CHAPTER 1

Health and Health Care Forecast

Executive Summary

Fifteen years ago, the key issues in the American health care system were classic: containing *costs* while improving *access* to care for people and maintaining *quality* of services. Then the rapid cost increases of the late 1980s, combined with the recession of the early 1990s, added a new issue to the list: ensuring *security of benefits.*

After the political dust of the 1992–1994 debate about health reform settled, several structural shifts in the system became apparent. Managed care—designed to contain costs—went from being an aberration to being the mainstream method of providing health insurance. Several new issues came to the forefront of health policy: monitoring the activities of managed care plans, organizing health care providers, and evaluating the quality of care delivered to patients. Although the recent strong economy and job market has increased the security of health benefits for some people, the issue of how to pay for care for a growing number of uninsured Americans remains with us.

None of these issues will be completely resolved in the next few years. Instead, a new group of issues will join them. They include organizing insurers and intermediaries, along with providers; incorporating consumers into health care decision making; determining responsibility for medical management; and improving the health behaviors of the American people. These will be the health battlegrounds of the next decade.

This chapter provides an overview of our 10-year forecast of health and health care. We describe the path from now until 2005 in terms of the future legislative and regulatory contexts; changes in the demographics and attitudes of patients, populations, and consumers; the concerns of payers about health care costs; the organization of health plans and insurers; the structure of hospitals, provider organizations, and the public health system; the role of medical information technologies; and the forthcoming shifts in care processes and medical management. Beyond 2005, our forecast splits into three scenarios—one optimistic about the impact of changes on the health of the population, one pessimistic about the ability of American society to provide coverage and access to care, and one in which incrementalism reigns supreme.

LEGISLATION

Legislative activity will be set against a background of incremental legislative reform. The failure of the health reform effort from 1992 to 1994 dulled the

appetite of most politicians for significant health regulation. In addition, there is almost no support for large-scale social programs targeting the poor or the uninsured. Major government reform is therefore unlikely. Strong support for the current Medicare and Social Security systems means that change in the benefits of these systems will be slow. There will be few initiatives to design new government programs beyond the limited programs enacted in the past few years—insurance portability and children's coverage. Neither of these two initiatives will have a significant impact on the overall number of uninsured or the general health insurance market.

Government legislation in two significant areas will have some impact on the mainstream health care system.

First, there will be legislative outcomes as a result of a backlash against managed care. While there are few clearly articulated alternatives to market-based health care in the United States, there is considerable support for legislation to curb what are seen as health plan abuses. Given that these regulations will require little money from public coffers, we can expect more regulation of health plan activity, including disclosure rules, mandates for clinical protocols such as the 48-hour hospital stay for maternity patients, and medical records privacy laws. Although the effect of such regulations on the overall market may be slight, there will be significant effects on plan and provider operations.

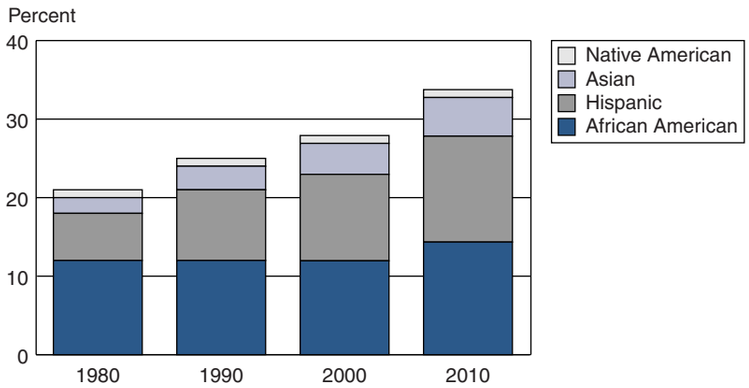
Second, Medicare may look very different than it did in the early 1990s, when its financial future became uncertain. Many Medicare recipients will not be in the traditional fee-for-service (FFS) program but instead will be in health maintenance organizations (HMOs), preferred provider organizations (PPOs), or some other organized health plan arrangement. Cost controls enacted in the 1997 Balanced Budget Act will have changed the way providers deal with Medicare patients, in particular placing the reimbursement for outpatient, home health, and skilled nursing facilities (SNFs) on a prospective payment system. It's plausible that the baseline will be sufficiently different that "incremental" legislation in the future could make a big change in the nature of the program. But Medicare remains the second most popular program among the most powerful demographic group in America—the elderly—and politicians have learned to tamper with it at their peril.

