Worthy

Healthcare Overview

It's not about funding. It's about fundamental change.

Healthcare costs are overwhelming our entire country, making it too expensive for many to afford health insurance. We pay for volume instead of value, reward complexity over clarity, and tolerate inefficiencies that leave patients frustrated and vulnerable. For too many, access to care depends less on medical need and more on income, geography and/or luck.

As a result, it is difficult to spend money on other priorities, and our children and grandchildren are on a path to inherit massive debt. In fact, healthcare costs are one of the leading causes of personal bankruptcy.

We need to deal with these mounting costs, and fast.

By aligning payment with outcomes instead of procedures; simplifying, digitizing and automating what we can; and by placing patients at the center of every decision, we can build a healthcare system that is worthy of us all and sustainably affordable.

I invite you to take a deep dive into the existing problems in health care and a path forward that is **worthy of us all**.

READ MORE

- The cost crisis →
- The cost and quality equation →
- Houston, we have a system problem →
- Pay for value, not volume →
- Digital health and automation →
- Putting personal care at the center of health care →

The cost crisis: rising health costs won't fix themselves

When I was living in New York in the 1990s, the Seinfeld show was at the peak of its popularity and I watched it every week. Given that my work focused on insurance companies, I found this segment to be particularly entertaining:

Just like Kramer, most people believe that there's plenty of money out there to pay for health care, and that the entities that have it should just "write it off." Unfortunately, as you will see with the analysis below, that is simply not the case.

Healthcare costs are overwhelming our entire country, making it too expensive for many people to afford health insurance or even seek care, crowding out our ability to spend money on other priorities, and generating a massive debt for our children and grandchildren to inherit. We need to deal with these costs and deal with them soon.

Workers are losing out on wages, families can't build strong financial foundations and the number one cause of bankruptcy in the U.S. is healthcare debt. People are routinely forced to choose between rent and their medications — a choice that no American should have to make.

The all-too-common response is that the government, employers or someone should spend more money. But it's important to understand that the money just isn't there to pay for projected healthcare costs. The U.S. government is a health plan and pension administrator with a large army and a huge credit card debt. That's not a political statement, nor are you likely to see it as a campaign slogan any time soon. It is an inescapable mathematical fact.

⚠ Nerd Alert!

Need convincing that the money isn't there? Read on for a deep-dive into the economics of healthcare. Want to skip the deep dive? Continue to the Cost and Quality Equation. →

⚠ Nerd Alert!: The Economics of Healthcare

Let's look at the numbers across all the major entities that pay for healthcare to help understand the impact on consumers:

1. Federal government spending
2. State government spending
3. Employer spending
4. Health plan spending

Federal Government Spending

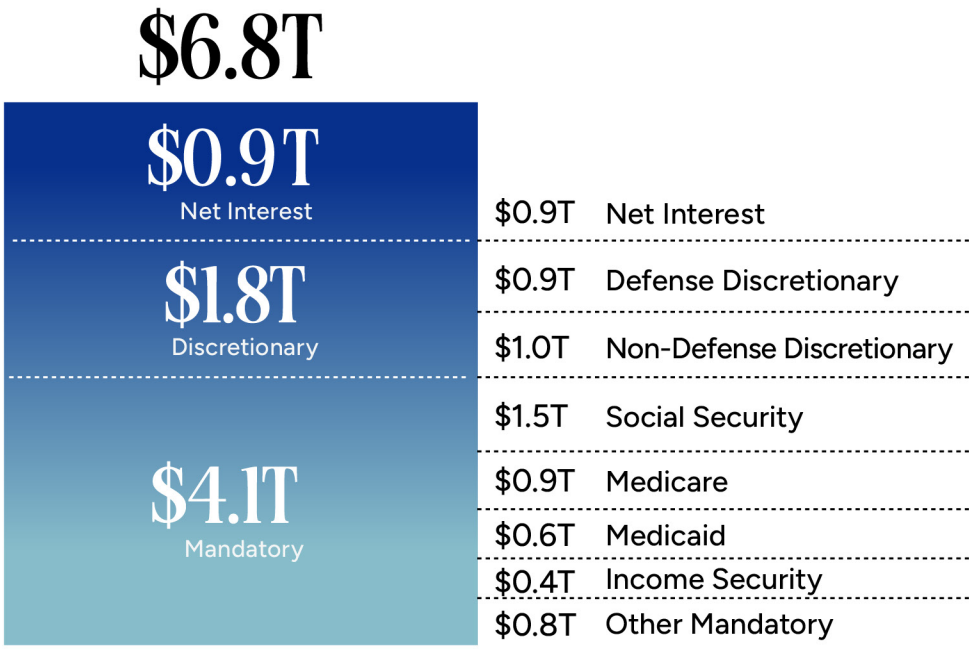
Let's examine federal government spending for 2024 broken into three broad categories:

