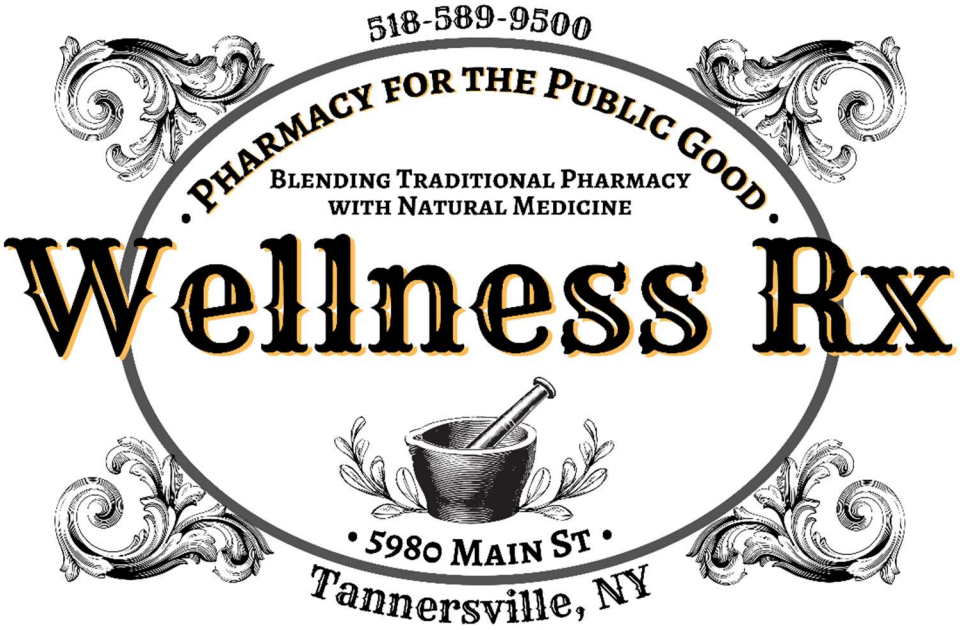
Wellness Rx Special Report:

Healthcare Today



Healthcare in America

Executive Summary

What is happening to our Healthcare System in America these days? In seven modules, Ed Ullmann examines the history of our healthcare delivery service, where it is today and offers ideas and strategies for tomorrow.

Module One *- **"Healthcare Today"** - Ed offers a historical perspective of our healthcare system through his 48 years of professional experience in the field and his observations and reflections during the COVID-19 pandemic and asks, "How did we get to where we are today?"*

Module Two *- **"Shortages in Healthcare Providers"** - With an ever increasing and growing need for care, especially in an aging population, where will the future healthcare workers come from and what can we do to keep those already in the critical positions?*

Module Three *- **"Are We Getting Our Money's Worth?"** - Can we afford to continue spending 18% of our nation's wealth for quality wellness and healthcare services? This is now 100% more than we spend on education and military costs each year and double the cost for most industrial nations, the biggest cost for health services of any of the other countries worldwide.*

Module Four *- **"Tensions in Healthcare"** – Employer / Employee / Government / Providers / Insurers / Investors - Who shoulders the cost of our families' health care and how much of that cost should each share? (Ed breaks down these numbers and asks, how do we help our veterans and senior citizens?)*

Module Five *- **"Hard Questions"** - Should healthcare services be considered a Basic Human Right? Ed digs deep into areas that are sensitive for many and for the good of all Americans from his decades of experiences in healthcare.*

Module Six *- **"Moving Forward with Improved Access to Care"** - Ed turns the focus in this series to how we can make impactful changes in wellness and healthcare going forward and build on what already works.*

Module Seven *- **"Managing Healthcare Spending"** - Ed concludes his series on Healthcare in America offering affordability models and discussing ways to challenge those who create our current systems and our policy makers for the good of Tomorrow's Kids.*

Healthcare or Health Care?

Healthcare: *the business, institution, or activity offering medical services*

Health care: *efforts made to support or restore physical, mental, or emotional well-being especially by trained and licensed professionals to individuals*

Module One - Healthcare Today

Today, we begin the first installment of a series of talks on the American Healthcare System.

