tight Labor Market With a Strong Economy



Source: Harris Interactive, Strategic Health Perspectives 2007
N=20* Pacific Business Group on Health, July 2007 Retreat

Physician Dissatisfaction With Practice at Historic Highs



Source: Harris Interactive, Strategic Health Perspectives 1995-2007

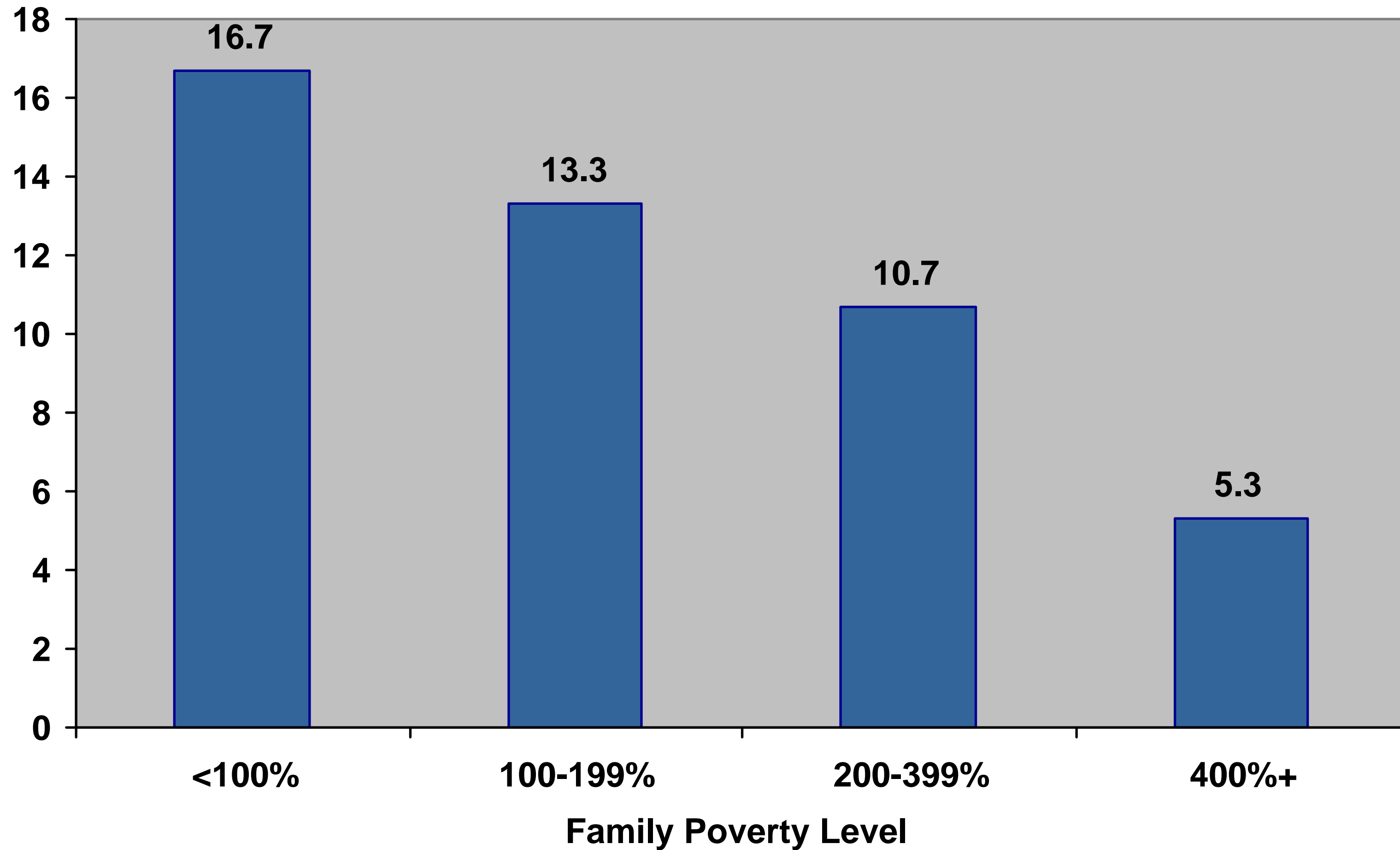
The Commonwealth Fund 15

- Promoting Health Information Technology
- Center for Medical Effectiveness and Health Care Decision Making
- Patient Shared Decision Making
- Public Health: Reducing Tobacco Use
- Public Health: Reducing Obesity
- Positive Incentives for Health
- Hospital Pay-for-Performance
- Episode-of-Care Payment
- Strengthening Primary Care and Care Coordination
- Limit Federal Tax Exemptions for Premium Contributions