- Mandatory: Health care (Medicare, Medicaid and financial support for the Exchange markets), Social Security and other income support programs
- Net Interest: Interest payments on the federal government's debt
- Discretionary: Defense and non-defense spending

US federal outlays by category (2024)

60%+ of federal spending funds health care & income support

Source: Congressional Budget Office



It is worth pointing out a few things:

- More than 60% of federal spending goes to health care, Social Security and other income support programs.
- If the U.S. eliminated spending on all non-defense discretionary spending, we would still have a budget deficit.
- The U.S. now pays more in interest every year for money it has borrowed, than it does on defense spending.

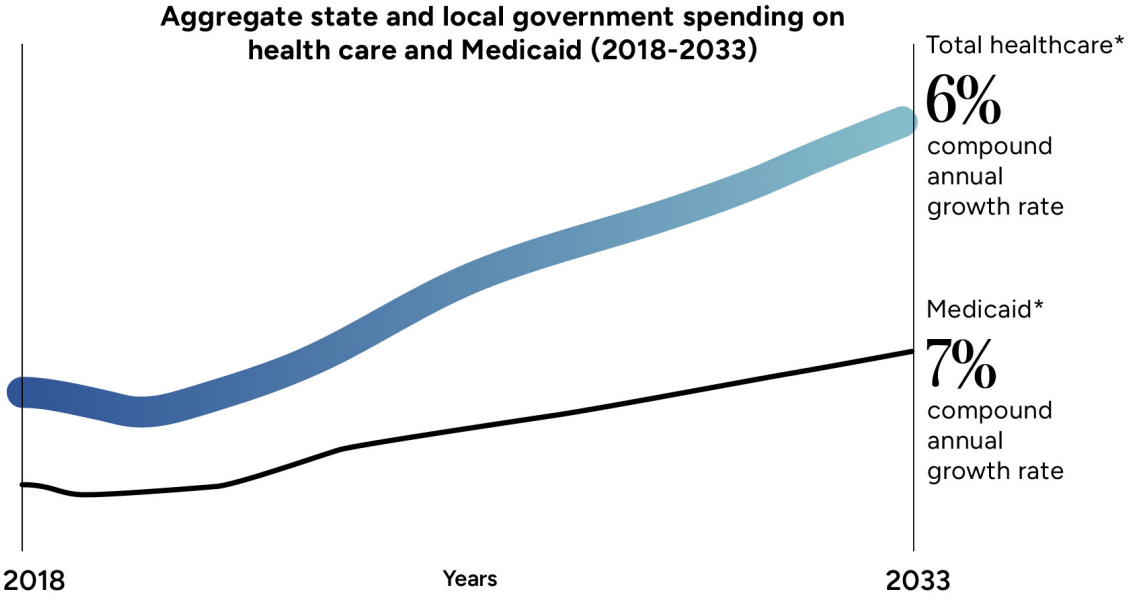
We are in a vicious cycle. Each year that the U.S. runs a deficit, we add to the total amount of money we need to borrow (our debt), which increases our interest payments. As politicians debate government action, the numbers paint a sobering picture:

- The taxes that our government collects cannot fully pay for mandatory spending plus interest and defense spending.
- Continuously growing healthcare costs are bankrupting our country and creating huge risks to our economy. It is simply unsustainable.