We will address where we are today during a pandemic, then we will look at the history of our healthcare system to better understand how we got to where we are today, and finally we'll discuss ideas for moving forward.

Our reflections will be a blend of hard facts and observations that I have made being in the healthcare arena for close to fifty years (50) in many roles from pharmacist, HMO founder/CEO, county mental health director, county legislator and explorer of natural medicine. So, let's begin on where we are today as we start to come out of a once in a lifetime pandemic.

First, the veil has been lifted on our national healthcare system that absorbs **eighteen percent (18%) of our Gross Domestic Product (GDP) or wealth.** To put that into context, Canada spends ten percent (10%) of their GDP and most other countries are even lower than that. America spends $11,000 a year per citizen on healthcare, while other wealthy industrialized countries spend $5,500 or half of that figure. Another perspective is that we spend five percent (5%) of our GDP on education and four percent (4%) on national defense. So together we spend nine percent (9%) on these vital services or fifty percent (50%) of what we spend on health care.

The war on COVID has also exposed a lot of things, but the deep gap in **access to care according to race and income** and the **complete separation of traditional healthcare from public healthcare** have been the most revealing to me. Who knew how unprepared we were for a pandemic; how dependent we were on international supply chains or how difficult it would be getting shots into arms? To achieve success, we had to use **mass vaccination centers** that often required patients to drive fifty (50) miles one-way to get a shot and then they had to repeat that process for the second shot. We had to recruit millions of volunteers of all backgrounds to assist with the cause and I was so happy to see our **American pharmacists step-up to provide thirty percent (30%) of all COVID immunizations.** And who knew how antiquated our public health systems were in reporting accurate vaccination statistics from around the country to the public. The fallout from COVID has been harsh and we are still in the tail end of this pandemic. American healthcare workers are exhausted, burned out and many remain angry with the **unvaccinated** that have accounted for ninety percent (90%) of COVID hospitalizations and deaths.

The end result is that we are seeing the **largest number of early retirements of healthcare workers in our history. Experts are now estimating a net 3-3.5% loss of overall clinical capacity**. This is significant as we are losing some of the best minds, the often senior and experienced minds who serve as our trainers for future healthcare professionals. As patient demand for health care services goes up after years of COVID hibernation so much of our healthcare system is on its knees, just trying to keep up. Appointments are backed up, most practices, especially on the primary care side, aren't taking new patients, and service is being compromised. Due to the time it takes to become a licensed healthcare professional in America, reinforcements are not going to be easy to find especially direct healthcare workers like our nurses, mid-level providers and doctors.

We also have observed during this COVID period that many Americans have enjoyed financial success through stock and real estate prices going up and being able to work from home without loss of income. Unfortunately, most Americans have not been so lucky and have been faced with great sacrifice and struggle. For example, the number of medically uninsured or those with no health insurance who can be forced into bankruptcy with a single hospital admission, is now back up to **over 12.5 % according to the Commonwealth Fund (increase would have been much greater without the expanded safety net of Medicaid).** The 12.5% compares to 17.8% in 2010; 14% the year after the major provisions of the ACA or OBAMACARE were enacted and **9.8% in 2021.** This increase places great strain on our nation's emergency rooms and the resulting bad debt that they often have to absorb since no American can be turned down from being seen at a hospital emergency room.

Healthcare revenue and profits during COVID have also been unequal. For example, if you operated an HMO or health insurance company which receives monthly premiums, you have enjoyed record profits as payment for healthcare claims have gone down as patients stopped going for medical services. On the other hand, if you operated a hospital, revenue and profits are down primarily due to the delay or cancellation of profitable voluntary surgeries (estimated that 28 million surgical procedures have been impacted).

Finally, let's take a moment to reflect on some **positive aspects of the epidemic.** So many of our healthcare workers, first responders, public safety enforcers, skilled laborers and millions of volunteers have stepped up to show America at its best. Although the immunization process started out quite rocky, overall, it eventually worked itself out primarily due to the great passion exhibited by our health care professionals, their administrative staffs and our volunteers.