- Reset Benchmark Rates for Medicare Advantage Plans
- Competitive Bidding
- Negotiated Prescription Drug Prices
- All Payer Provider Payment Methods and Rates
- Limit Payment Updates in High-Cost Areas

Covering the Uninsured: Who Pays? Who Gets? Who Cares?

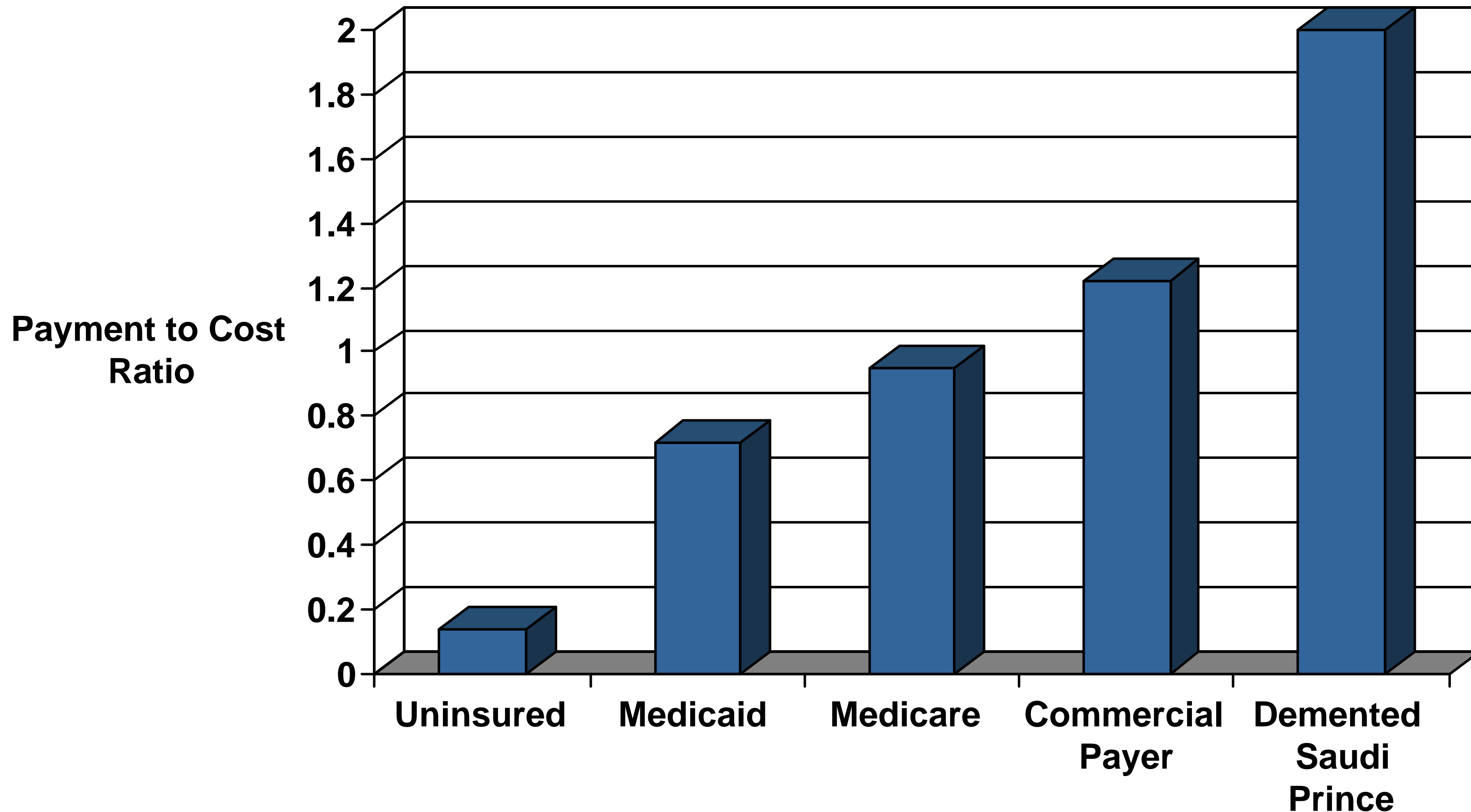
- Who Pays?
  - American health care financing is regressive
  - Single payer is a massive transfer of income from rich to poor
  - Making $20,000 earners buy a $15,000 health care policy is problematic
- Who Gets?
  - Having a card doesn't guarantee getting care
  - Growing use of ER, minute clinics and off-shore options even by the insured population
- Who Cares?
  - How much reimbursement goes with the card?
  - Do we need coverage, or do we need care?
  - Are the insured getting the right care?