State government spending

The picture isn't any better at the state level. Healthcare costs at the state level have also been growing at a rapid rate. In fact, total healthcare spending is projected to grow from $0.9 trillion in 2018 to $1.3 trillion by 2026 — an annual growth rate of almost 6% (see chart below for source). By reducing or eliminating some of the mechanisms states use to increase federal funding for their Medicaid programs, such as provider taxes, this cost pressure is likely to increase substantially in the next few years.

State government spending on health care continues to rise at rapid rates



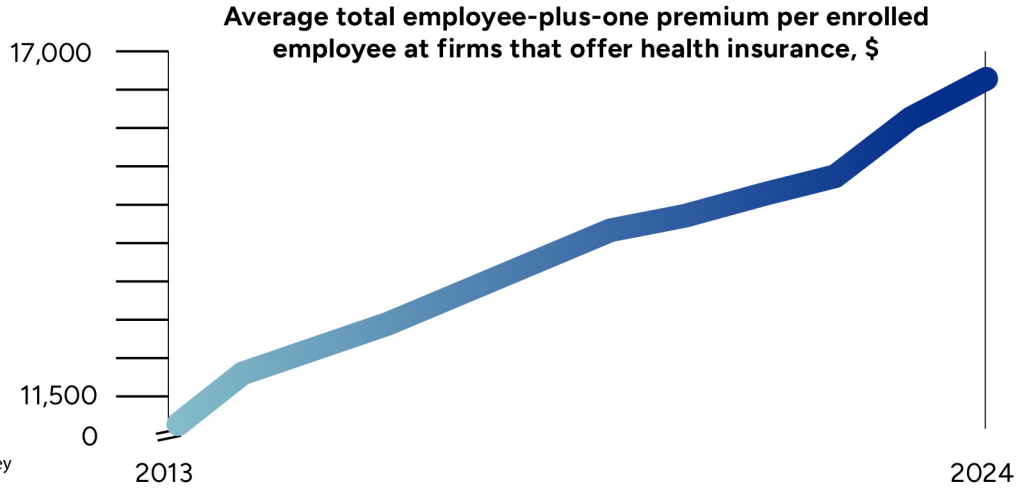
*Total healthcare includes state and local government spend on Medicaid in addition to employer contributions to private health insurance, payroll taxes paid to Medicare trust fund, and other programs such as CHIP, public health activities, research, and CapEx. Medicaid line refers to state and local spend on program excluding federal match. Source: CMS NHE, Federal Reserve Bank of St. Louis