In the end, we **must** do better. There's just so much at stake.

Module Two - Shortages in Healthcare

Experts are predicting a need for 30 - 45,500 primary care providers, 50,000 specialists, and a need for most other healthcare providers especially nurses and mental health professionals. The need for these skilled professionals is guaranteed to grow as we **live longer, providers retire early, and patient demand** increases for the treatment of chronic conditions such as obesity and diabetes, heart disease, dementia, and COPD.

Today, **five percent (5%) of Americans account for fifty percent (50%) of all healthcare spending.** That's right, just 5% or very sick Americans account for fifty percent (50%) of spending with the highest spending occurring during the last year of one's life. It's a big challenge and a great opportunity for fresh ideas to reduce costs while improving the quality of care. How do we provide care to these **high-risk individuals with dignity and compassion while we manage cost and quality?**

It's estimated that our **senior population will grow by 40% in the next ten years** and **40% of all practicing physicians today will soon be over age sixty-five**. Can we afford to lose the wisdom and experience that our senior providers bring to our healthcare systems, if the trend toward early retirements continues?

Today, the United States has the **lowest number of physicians per capita** than any other industrialized nation. That's a cold fact. We spend a lot of money on health care but, in reality, we don't have a high physician population. We average **2.5 physicians per one thousand persons.** Sweden on the higher end has double that (five physicians per thousand persons). Also, the normal influx of international students and providers to our healthcare system has been disrupted by COVID and immigration restrictions. These international professionals often account for up to **10% of all of our clinical capacity.**

Under normal economics, this shortage or demand would easily be met by an increase in supply. Trying to meet this need for supply is a record number of applicants to our medical schools (often **over 100 applicants for each open position**). However, healthcare is different. The cost and time it takes to train a new licensed healthcare professional is expensive and demanding (**more than 10 years for physicians)**. The **big problem is the small number of residency and teaching positions available for this needed training.**

In the United States, physician residency positions are primarily paid for by Medicare payments to hospitals. This has led to a **national legislative cap on the total number of residency positions available for the past 10 years.** So, we have an escalating increase in demand for those who want to become healthcare professionals, but we lack the appropriate number of residency positions or teaching positions to meet this demand.

The issue is also acute with the training needed for **mid-level professionals** like physician's assistants and nurse practitioners. Evidence shows that these professionals have relatively l**ow cost of entry to provide primary care, their productivity is almost equal to doctors and patient satisfaction is high**. Yet, at Albany Medical College in upstate New York there were only 42 physician assistant positions available last year for over 3,000 student applications. This is our challenge.

On the positive side, young Americans inspired to make a difference in the world after COVID are applying to medical schools in record numbers. But, unless more training positions become available, the competition for the limited number of positions available will only increase.

Perhaps technology and the promise of increased efficiency and quality can make a difference. It is estimated that today's physicians spend about **30% of their time completing administrative** tasks such as paperwork, increased regulatory requirements and demands from insurance carriers and health systems. With the average physician making $187,200 plus benefits a year, this appears to be an inefficient use of expensive labor and certainly will not help our country much in meeting our supply challenge of increasing clinical availability for patients.

So, in the near term, Americans must brace themselves for a healthcare system that will provide more complicated access, more consolidation, and unpredictable service. More costs will be passed onto the consumer (i.e., deductibles, co-pays, services not covered, etc...) and unless something changes in the near term, more health care professionals will continue to retire early due to exhaustion and **broken spirits** (experts are estimating a 3-3.5% lost clinical capacity coming out of COVID).

Time for innovation and creativity. **We can't just buy ourselves out of this cold reality**. We must and we can do better.

Module Three: Are We Getting Our Money's Worth?

Is society getting its money worth spending 18% of its wealth on healthcare? That's $11,000 per citizen, or 100% greater than what we spend on total education and national defense budget combined. Far more than any other nation in the world.