Consequently, our forecast for legislation is one of continued incremental program change directed primarily at providers and with little direct effect on beneficiaries. The real challenge—changing Medicare so that it can afford to cover the vast number of baby boomers retiring after 2010—will not be dealt with until later in the decade.

Demographics: Patients, Populations, and New Consumers

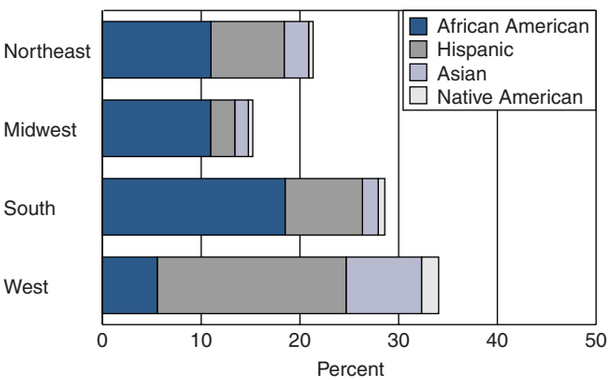
In the next decade, Americans will be getting older and living longer. By 2010 the average life expectancy will be up to

Figure 1-1. Increasing diversity of the United States population



Source: IFTF; U.S. Census Bureau, *Statistical Abstract*, 2000.

Figure 1-2. The real story of diversity in 2010 is regional.



Source: IFTF; U.S. Census Bureau, *Statistical Abstract*, 2000.

Tiers of Coverage

Empowered Consumers:	38 percent
Worried Consumers:	34 percent
Excluded Consumers:	28 percent

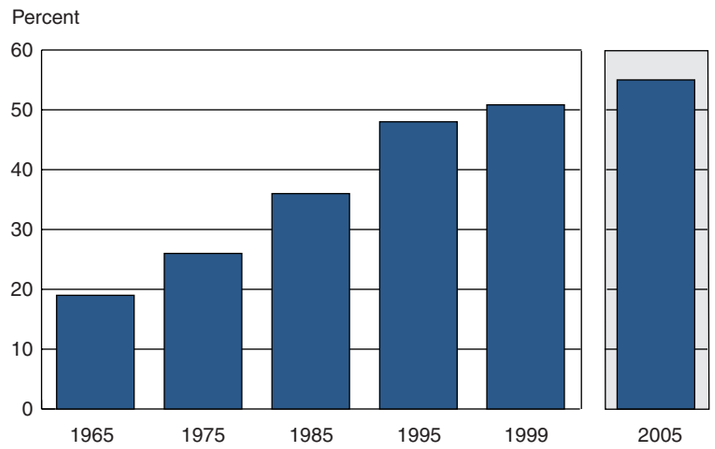
86 years of age for a woman and 76 years for a man. In addition, there will be more than 100,000 people over the age of 100 in the year 2010. However, the first baby boomers will not turn 65 until 2010, so although the population is aging, it's aging quite slowly.

America will soon be a more ethnically diverse nation (see Figures 1-1 and 1-2). Currently 74 percent of the population is white, but that will decrease to about 64 percent by the year 2010. Asians will make up 5 percent, and African Americans 13 percent. In the more densely populated western states, approximately 15 percent of the population will be Hispanic.

The population will also be better educated in 2005: 55 percent of the population age 25 years and older will have the equivalent of one year of college (see Figure 1-3). Income disparity—a critical factor in determining health—will increase slightly. In the year 2005, 50 percent of the population will have a family income of $53,000 or more in constant 1998 dollars, and the distribution will be slightly more equal.

Access to care will remain "tiered" and that tiering will become much more extreme. The top tier, the "empowered consumers," have considerable discretionary income, are well educated, and use technology (including the Internet) to get information about their health. These new consumers increasingly will engage in shared decision making with their physicians.

Figure 1-3. A growing number of adults in the United States have attended college. (Percentage of people age 25 years and older who have attended college)



Source: U.S. Census Bureau, *Statistical Abstract*, 2000.

The second tier is made up of the "worried consumers." These are consumers who have access to some health insurance but have little or no choice of health plans. This tier includes those whose employers only offer one type of coverage and those who may be temporarily employed and face an even less secure health insurance outlook. This "worried" group also includes early retirees and others who do not have the same access to discretionary income as the empowered consumers.