Employer spending

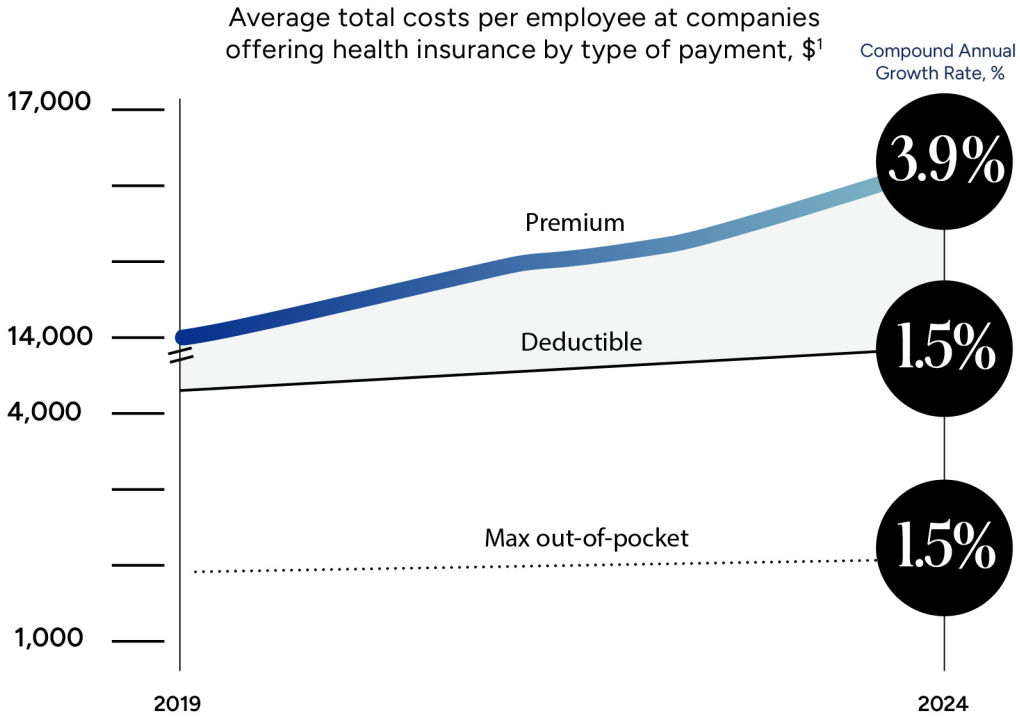
Employers are another major source of funding for healthcare costs, but their healthcare costs have been growing at rates faster than almost any other business expense. Their response? Reduce their contribution for the total bill by increasing employee contributions to premiums and increasing deductibles, co-payments, and out-of-pocket maximums.

Employer premium costs have increased steadily over time.

Source: Medical Expenditure Panel Survey



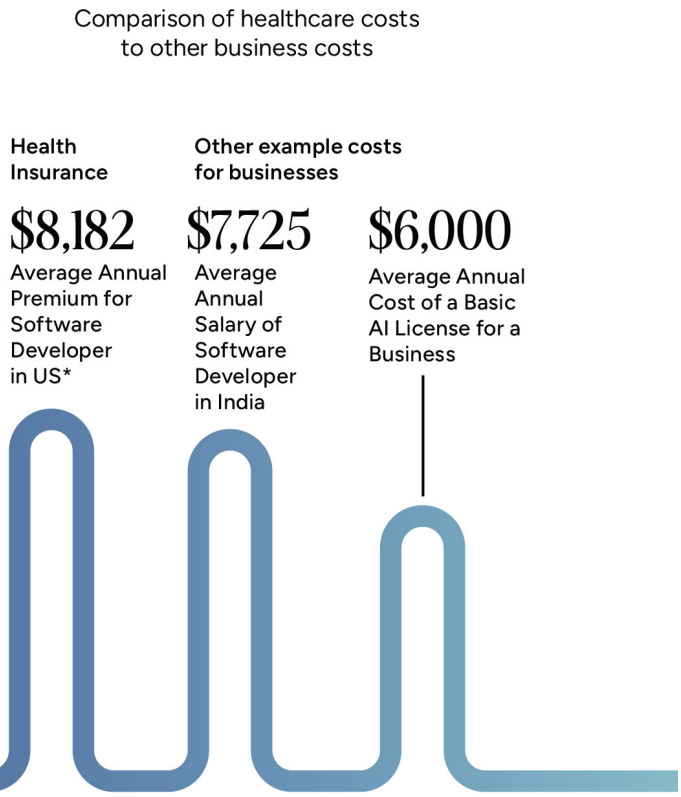
Out of pocket healthcare costs are rising



While challenging for employees, it is easy to understand why employers, particularly small employers, feel they have no other choice once you see the data. Healthcare costs are at such a high level today that they run the risk of swaying major business decisions, including who to hire.