Number of Uninsured 2005



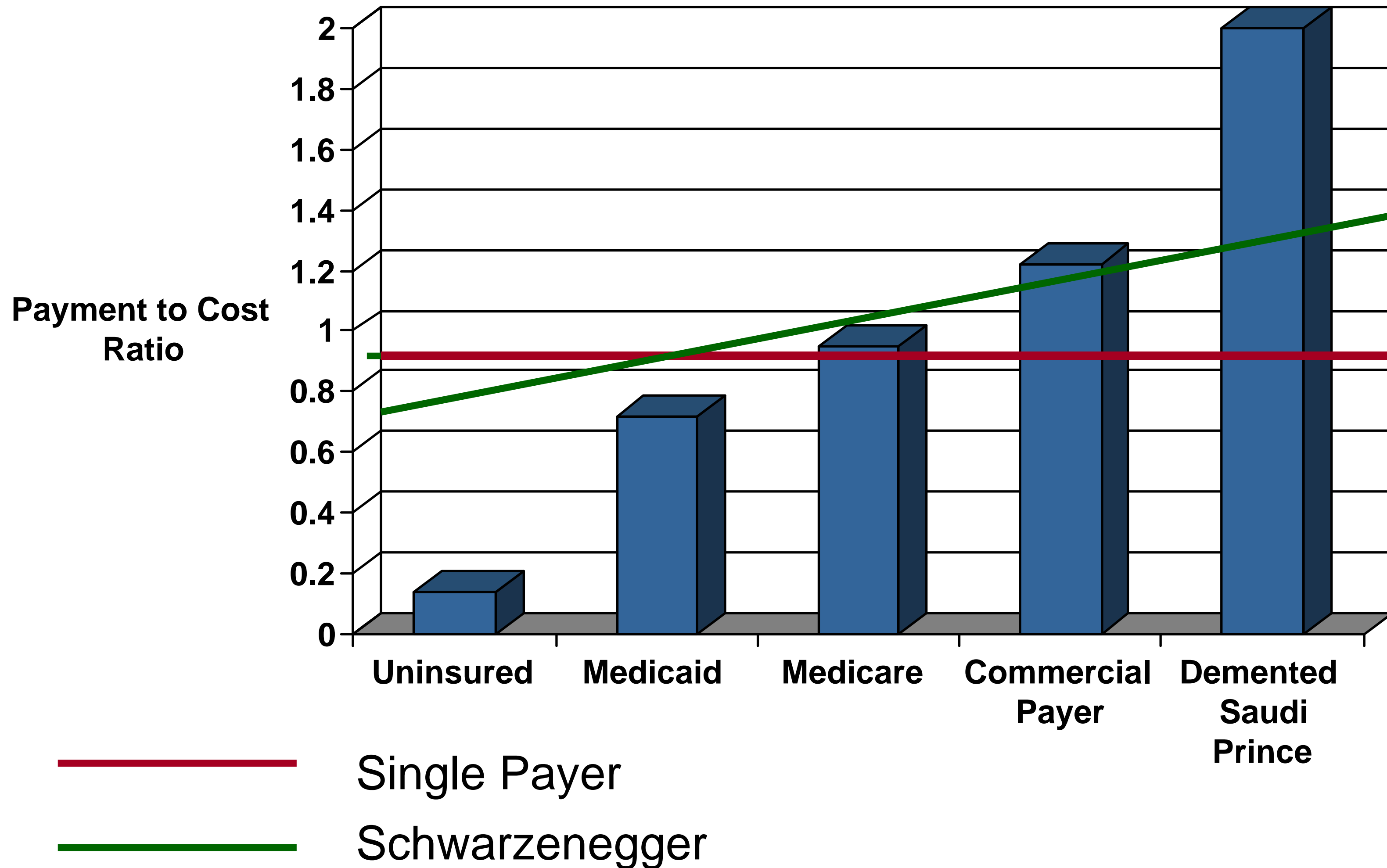
Source: KFF, 2006

Payment to Cost Ratio (Illustrative)



Source: Morrison Estimates, in other words a good guess

Payment to Cost Ratio (Illustrative)



Source: Morrison Estimates, in other words a good guess

Why I Like Australia

"Where the bloody hell are you?"

Australian Tourist Board

- Everyone Is Covered
- Tax-Financed Universal Ambulatory Care
- Clear Bargain on Hospitals:
  - Free hospital care with no provider choice and no high amenity versus
  - Private hospital, or higher amenity public hospital and provider choice if you have private insurance
- 50% Have Private Insurance (43% for Hospitals), but You Still Pay Into the Base System
- Flat 30% Subsidy
- Incentives to Sign Up Young
- No Involvement of Employers
- PBS Works to Control Costs

New American Compromise

- Shared Sacrifice
  - Health care is both a right and an obligation
  - Example: "Health care for all, paid by all" (AHA)
  - Rhetoric behind Massachusetts and California
- Strategic Incrementalism
  - Build on existing public and private programs
- Compel Participation
  - Employer mandate: Pay or play
  - Individual mandate
  - Provider contribution: Hospital or physician taxes
  - Other sources of payment; e.g., tobacco tax
- Restructure/Regulate Insurance Market
  - Connectors
  - Guaranteed issuance and terms of offer