Let's first look at our accomplishments through spending this amount of money. Without question, we have some of the world's greatest health systems in the world. The Mayo Clinic is a wonderful example. We can do remarkable high-level surgeries to keep patients alive. We conduct lifesaving organ transplants, as well as doing a wonderful job managing emergencies. Just recently a close family member had a successful heart and lung transplant at NYU in New York City. The best of American medicine.

We have created game changing pharmaceuticals including the recent COVID gene vaccines, introduced advanced high tech diagnostic tools and robotics and are successfully delivering lower cost outpatient and emergency services that are well received by the public. The training of our healthcare professionals operates at a high level and some of our older group and staff model Health Maintenance Organizations (HMO), especially out west, continue to do a good job providing quality services in an efficient manner. Our hospitals are also often extremely efficient with the l**owest length of stays in the world.**

But what do our outcomes tell us? Are we getting what we pay for?

Let's start with what we all want: **longevity or the ability to age gracefully with dignity.** While we are living to an average age of about seventy-eight years old (women live longer than men), according to the New England Journal of Medicine, America ranks a **cold thirty-sixth among industrial nations for life expectancy.** Not very impressive and the challenge gets tougher with the 1,000,000 COVID deaths, escalating suicides, escalating domestic violence and homicides, escalating drug overdoses and escalating chronic health conditions. Not a pretty picture.

While our longevity remains a challenge, is anyone cheering on the way we handle long-term care in America or celebrating our infant and maternal mortality rates. More American women **die today during childbirth or experience serious injury during childbirth than any other developed nation in the world.** We have great technology to keep premature infants alive, but we do a terrible job of keeping maternal death down and it's **even higher if you are minority mom.** We have to do better than this.

We also have to become frank with ourselves about the **American lifestyle.** We live a high paced type of existence driven by social media and a hunger to get ahead. But what does that lead to? We have become leaders of the world in **dealing with anxiety, depression and sleep deprivation. 66% of Americans are now reported to be overweight, diabetic or pre-diabetic.** And then there's pain management where Americans ingest **90% of the world's opioid production.**

So, the first question we need to ask is, do we have a **disease-based healthcare system in America or a wellness-based system?** I think we all know the answer. While we do not like it, it is the truth.

We then must ask if our current strategy that asks **market forces to design and manage our healthcare system for both costs and quality the best that we can do?** What is the outcome from this decision?

This has led to **unabated consolidation in the industry.** More power in the hands of a few companies in each region of America and a big miss-match in the **delivery of services between rural and urban America.** So, we must ask, are we paying healthcare providers across the board, from hospitals down to primary care physicians, based on society's needs? Or are we paying them **based on demand created by healthcare professionals and providers?**

The last question is important and needs careful examination. Here's a few examples of the issue:

Our current healthcare system has the best in high tech diagnostic services for our citizens. Access to better diagnostics has helped providers with better decision making, but it comes at a high cost.

In the United States, we have **twice as many Magnetic Resonance Imaging (MRI) and Computerized Tomography (CT) scan machines than any other nation, and three times that of Canada.** That is a lot of excess capacity of diagnostic devices. The easy access could be good or bad, but it is certainly costly.

88% of our physicians are specialty trained. England has 73%, while **Canada has 52%.** Most other countries emphasize lower cost primary care services over specialty services while America has placed a higher premium on specialty medicine over primary care. This decision then **leads to a greater dependence on high-cost technology services.**

Consolidations along with mergers and acquisitions, among hospitals, healthcare systems and medical groups throughout America continues at a record pace. For example, this has led to America having **fewer acute hospital beds per capita than any other nation** and the reduction of underperforming hospitals in both rural and urban America. This could be good, if the consolidation leads to better outcomes and an economy of scale for cost savings to help expand primary care services. However, according to the Healthcare Association of New York state, **"60-80% of all mergers failed to deliver on their expectations. In reality, the truth is that instead prices have gone up."**