Take this example:

Health care costs are forcing employers to consider economic alternatives



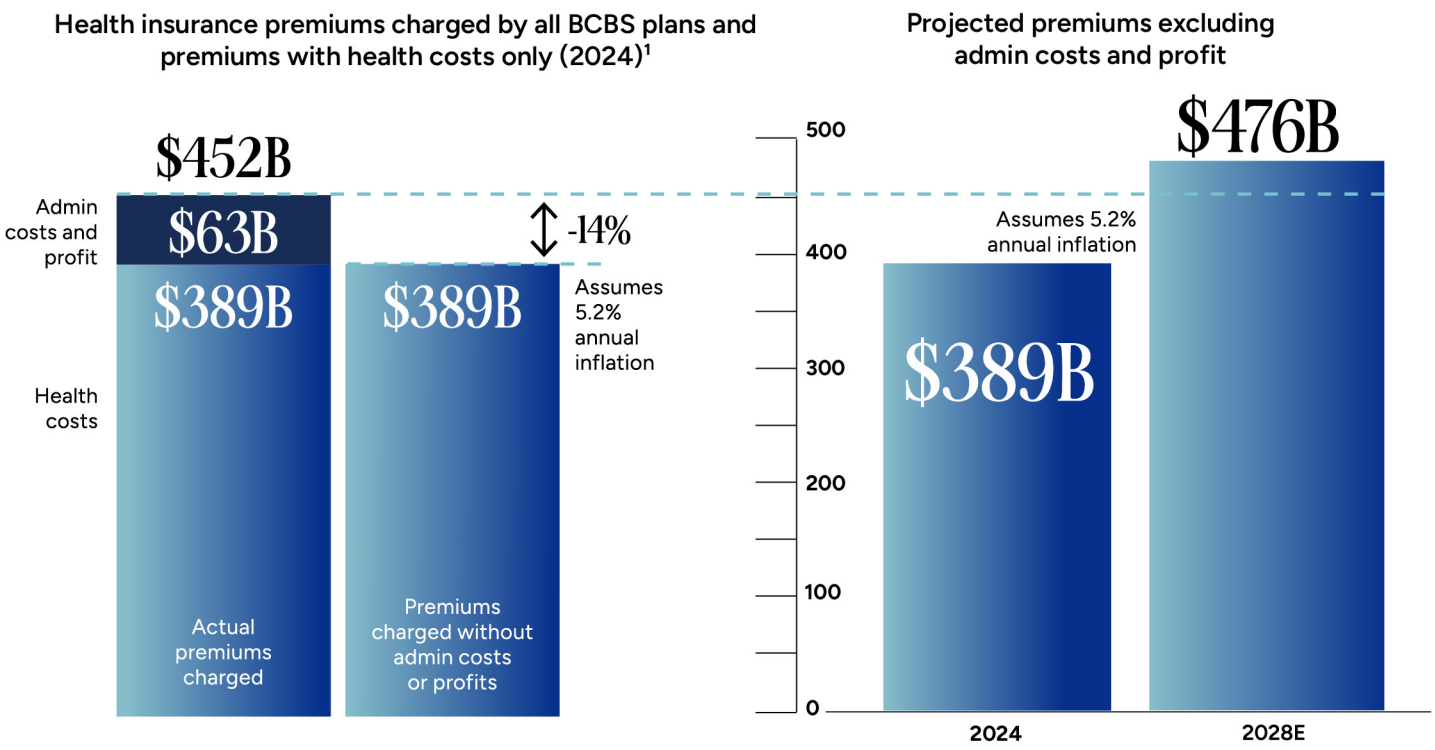
*Premium per single enrolled employee.
Source: KFF, CodeSubmit.IO, WebFx

Businesses are trying to keep the prices they charge their customers competitive, but they will struggle to do that if they keep paying the same percentage of a rapidly growing healthcare bill — and thus, rapidly growing expenses to the business. If healthcare costs continue their rapid rise, employers are also likely to actively explore options that can get the proverbial job done without having to pay for health benefits. Our workers — and our business owners, too — are worthy of so much more.