- Federal Matching of Medicaid Investment
- More About Coverage Expansion Than Cost Containment

The California Case

- New American Compromise Model, but There Were No Willing Republican Legislators Beyond the "Governator"
- What Killed the Plan?
  - Money: Bad time when the budget deficit was $14 billion, fear it wasn't budget neutral (2/3 rule for new money)
  - The Details: When there is something for everyone to like, there is also something for everyone to hate (about who pays, who is covered and how)
  - Democratic Infighting: Single payer versus incrementalists, bad blood between Perata and Nunez, the SF Union position
  - Lack of solidarity within each stakeholder group: Labor, business, health insurers, Democrats, providers, split among themselves
  - Federal versus State: Concerns about Federal MediCal matching, about ERISA pre-emption and so forth

Political Scenarios

- Scenario 1: Maverick
  - McCain wins with a weak Democratic Congress
  - Incremental attempts at expansion; e.g., SCHIP
  - Same old, same old
- Scenario 2: Democratic Incrementalism
  - Democrats win White House and slim majority in Congress
  - Push aggressively for coverage expansion but meet financing challenges
- Scenario 3: Democratic Landslide
  - Big majority in Senate
  - Make health reform the key domestic priority
  - Seize a historic opportunity for reform: coverage expansion and health system transformation