The third tier is composed of the "excluded consumers." In this group are the uninsured, people on Medicaid, and others who don't have access to market-based health insurance. Throughout our forecast, these three groups are affected in varying ways by different aspects of the health care system.

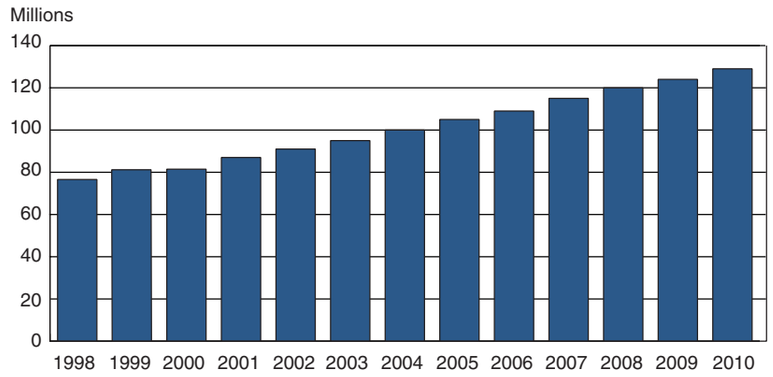
Payers and Health Care Costs

The health care system has been dominated by cost concerns for the better part of 30 years, but that domination will wane during the next decade. From 1965 to 1991—from the inception of Medicare and Medicaid through the recession that precipitated the health care reform debate of 1992–1994—health care grew from 5 percent of the gross domestic product (GDP) to more than 13 percent. It is now at about 14 percent of GDP, with virtually all the reduction in cost growth coming from savings in the private sector.

We forecast a moderate but consistent increase in the cost of health care between now and 2005. Health care will grow as a share of the economy,[1] albeit more slowly than in the 1960s, 1970s, and 1980s. By 2005, the health care sector will account for about 15 percent of GDP. Employers in the private sector will see the short-lived cost decreases of the mid-1990s fade away.[2] They'll see nominal cost increases of 3 to 6 percent per year. Despite the best efforts of Congress to reduce spending in the Medicare system, public programs will continue to grow between 6 and 9 percent per year.

Between now and 2005, business and government will put several strategies in place to repress large cost increases. These strategies tend to assuage the symptoms rather than to attack the cause of the increases. The strategies include reducing insurance coverage, passing on the costs of health care premiums to beneficiaries, and increasing the restrictions on access to care via financial disincentives for utilization.

Figure 1-4. Americans move into HMOs.



Source: Group Health Administration of America, Interstudy, American Association of Health Plans.

Health Plans and Insurers

The biggest change in the health insurance market over the past 10 years has been the fast growth of HMO enrollment. In 1998, more than 76 million Americans were enrolled in HMOs, and a majority were in some kind of a managed care plan. By 2005, HMOs will capture the majority of the commercial market and more than 25 percent of the Medicare market. Sixty percent of Medicaid recipients will be in some form of HMO by the year 2010.[3]

Among this plethora of new products, it will be increasingly difficult to distinguish one health plan from another. They'll all offer similar—and often the same—providers and pay those providers through a mixture of discounted FFS and capitation (a flat fee per patient). By 2005, more than 100 million people will be in these "HMO descendants." (See Figure 1-4.)

The health insurance market will evolve into a mix of different health plan models, many of which will spend the next several years in a constant flurry of reorganization and mergers. Four dominant "intermediary" models will emerge by 2005: the case manager, the provider partner, the high-end FFS broker, and the safety-net funder. As a result, in 2007 close to 50 percent of the population will be in health plans for which cost containment is a key issue.