Health plan spending

Health plans are commonly believed to have plenty of money to cover increasing healthcare costs. However, let's look at an analysis of Blue Cross Blue Shield (BCBS) plans nationally as an example. As you can see, below, even if health plans have no administrative costs, paid their executives nothing and made no profit whatsoever, health insurance premiums would return to the same level as today within about three years, based only on healthcare costs. And, unless we make big changes, those healthcare costs are projected to keep growing from this level at a faster rate than inflation.

Administrative cuts alone won't fix healthcare costs.



[1] 2024 actual financials aggregated across 35 BCBS plans, including Elevance, based on exhibits and filings submitted to the National Association of Insurance Commissioners (NAIC). Covers health insurance operations and lines of business reported to NAIC only, including commercial, Medicare and Medicaid [2] Projected premium revenues if they were health costs only after applying projected CAGR for private health insurance spend (5.2% p.a.) as based on CMS National Health Expenditures (NHE) dataset

Source: NAIC Exhibits, CMS NHE

Across all BCBS plans actual premiums as of 2024 were $452B, incorporating both $389B in health costs & $63B in administrative costs and profit. If we removed administrative costs and profit premiums for these payers would be health costs only at $389B.

If we applied a 5.2% annual growth rate to hypothetical premiums based on health costs only across BCBS plans they would exceed actuals by 2028 and reach ~$476B.

There is also a misconception that health plans have plenty of "reserves" that could be used to pay for healthcare costs. Although regulators require health plans to maintain reserves to cover unexpected costs, the average health plan only has enough to pay for approximately two months of claims. Put another way, health plans could use up all their reserves by paying for claims for a few months, and then prices would have to go back to the levels in the prior chart and keep growing rapidly for the foreseeable future.

Health plans hold less than two months of claims in reserves.

Average reserves and monthly claims costs for health plans (2024)

* Calculated as total reserves (~$160B in 2024) and claims costs (~$1.1T) divided by 12 averaged across 262 health plans nationally that reported data on these metrics.

Source: S&P Global CapIQ, NAIC Exhibits

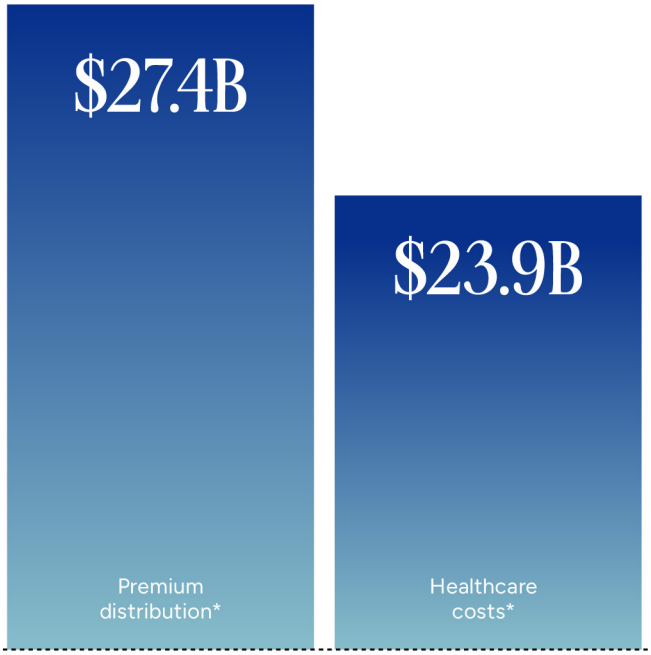
It might be hard to accept that health plans don't have more money to cover these rising costs, but health insurance is really a pay-as-you go model. As sourced in the following chart, about 86% of your health insurance premium each year is paid to physicians, hospitals, pharmaceutical companies and others for health care. In other words, most of all that money health plans collect in premiums each year goes to pay for healthcare costs in that year — which means health plans must charge ever-increasing premiums to pay for ever-increasing healthcare costs.

Health insurance is a pay-as-you-go model with 86% of premiums paying for the cost of health care

* Estimated using Blue Shield CA audited financials for 2024; uses total revenue from net premiums, other sources, and investment income; assumes Blue Shield CA would have achieved a 2% net profit margin, achieved from adjustments proportional to spend in each category (admin expenses, taxes and fees, healthcare costs).