Features of Building Blocks + System Reform and Presidential Candidates' Approaches to Health Care Reform

	Building Blocks/ System Reform	Clinton	McCain	Obama
Coverage Expansion				
Aims to cover everyone	X	X		X
Individual requirement to have insurance	X	X		Children only
Employer shared responsibility	X	X		X
Group insurance "connector"	X	X		X
Medicare/public plan option for < 65	X	X		X
Subsidies/tax credits for low- to moderate income families	X	X	X	X
Regulation of insurance markets	X	X		X
Improves Medicare benefits for > 65 and buy-in for older adults	X			
Medicaid/SCHIP expansion	X	X		X
System Improvements				
Expanded use of Health IT	X	X	X	X
Medical effectiveness research	X	X	X	X
Pay providers for performance	X	X	X	X
Reduced Medicare Advantage payments	X	X		X
Negotiated Medicare Rx prices	X	X		X
Primary care and care coordination	X	X	X	X

Source: S. R. Collins and J. L. Kriss, *Envisioning the Future: The 2008 Presidential Candidates' Health Reform Proposals*, The Commonwealth Fund, January 2008.

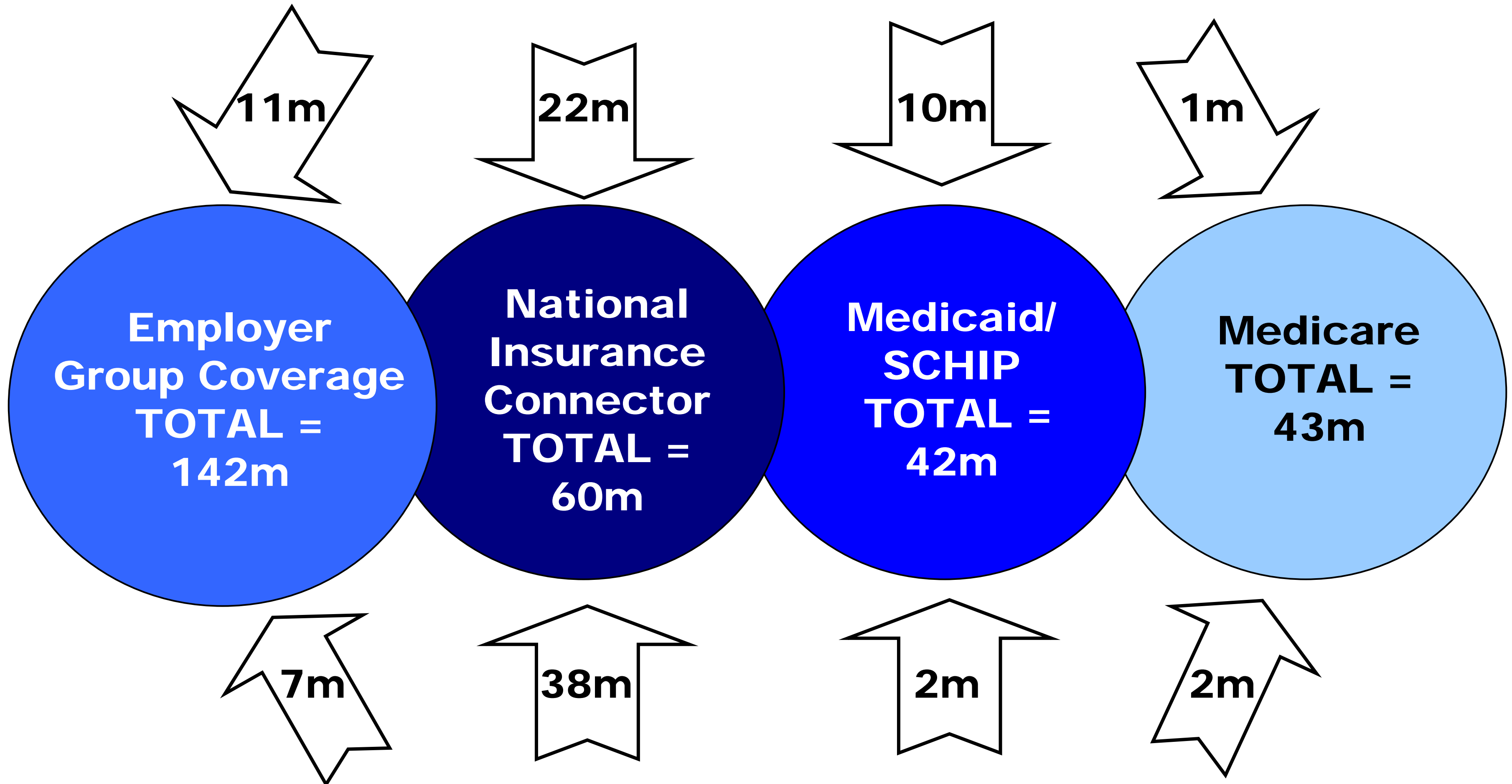