Another example is **pharmaceuticals which account for over 10% of all health care costs.** Americans take **twice as many drugs than any other nation** and pay over **twice as much for prescription medications than any other nation.** Today, 83% of all drugs dispensed are lower cost generics and **17% are high-cost brand medications**. In a market driven world, wholesalers and pharmacies would shop for the best price throughout the world and large payers like Medicare would negotiate for best prices for their members. **Both activities are prohibited by national legislation.**

Helping to drive this demand for expensive brand drugs is the fact that America and New Zealand are the **only two nations in the world that allow for direct advertising of prescription medications to the consumer**. So, the more these companies advertise these products, the greater the demand. It's no wonder that **drug advertising now accounts for about thirty percent of the annual revenue streams of** our traditional or legacy television stations (i.e., CBS) who are competing with cable television for market share. This revenue is

important to keep them in business. In an odd way, it's become a **form of codependency** and a phenomenon seen throughout the healthcare industry.

Pharmaceutical companies also claim that the higher prices are needed for research and product development to produce the new drugs for tomorrow's Americans. That makes sense and the industry has had excellent success over-the-years in providing our citizens with life-changing therapies. However, the ugly truth is that research and development budgets for pharmaceutical companies in the United States have **gone down over the last twenty years (often by 50%).** Companies have also benefited from **grants from the federal government in public-private partnerships.** For example, the funding for the Moderna COVID-19 vaccine all came from the federal government and the life-saving vaccine was the first product ever brought to market by the company.

As we move forward, solutions are going to be tough, especially with the reality that **13.5% of the nation's jobs today, are related to America's healthcare system**. Every projection for the next ten years is looking for healthcare jobs as being the **number one driver of new jobs or new occupational based jobs in this country**. Again, another codependency that occurs within the healthcare industry.

Our structure for managing the American healthcare system also leads to the highest administrative costs of any nation. It's common to see up to **fifteen percent (15%) of a health system's budget** being spent to administer the process.

Finally, the American healthcare system today still remains dominated by a **high-cost fee-for-service system** (you provide a service and get paid under a defined fee schedule) and defensive medicine remains a reality as providers need to protect themselves from potential lawsuits. This system is simply not sustainable. Our future reimbursement systems must shift to a **value-based medicine** where healthcare providers and administrators are compensated more on **performance and accountability** than on a system where providers can often create their own demand.

Module Four - Tensions in Healthcare

Tensions in our American healthcare systems make it difficult to make long-term changes for the public good. Let us look at the different sectors involved in healthcare to better understand how their agendas don't always match up with society's agenda of equity and the improvement of the health care status of its citizens.

First, we look at the **payers of healthcare services.** After WW2, our country made a decision to adopt a system where employers would provide healthcare coverage for their eligible employees. Early on, the insurance system was dominated by state regulated BC/BS plans and each employer (and sometimes in partnership with union representation) would decide on the benefit package for their employees along with cost-sharing provisions in the form of deductibles, co-payments, and payroll deductibles. Through the years the system has had reasonable success as employers try to secure competitive monthly premiums from insurance companies and try to push costs onto employees whenever possible. Employees or consumers of healthcare services, on the other hand, want to maximize their benefits with as little cost sharing as possible.

In 1965, Medicare or the national public healthcare program for seniors and Medicaid, the state/federal program for the poor were enacted into law. 56 years later, these two public programs now provide health coverage to **26% of Americans.** However, If you add the **total costs** of **Medicare** where seniors need a higher level of care to **Medicaid** costs and then to the cost of our **VA health system** for veterans and the cost of healthcare **benefits for public sector employees and retirees,** it is estimated that these combined sectors now exceeds **57% of all healthcare spending in America.** So, in many ways, we already have a **publicly financed system of care** in America that tries to promote society's agenda.

Next, we look at the insurers of care which are now dominated by national and regional Health Maintenance Organizations (HMOs) or managed care organizations (MCOs). **70% of eligible Americans** are now enrolled into one of these organizations which coordinate and manage both the financing and delivery of healthcare for their members. **60% of managed care organizations are now non-profit organizations** and 40% are for-profit with most being publicly traded enterprises. Regardless of structure, these organizations have stakeholders, shareholders and boards of directors that demand accountability for profitability and sustainability. Their agendas are often not society's agenda.