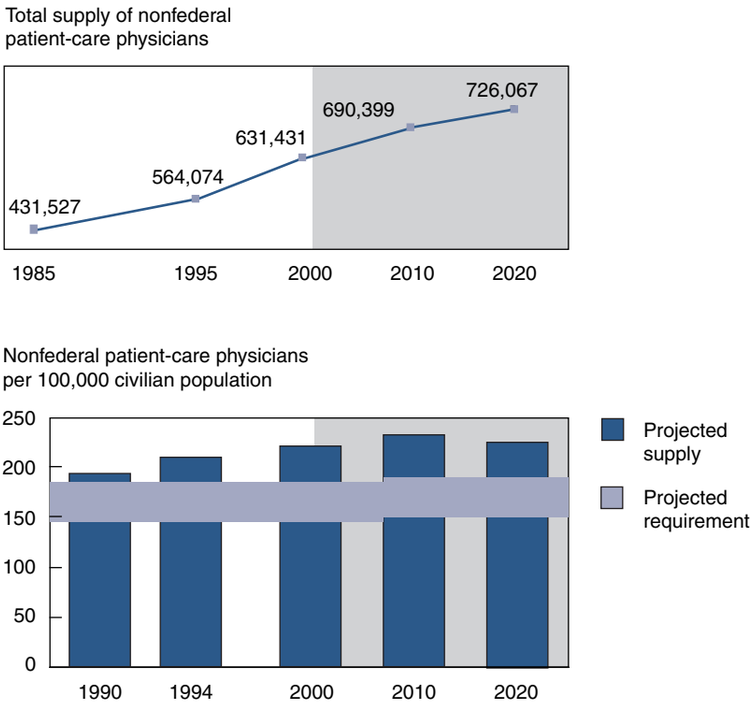
Despite all the pressures toward increasing costs in the system, these new strategies will be successful enough to keep costs from exploding again as they did from 1960 to 1990.

Hospitals and Physicians

As the demand side evolves, changes in the ways providers are organized will occur in the context of significant provider oversupply (see Figure 1-5). There are approximately 630,000 physicians in the United States and another 170,000 in the medical school pipeline. There are nearly three new physicians for every one doctor who retires. Moreover, the numbers of nurse practitioners (NPs), physician's assistants (PAs), and other non-MD clinicians will increase rapidly over the next decade. Physicians are moving into group practices, yet it will be 2005 before most office-based physicians are in groups, and most of those will be in groups of six or fewer.

On the hospital side, occupancy percentage rates have fallen from the low 80s to the low 60s in the past decade, but neither beds nor hospitals have closed at a

Figure 1-5. In excess: Physician supply and estimated requirement (including residents and interns)



Source: IFTF; Bureau of Health Professions, American Medical Association, Council on Graduate Medical Education.

rate that's close to the drop in demand. Set against this background of institutional inertia, no dominant model will emerge to replace the large teaching hospital and smaller community hospital models that provided medical care from the 1930s to the early 1990s.

There will be some hospital closings and bed reductions, but hospitals will continue to be difficult to shut down. From a total of just over 850,000 beds in 1997, we anticipate a further reduction of 130,000 beds by 2005.[4] The advances in medical technology and the aggressive interventions of health plans that have driven much activity out of the inpatient setting will continue, but at a relatively slower pace.

Medical and Information Technologies

Technological change is accelerating in two areas that will affect health care dramatically: medical and information technologies. Medical technology has been one of the major drivers of the health care system since the introduction of effective pharmacological agents in the early part of this century. Its impact will continue in the next decade. However, health care has not made significant use of the advances in information technology that have transformed most other industries. That situation will not continue for much longer as the boundaries between information and medical technologies begin to blur.

Medical Technologies

The health care system has quickly adopted new medical technologies, both devices and pharmaceuticals. Despite increased interest in cost-benefit assessment techniques, the pace of introducing new technologies is unlikely to slow, and there will be a significant increase in the number of new technologies available in the coming decade. Some of the most interesting new technologies include:

- *Rational drug design*. The use of computers to design drugs that target a particular receptor.
- *Advances in imaging*. The use of new imaging technologies—such as

electron-beam computed tomography (CT), harmonic ultrasound, high-resolution positron emission tomography (PET), and functional magnetic resonance imaging (MRI)—to look at the form and function of organs that were once examined only in surgery.

- *Minimally invasive surgery.* The use of miniaturized devices, digitized imaging, and vascular catheters in neurosurgery, cardiology, and interventional radiology.
- *Genetic mapping and testing.* The identification and testing of genes and genetic interactions that cause disease.
- *Gene therapy.* The use of site-specific genes to treat a variety of inherited or acquired diseases.
- *Vaccines.* The use of vaccines to bolster immune systems, target tumors, or immunize against viruses, and of delivery methods including oral and nasal sprays to simplify the vaccination processes.
- *Artificial blood.* The use of recombinant hemoglobin, using *E. coli,* to create a blood substitute.
- *Xenotransplantation.* The transplantation of tissues and organs from animals into humans, primarily bone marrow and solid organs.