Implications for Federal Reform

- Possibility of a Big, Bad Replay of California at the Federal Level
- A Lot of Stakeholder Groups Close to the New American Compromise and Mayo Model
- Republicans and Democrats Are Much Further Apart Than Stakeholder Groups, but That Matters When Politics Trumps Policy
- Legislation Will Have to Pass Through a Political Process
- Possible Areas of True Political Compromise Are Narrower:
  - HIT
  - Transparency initiatives
  - SCHIP expansion for very low-income families
  - Comparative Effectiveness
  - P4P
  - Tax credits for coverage
  - Other?
- God Is in the Details: And That’s When the Knives Come Out

No Matter What

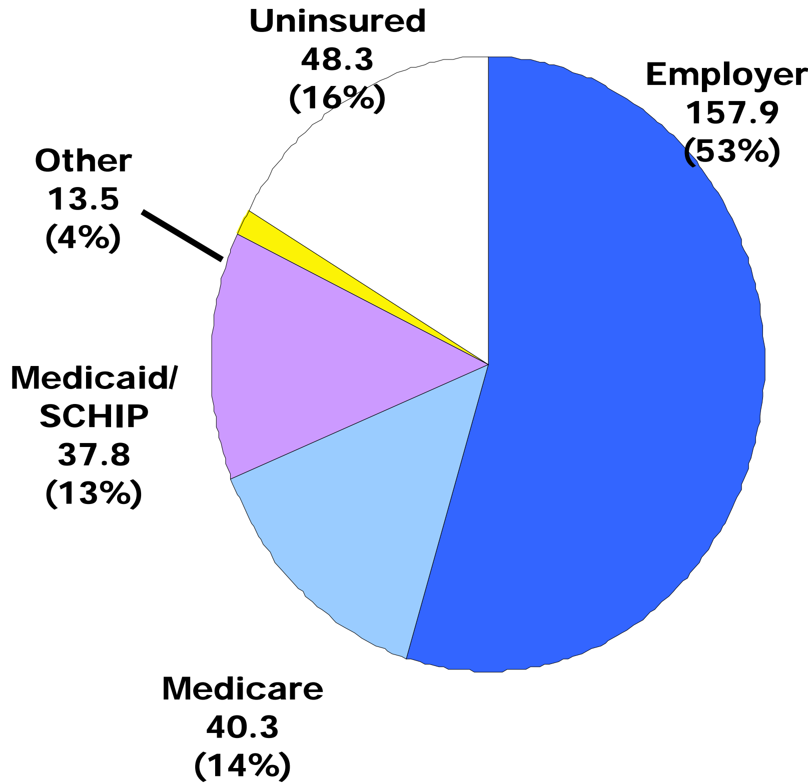
- Rising Costs and Continued Unaffordability
- The Unfunded Medicare Liability
- Rising Transparency and Value Purchasing
- Creation of NICE Lite
- Institutional Re-engineering for Value
- Payment Reform to Support Improvement?
- Growing Science of Molecular Biology Enables Customized Genomic Medicine
- HIT as Opportunity