Then we have the providers of care. We start with our nation's hospitals which account for **33% of all healthcare spending.** Interestingly, **82% of all American hospitals and their healthcare systems are non-profit entities**, and for the most part, they do understand their responsibility for the public good. Our next highest sector for healthcare spending is **physician, professional and clinical services at 20%.** While **70% of physicians are now employed by hospitals, health systems, medical groups or private equity firms,** the majority of physicians (and related clinical services) in America still remain part of for-profit ventures. **Pharmacy services account for 10%** of healthcare spending and almost 100% of retail pharmacy is for-profit medicine. The remaining balance of healthcare spending is related to diagnostic services, long term care, laboratory services and miscellaneous smaller services.

Finally, we have what I call the **investors in healthcare.** That is, our pharmaceutical companies, medical device companies, our banking industry, Wall Street investors in the form of

equity firms and the stock market and the countless small, medium and large businesses, vendors and consulting firms that depend on healthcare spending for their livelihood.

In conclusion, when we look carefully at the tension between healthcare payers, health insurers, providers of care and investors involved in the American healthcare system, each with their own agendas, it is easy to see how society's agenda of fairness, equity and the overall healthcare status of its citizens may not always be center stage.

Module Five - Hard Questions

The COVID pandemic has exposed many limitations and holes in our healthcare system, especially the challenge of providing equity for all citizens and the challenge of recovering from an exhausted healthcare workforce that has resulted in a record level of early retirements of healthcare providers and staff losses due to vaccination mandates.

How do we rebuild this shortage especially in the growing south and Midwest regions of America that were already experiencing the greatest need for both primary care and specialty care services? COVID has also exposed our complete separation of **public health services from traditional health services. How to bring these sectors more together?**

So, we must ask,

- *Can America afford to **continue to spend 18% of its wealth on healthcar**e? If not, tough decisions need to be made today for tomorrow's kids.*

- *Like access to clean water and public education, should access to health care services also be considered a **basic health right in America? I**f so, this must guide our policy decisions?*

- *Should **market forces remain the dominant driver of the American healthcare system? I**s the resulting consolidation of more power and resources into fewer companies supported by Americans? Do Americans want to see more not-for-profit or for-profit corporations providing healthcare services in the future?*

- *Can we as a nation continue to operate a **disease-based system of care** that puts access to prevention, wellness and primary care services secondary to specialty and high-tech medicine?*

- *As **high-tech medicine**, especially gene therapy and genetic engineering, continue to show great progress, can we manage the process ethically and with fairness or will it end up managing us?*

- *And finally, can we continue to go forward with the **American lifestyle th**at is leading to more obesity and chronic illnesses, more anxiety, depression and sleep deprivation and more public health challenges like domestic violence, suicides, homicides and drug overdoses?*

Our final two modules will discuss some ideas for moving forward with developing a sustainable healthcare future for tomorrow's kids.

Module Six - Moving Forward with Improved Access to Care

Let's take a look at ideas to address the new and old challenges of the current American healthcare system. Our most immediate challenge is **access to care.** COVID hit our system hard with a record number of early retirements and losses from vaccination mandates. In total, it's estimated that we have lost about 3-3.5% of our clinical capacity in the past 2 years. Add this to the estimated shortage of 40,000 primary care physicians before COVID, and you can start to see the challenge we have especially in the growing south of our country and for the poor.

Let's first look at what has been working and build off of these systems.

Federally Qualified **Community Health Centers (CHCs)** are distributed throughout the US and primarily serve our poor and high-risk populations in underserved communities. The Centers recruit high quality providers since the government helps with the repayment of their student debt. The Centers cannot refuse care to anyone and offer a sliding fee schedule to those in need. Let's **increase these Centers all across America.**

Let's then **increase the number of internships and training positions f**or new physicians and especially for mid-level professionals like physician assistants and nurse practitioners which are highly efficient clinicians and well accepted by patients. Let's stop relying on Medicare dollars alone to increase these positions. Instead, let's ask each state to impose a **quarter of 1% Primary Care Access Tax** on each HMO or managed care organization licensed under their jurisdiction.