Information Technologies

The information and communications revolution will move into the health care system in the next 5 to 10 years. We forecast that four main areas will be affected by new information technologies and that together they'll be the drivers behind new clinical care processes. They are:

- *Automation of basic business processes.* The transaction standards mandated in the 1996 Health Insurance Portability and Accountability Act (HIPAA) legislation are beginning to move plans and providers toward automation of the submission and adjudication of claims, determination of patient eligibility, coordination of benefits, and authorizations of referrals.
- *Clinical information interfaces.* The creation of an electronic medical record (EMR) has stumbled because of resistance from providers, even while many of the basic building blocks are being put into place. Over the next decade, the availability of computers, sophisticated decision support systems, and voice recognition will create interfaces that are clinician-friendly. A combination of low equipment prices, younger, computer-savvy clinicians, and the move of physicians into groups will cause a slow but certain adoption of computerized medical records in the years after 2005.
- *Data analysis.* In the next few years, administrative and claims data sets will be extensively "mined" to gain a better understanding of a population's future illnesses and an improved ability to risk-adjust payments to health plans and providers. After 2005, there will be more data available directly from clinical records. There will be close to real-time online analytical processing of information about patient and provider outcomes, and

that information will be used in all aspects of health care.

- *Telehealth.* A combination of computer-supported case management, remote telemetry via sensors, and better-informed patients will create new ways of delivering health care. Chronically ill patients will be monitored remotely by using a variety of sensor devices, such as video cameras, blood pressure monitors, blood glucose readers, and smart pill boxes. Sensors will be linked to computer systems that enable the provider to catch adverse events almost before they happen. The vast increase in information about health that the Internet, interactive TV, and other communications media bring into the home will also affect the health care system. Patients will use these media for disease-specific research, psychosocial support groups, self-care, and shared decision making.

We forecast that the impact of medical technologies on the health care system will continue to be significant, although the true gains from using information technology and computerizing clinical care processes will not be seen until after 2005.

Care Processes and Medical Management

Medical management—the active management of the care of patients and populations—is currently applied sporadically, if at all. There are two main issues in the future of medical management. The first is the debate over which care processes are used. Many groups are developing guidelines and practice protocols, but none has agreed how, where, or when to use them. The second is the need to reduce variations in practice, thereby reducing costs and improving clinical outcomes. Since an individual clinician is less able to judge adherence to protocols than is a manager reviewing records of an entire organization, decisions about medical management will continue to shift away from the prerogative of the independent physician. Instead, internal managers in provider organizations and external managers working for intermediaries and plans will assume increasing authority in managing physicians' behavior and patients' compliance. Because medical management will depend on information systems to monitor and track both processes and outcomes, we forecast that putting these medical management processes in place will take closer to 15 years than 5 years.

In the interim, disease and demand management programs for the well population—advice nurses working with patients using the telephone and the Internet—will be commonplace. The advent of disease management programs and the adoption of clinical guidelines will have a significant impact on medical practice and patient management by 2005 and a sporadic but discernible effect on practice variation a few years later. However, the struggle between intermediaries and providers and among different provider organizations over who controls patients' and physicians' behavior will not be resolved by 2010.

Public Health

Over the past 30 years the public health system has operated under pressures of resource scarcity, limits in leadership, and

organizational fragmentation. As the public health system assumed the role of safety-net medical provider, the economic burden upon it became almost unbearable. Public health also suffered an identity crisis as the public confused public health with indigent medical care, further diminishing support for a population-based health infrastructure. At the same time, new health challenges emerged, such as HIV/AIDS and environmental contamination, that required strong leadership and an integration of population-based approaches into public health.

Overarching global forces will determine the context in which public health functions in the future. By the end of this decade the currently inchoate social vision reshaping government will have fully emerged and will determine the players and resources in future public health leadership and action. Furthermore, global economies and populations will drive increases in health risks, and by the next decade, national public health concerns will be embedded in a global context of threats and opportunities. Cost-effective technological advances, while mitigated by ethical debate, will enhance screening, surveillance, and environmental health. Finally, public health will increasingly employ "ecological" strategies that simultaneously address multiple human and structural determinants of health and health behavior.

During most of the next decade, public health will continue to be underfunded and marginalized, and efforts to address these underlying problems will be largely incremental. Breaches in public health prevention systems will become increasingly evident, but the system will not totally collapse because support for public health will increase enough to maintain at least a minimal system. The rise of the new consumer will also increase support for public health measures.