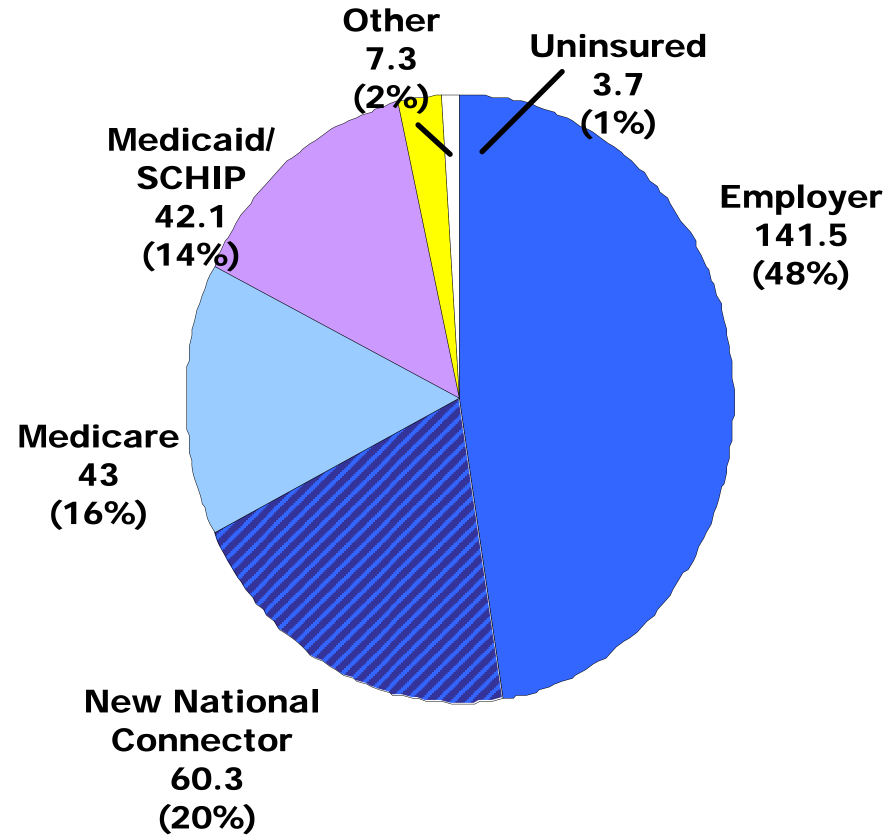
Building Blocks for Automatic and Affordable Health Insurance for All



Source: Based on analysis in C. Schoen, K. Davis, and S. R. Collins, "Building Blocks for Reform: Achieving Universal Coverage with Private and Public Group Health Insurance," *Health Affairs,* May 13, 2008 27(3):646–57, from Lewin Group modeling estimates.

Commonwealth Fund: Distribution of People by Primary Source of Coverage Under Current Law and Building Blocks Framework, 2008