Let's challenge our young adults to become **licensed mental health professionals and other needed specialties** with full college scholarships in return for 5-year commitments to serve those in need.

Let's give our pharmacists the incentive to expand their clinical services and to become public health leaders for their communities. Let's give them **provider status as a mid-level professional.** Let's reimburse them to keep their patients healthy and to only fill medications if truly needed. With these incentives, let's challenge pharmacists to open-up new wellness centers especially in rural America that include expanded clinical services, nutritional counseling, mental health services and natural medicine.

As COVID has demonstrated, **lower cost telemedicine** can work for employers, providers and patients. Let's perfect the field and let's also increase at-home visits especially for seniors and those with disabilities. And while electronic medical records and other technology to provide more efficient administration is good, can we really afford to have our providers spend 30% of their time on these activities which often benefit health insurance companies and facility managers more than patients?

Finally, we must ask "**why do patients enter the American healthcare system to begin with**". It may surprise you, but the majority of visits to a doctor in America doesn't result in a specific diagnosis and the visit is often related to a mental health challenge. When there is a diagnosis, the number of reasons is allergies, sinus issues or upper respiratory illness followed by skin disorders, joint disorders, headaches, digestive issues, back pain and hypertension. Isn't it time that we challenge ourselves more to become our own personal investigators and to do more with self-analysis, self-care and to explore alternatives like natural medicine?

In summary, increasing access to healthcare services is really a three-step attack:

- create more providers (especially lower cost primary care services)
- increase the scope of practice for providers like pharmacists to provide more low cost and accessible primary care services
- challenge ourselves to reduce demand for services by exploring more self-care and healthy lifestyles

Module 7: Managing Healthcare Spending

We end the series with the most urgent question:

> ***Can we continue to spend 18% of our wealth on healthcare services?*** *This is twice as much as most industrialized nations. This is also twice as much as we spend on public education and national defense combined.*

Being honest, we know we have a runaway train wreck in the making, especially coming out of COVID when **costs have only gone up (according to the Centers of Medicare and Medicaid Services'(CMS), the gross domestic product (GDP) devoted to health care increased from 18% to 19.7% (10% increase) in 2020. CMS anticipates a decline back to 18% in the 2022-24 period).** It's time for tough decisions to be made. It's time to deal with reality before the medically uninsured population continues to grow, the rationing of care comes out of the shadow, the shifting of costs from employers to employees increases to levels that make patients hesitate to get care and the continuing **consolidation of healthcare power and decisions** into the hands of fewer and fewer entities **becomes the only short-term option we have**. We must now clearly understand from the COVID epidemic that **public health is linked closely to the economic health of the country and our physical well-being.**

What steps for change can be done today that most Americans, most public officials and most providers of care will feel are reasonable? In this vein, we must start at the federal level where public funds now pay for **57% of all healthcare spending.**

To be bold, we could establish **a national cap on healthcare spending at 18% of our wealth.** With a cap in place, we could then establish **global spending budgets for each state based on population, past experience and an understanding of the unique characteristics of market conditions**. States could then establish **regional global budgets for their populations** and decide on what level of benefits and quality assurances they want for their citizens and what level of **risk sharing** they want to impose on the parties. For example, a state could establish a **uniform reinsurance arrangement** that would absorb the cost of any citizen's care within their jurisdiction that exceeds $500,000 dollars in a single year, or the state could link approval of private and public health insurance premium requests to performance.