Over the next decade, national public health policy will be generally piecemeal, but dynamic state-level actions will generate enough momentum to reignite federal comprehensive health care reform debate. Community coalitions that assure access to basic personal and public health services will become more common. Managed care will continue to dominate, but will be augmented by the integration of population and personal health, public and private patient bases, and a variety of reimbursement strategies. The full potency, limitations, and consequences of public health litigation, à la tobacco, also will be evident in the next decade.

The future of public health service delivery will be shared among the local public health agencies, the community's private health care providers and organizations, and community-based organizations and leaders. The science of epidemiology will continue to be one of public health's most useful guides and will extend beyond biomedical applications to evaluate innovative and comprehensive public health prevention strategies.

Tobacco use will continue its steady decline, but at a very slow pace. In some geographic regions, use may remain at the current plateau. Community-based actions and local legislation will remain effective tactics in curbing tobacco use in public places. A persistent influx of youth smokers will require constant vigilance,

Forecast Through 2005

Health Care Spending Growth:	2 percent per year above nominal GDP growth
Health Care Spending:	15 percent of GDP, $6,424 per capita
Uninsurance Rate:	44 million uninsured, 15 percent of population

especially as smoking interacts with alcohol and illicit drug use. Abuse of these substances, in the absence of significant augmentation of treatment and prevention programs, will continue to fluctuate at high but not record-breaking levels. Barring a massive economic recession, firearm injuries related to violence will continue their decline, which began in the mid-1990s, with slower declines in nonviolent firearm injury gaining momentum as an array of interventions take effect. Although levels of infectious disease in the early 21st century will not approximate those of the early 20th century, (re)emerging infections, drug resistance, resurgence in risky behaviors, threats of bioterrorism, and the interaction of infectious and chronic disease will keep infectious diseases on the public health attention list. Finally, the by-products of our modern society will gain markedly increased attention in the next decade as food safety and air and water quality reach critical points. The crucible for environmental health action will be child health and safety actions and standards.

What Level of Health Care Spending Growth Is Sustainable in the Long Run?

A sea change in health care spending took place in the early 1990s. The annual growth rate dropped from 11 percent—a rate that had been sustained since the 1960s—to 6.75 percent. A combination of forces converged to lower spending growth: strong price pressure from employer coalitions and other large purchasers; a low point in the health insurance underwriting cycle; and providers' and suppliers' keeping their prices in check during the health reform debate and its aftermath. A key question for the next 10 years is this: Do we sustain the 1990s pattern of low growth rates in spending or do we return to the historical, 30-year pattern of higher growth? Scenario One reflects the 30-year pattern of spending growth. Scenarios Two and Three reflect the more recent pattern of spending growth.

Three Scenarios

Our forecast is relatively certain and stable through the year 2005. Beyond 2005, we have created three scenarios to describe how the health care landscape might evolve.

Scenario One: Stormy Weather

In the Stormy Weather scenario, pressures from rising costs, dissatisfied providers and patients, marked inequality of access to care, greedy profit takers, and repeated health care scandals accumulate through the year 2005. None of the fundamental problems of cost, quality, or access are addressed in a meaningful way. Between 2005 and 2010, the barometer drops, winds converge, and stormy weather erupts. The primary driving forces in this scenario include:

- Managed care programs that fail to deliver on their promises to contain costs or to improve quality. Instead, they default to more hassling of providers and gaming of utilization management systems.
- Consumers and providers who react to the adversarial climate with a strong, unified backlash to managed care. They succeed in getting legislation

Scenario One Indicators

Health Care Spending Growth:	2.5 percent per year above nominal GDP growth
Health Care Spending:	19 percent of GDP, $10,200 per capita
Uninsurance Rate:	65 million uninsured, 22 percent of population

passed that further erodes the effectiveness of managed care by intervening in a variety of clinical and structural decisions, such as regulation of lengths of stay for various procedures, staffing ratios, and any-willing-provider laws.