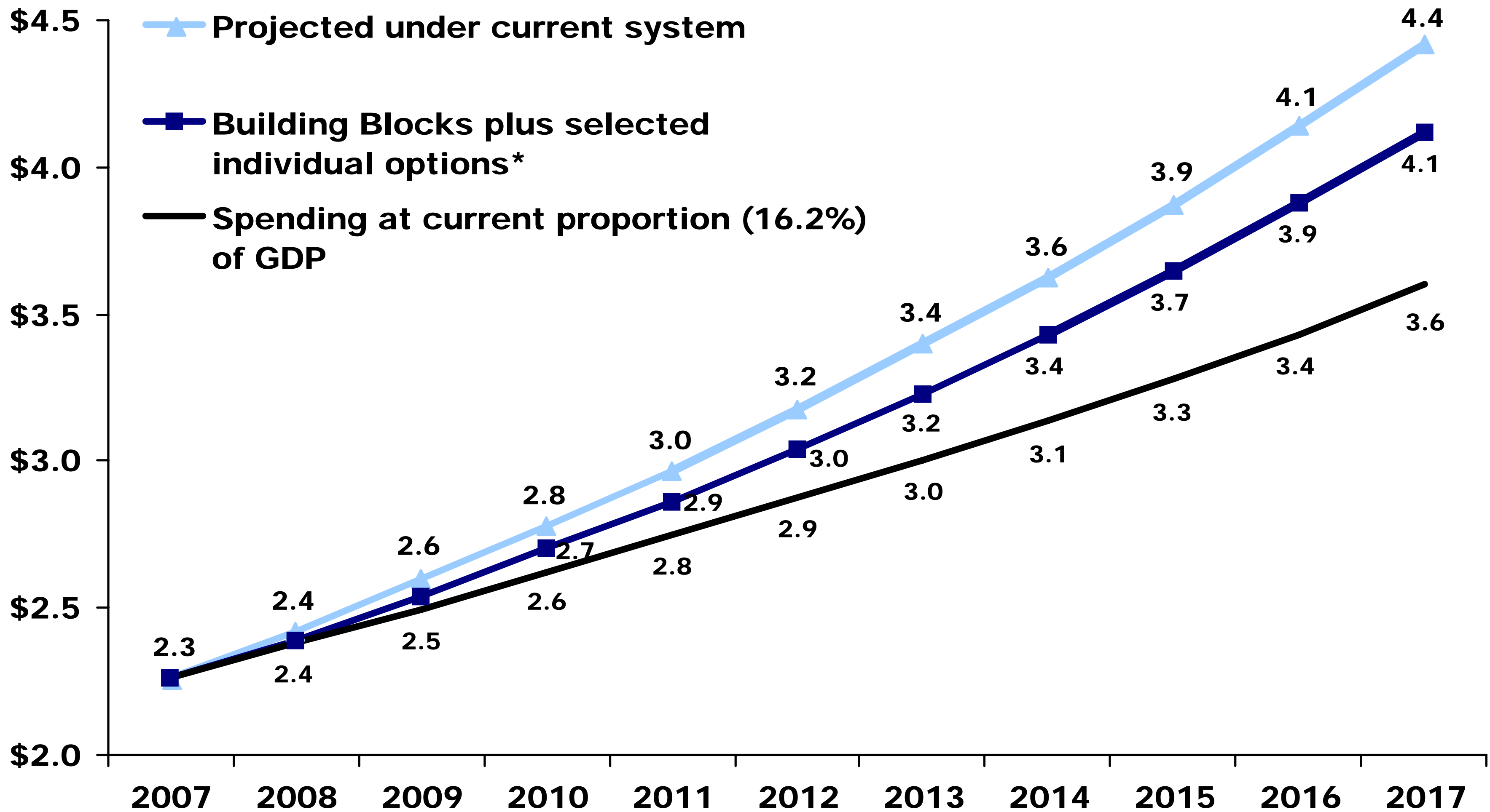
Total population = 297.8 million

Source: Based on analysis in C. Schoen, K. Davis, and S. R. Collins, "Building Blocks for Reform: Achieving Universal Coverage with Private and Public Group Health Insurance," *Health Affairs,* May 13, 2008 27(3):646–57, from Lewin Group modeling estimates.

Strategic Health Perspectives

Total National Health Expenditures, 2008–2017 Projected and Various Scenarios

Dollars in trillions



* Selected individual options include improved information, payment reform, and public health.

Source: C. Schoen et al., *Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spe* Fund, December 2007. Data: Lewin Group estimates.

Implications

- The Web will help but won't solve basic drivers of cost, quality, and access
- Consumers will become more engaged in value decisions, but we cannot rely on them absolutely
- The systems of health care need to be continuously improved to deliver greater value
- This will require clinical skills, process skills, use of cutting-edge technology and big-time capabilities by plans, providers and patients themselves
- Most of all, it will require leadership