This push down of global budgets to the states will force the alignment of public and private interests for cost containment and quality of care. Let's call it **mutual accountability for the structuring of a sustainable and fair healthcare system for tomorrow's kids.**

In this model of trying to reach common ground, I suggest that states look at **partnering with the HMOs, or managed care organizations,** which are licensed to do business within their jurisdictions. While I remain disappointed with the shift of most HMOs to become large insurance companies at the expense of healthcare delivery, **they are grounded,** have established a history of performance, and they understand risk sharing. For example, **Medicare advantage plans** operated by most HMOs in partnership with Medicare have proven to be highly successful for the government, the HMOs and Medicare-eligible members. In these plans, Medicare pays the HMO a fixed monthly fee (let's say $3,000) to assume the responsibility for providing all medical services, including prescription drugs, to the assigned beneficiary or HMO member. The HMO retains the flexibility to then enrich the benefit package for its members and to push risk sharing down to their contracted healthcare providers. And with over **70% of Americans now enrolled in a managed care organization and the fact that**

60% of these organizations are nonprofit entities, I suggest that this is a perfect middle road for going forward.

Now, with a push down to global budgeting and greater risk sharing for managing healthcare dollars, we will set the stage for:

1). Greater partnership between healthcare systems, HMOs, our government and our citizens

2). A shift away from fee-for-service medicine to a **value-based medicine** where healthcare providers and healthcare administrators are reimbursed based more on performance and accountability than on a system where providers can often create their own demand.

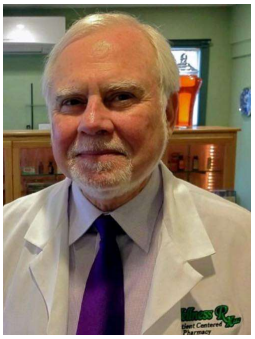
3). A shift away from high-cost specialty and high-tech medicine to **lower cost primary care and preventative care medicine.**

4). **A new era of creativity and innovation in healthcare management and delivery.** This will especially lead to more grass roots efforts at the local level, more partnership between public health and traditional healthcare systems, better decisions for managing our escalating technology and more incentives for consumers of care to live healthier lifestyles and to become their own investigators for exploring self-care and alternative options like natural medicine.

5). We can also delay ugly decisions on the rationing of care for our citizens, delay the cost shift from employers to employees in the form of higher deductibles, co-payments and cost sharing for health insurance premiums and we can keep healthcare jobs growing for our economy (**now 13.5% of all jobs; anticipated by futurists to be the #1 driver for new jobs).**

Finally, we must immediately address the growing medically uninsured and under-insured population in America. We must mandate the **expansion of Medicaid eligibility to every state in the nation**, we should continue to perfect the 2014 ACA or Obama Care legislation which expanded coverage and provided exchanges and subsidies for individuals to purchase health insurance, we must expand the number of federally qualified community health centers in America that are mandated to provide access to care to all patients and to offer a sliding fee schedule to those in need. We must expand the number of residency and training positions available for the growing number of young Americans that wish to commit their careers to the service of others.

This concludes our seven-module series exploring the American healthcare system. It is our hope that we put a spotlight on some of the hot issues that we are facing together as a nation, and I hope we planted some ideas or seeds for **taking action for tomorrow's kids**.



About Edward A. Ullmann – Ed is a proud and valued board member on the President's Advisory Council at the Albany School of Pharmacy and Health Sciences. He also serves as an Adjunct Experiential Faculty member for the school. He holds a Bachelor of Science degree in Pharmacy from Albany College of Pharmacy and Health Services, an MPA degree from the Maxwell School of Citizenship and Public Affairs, Syracuse University, and was a National Health Maintenance Organization (HMO) Fellow at Georgetown University Medical School, Washington D.C. Ullmann has developed over 30 start-up companies, and for 16 years served as an HMO founder and CEO at Wellcare. He has also been a Pharmacy District Manager, a Mental Health Director, County Legislator, and was owner/operator of the world-renowned Warm Mineral Springs in Florida. He was named "1994 HealthCare Entrepreneur of the Year in Southern New England" by Inc. Magazine and received the "Community Health Improvement Partnership (CHIP) Visionary Award" from Sarasota County, Florida in 2007. In October of 2020, Ullmann was honored by the "Pharmacy Times" a national publication in the pharmaceutical trade in their "Faces of Pharmacy" feature section.