- Health plans that engage in substantial adverse selection and cream-skimming of beneficiaries as Medicare moves toward managed care and a wider range of choices for its beneficiaries. Medicare risk plans manage to get the bulk of low-cost, healthy beneficiaries, leaving the sick, costly people to the conventional indemnity plan. Each attempt at risk adjustment is met with strategies that boost overall Medicare spending.
- Provider oligopolies, including large group practices, physician practice management firms, national single-specialty groups, and large hospital chains, that are able to sustain high prices in an environment that demands open provider networks. They threaten to leave the networks of plans that don't pay well and the plans blink first.
- Large employers that continue to offer insurance as a benefit of employment in the face of a tight labor market and are unable to demand substantial price breaks from health plans. Many small employers, meanwhile, drop insurance benefits altogether, substantially increasing the number of uninsured.
- The march of new medical technologies, which continues unabated. Consumers, prompted both by pharmaceutical companies' direct-to-consumer advertising and by "gee-whiz" articles in the popular press, demand access to the latest, greatest, and most expensive drugs and medical technologies. Beleaguered health plans concede the point and lose control over cost and quality.
- Costly medical technologies for extending life that are not restricted, as no social consensus develops to limit spending on health care near the end of life.
- Information technologies, once thought to be the way to efficiency, consistency, and higher-quality care, that prove to be costly and ineffective. Plans and providers find that their investments in the late 1990s and early 2000s don't pay off, but seeing no better way, they continue to invest after 2005.
- The public health system, which will be in tatters, with local public health departments retreating from service provision and only minimally fulfilling mandated functions, and no compensatory response from the private sector.

Scenario One plays out with a range of difficult consequences. Health care spending, by 2010, constitutes almost one-fifth of gross domestic spending. Even with expenditures at that level,

more than one in five Americans remains uninsured. A majority worry about losing their health benefits. Insecurity of benefits is widespread as many people are just one job change away from being without health insurance. Even those who retain insurance are a lot less happy as their out-of-pocket costs rise.

The health system exhibits radical tiering, with much poorer access to care for the uninsured and people on Medicaid. Medicaid itself puts enormous strain on states, as the state programs are faced with medical costs that overwhelm recession-depleted state budgets. A number of major public hospitals are forced to close their doors. Although their closing helps bring the supply of hospital beds into closer relation to the demand, it also strands many people who have nowhere else to go. The Medicare program finds itself unprepared to absorb the baby boomers, who begin to become eligible in 2010. By the end of the forecast period, health reform is again on the public policy agenda.

Scenario Two: The Long and Winding Road

In Scenario Two, The Long and Winding Road, incrementalism reigns. The successive attempts at revising a portion of the health care system work sufficiently well that tinkering continues well past 2005. As costs get pushed down in one place, they pop up in another, but the system is able to respond rapidly and keep costs in balance. The primary driving forces for this scenario include:

- Employers who continue to pay close attention to health care costs and their benefit structures. They keep substantial price pressure on health plans, limiting increases on the commercial side to 3 to 4 percent per year. They also shift cost and risk to employees by moving increasingly from a defined benefit plan to a defined contribution program. As beneficiaries' out-of-pocket costs increase, utilization of health care services drops off in response.
- Health plans that, in turn, increase pressure on providers. They convince employers that they can only control utilization in a more closed network, so the expansive networks of the late 1990s disappear. In their place are more tightly controlled networks that exert both clinical control and strong price pressure on providers.
- Providers who—stung by the high cost and organizational difficulty of forming large units and integrating care—adopt few of the innovations of the leading-edge provider groups. Instead, they engage in sustained, and largely unsuccessful, resistance to being "hassled" by insurers.
- The cost-containment provisions of the 1998 federal budget, which rein in both Medicare and Medicaid spending. The provisions stick. That bill sets the standard for budget bills for the first 10 years of this century.
- The public health system, which will engage in the dynamic competition with the private sector in service delivery.

The period of 2005 through 2010 is one of turbulent, disorganized change. The health care landscape changes as much in

Scenario Two Indicators

Health Care Spending Growth:	1 to 2 percent per year above nominal GDP growth
Health Care Spending:	16 percent of GDP, $8,600 per capita
Uninsurance Rate:	47 million uninsured, 16 percent of population

those 5 years as it did in the period from 1993 to 1998.

In Scenario Two, costs grow only a little faster than nominal GDP growth, reaching 16 percent of GDP by 2010. Federal and commercial cost containment work well enough to make insurance coverage affordable for most employers. About one in six Americans (47 million) is uninsured.

The health care system remains tiered, with about 20 percent of Americans in the bottom tier of public coverage and uninsurance, 60 percent in managed care plans that substantially restrict their choice of providers and limit providers' autonomy, and 20 percent in high-end, indemnity-type programs.

The bottom tier safety-net providers face tighter conditions, with cuts in disproportionate share hospital (DSH) funding, an end to cost-based reimbursement for outpatient clinics, and tight state and local budgets. But they manage to muddle through as usual by patching together a range of disparate funding sources.

Care delivery is still fragmented, as national players remain relatively rare and small. The majority of physicians now practice in groups of three or more, but most of those are in three- to six-doctor groups. These groups are not large enough to accept global capitation safely, align with a hospital, or influence their physicians' practice patterns radically.

Comprehensive health reform does not enter the public policy debate, as incremental changes each year reassure elected officials that they are "doing something about health care."

Scenario Three: The Sunny Side of the Street

In the Sunny Side of the Street scenario, all the hard work and investment from now until 2005 pays off after 2005 in the form of a sustainable, efficient health care system. Competition helps drive excess capacity out of the system. We learn what does and does not work in medicine, and especially how to get providers and patients to work effectively together. Health plans and providers put in place information and management systems that can take the health care system through the next 2 decades. The driving forces for this scenario include:

- Competition at all levels of the health care system, but especially among providers, which helps drive costs down. Young physicians enter the market with lower income expectations and more of an employee mentality than their predecessors.
- The wave of consolidation of the late 1990s, which continues through the early 2000s. Efficient health care organizations, which can assimilate the best practices from their constituent parts, emerge. Consolidation also

Scenario Three Indicators

Health Care Spending Growth:	1 percent per year above nominal GDP growth
Health Care Spending:	15 percent of GDP, $8,100 per capita
Uninsurance Rate:	30 million uninsured, 10 percent of population

serves to drive some excess capacity, especially of hospital beds although not necessarily hospitals themselves, out of the system.

- The provider service networks (PSNs) that form to contract with Medicare. PSNs find that they have efficient administrative structures. They begin to contract directly with employers in certain parts of the country. Medicare encourages further growth in its risk contracting as it develops effective risk-adjustment methods that make risk contracting cost-neutral for the program.
- Innovative payment approaches that are developed throughout the health care system. Prospective payment for outpatient services is put in place first by Medicare, then by commercial health plans.
- Health care information systems, which make significant progress beyond their current administrative functions. Clinical information systems are put in place that successfully improve care processes and outcomes. The EMR sees the light of day.
- Developments in medical technology that focus both on improving outcomes and on reducing costs. Regulators favor technologies that can demonstrate their cost-effectiveness as well as their safety and efficacy with more rapid approvals. Health plans and providers, through their improved information systems, develop the capacity to make trade-offs among therapies according to their cost-effectiveness.
- The public health sector, which will embrace public-private community partnerships, where service delivery occurs in the private sector and government focuses on assessment, development, and assurance.

In Scenario Three, cost growth is also just 1 percent above the nominal growth of GDP. By 2010, it reaches 15 percent of GDP. These moderate cost increases make health insurance more affordable. People experience more security of benefits, leaving an uninsurance rate of 10 percent (30 million people).

The good news is that the basics are in place—health systems are equipped to minimize unnecessary variation in practices, they operate efficiently, they can track what they're doing. The time spent cultivating a well-organized health system pays off in the long run. The bad news is that we still have 30 million people who are uninsured.

Medicare and private plans begin thinking about the long term. They put in place incentives to reward population management in addition to individual patient care. They also provide incentives for a longer-term focus on today's health care decisions. The system appears well equipped to take on the wave of baby boomers who will begin to be eligible for Medicare starting in 2010.

ENDNOTES

[1] We forecast that, until 2010, real economic growth will remain at 2.5 percent, with general inflation in the economy averaging 3 percent. Health care cost growth at 5.5 percent will mean no change in the share of GDP going to health care. Faster growth of health care costs will mean that health care will grow as a share of GDP.

[2] Overall private sector cost increases averaged 4.8 percent from 1991 to 1995, but many large employers extracted actual premium decreases from health plans in a string of "famous victories" between 1993 and 1997.

[3] These 60 percent will account for only 30 percent of the costs of the program, as the blind, disabled, and dual-eligible elderly will still consume most of the resources.

[4] This doesn't tell the whole story as beds are often allocated to SNFs, 23-hour beds, or long-term care without moving from the same facility, but this projection is based on the official American Hospital Association (AHA) data for inpatient beds.