**Estimated based on 8% of hospital costs (6.2% outpatient pharmacy, 1.8% inpatient pharmacy), and 10.6% of professional office-administered costs being allocated toward prescription drugs. Based on Blue Shield CA incurred expense report and Commercial claims analysis, 2024.
Source: Blue Shield CA Financials, Blue Shield CA Incurred Expense Report (2024), Blue Shield CA Commercial Claims Analysis (2024)

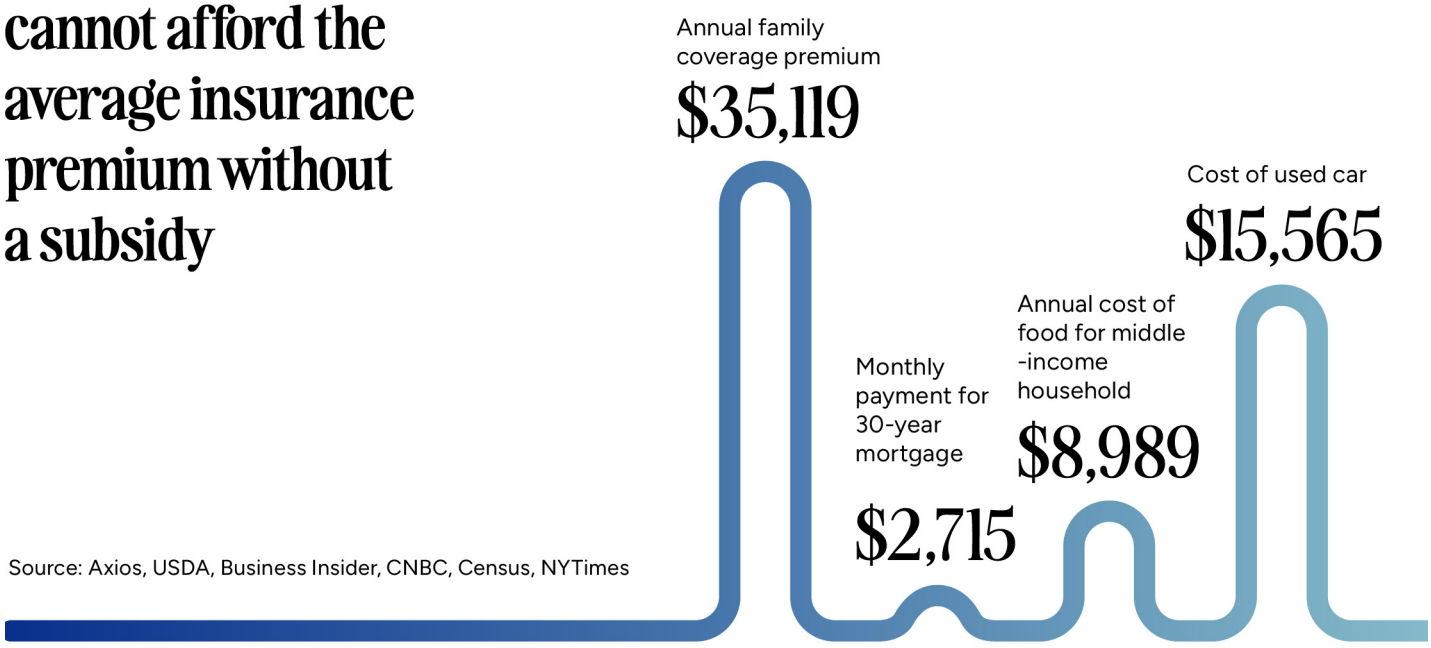
Blue Shield of California distribution of dollars (2024)



As you can see, the result of these relentless cost increases is that Americans can no longer afford the average health insurance premium without a subsidy.

The average American cannot afford the average insurance premium without a subsidy

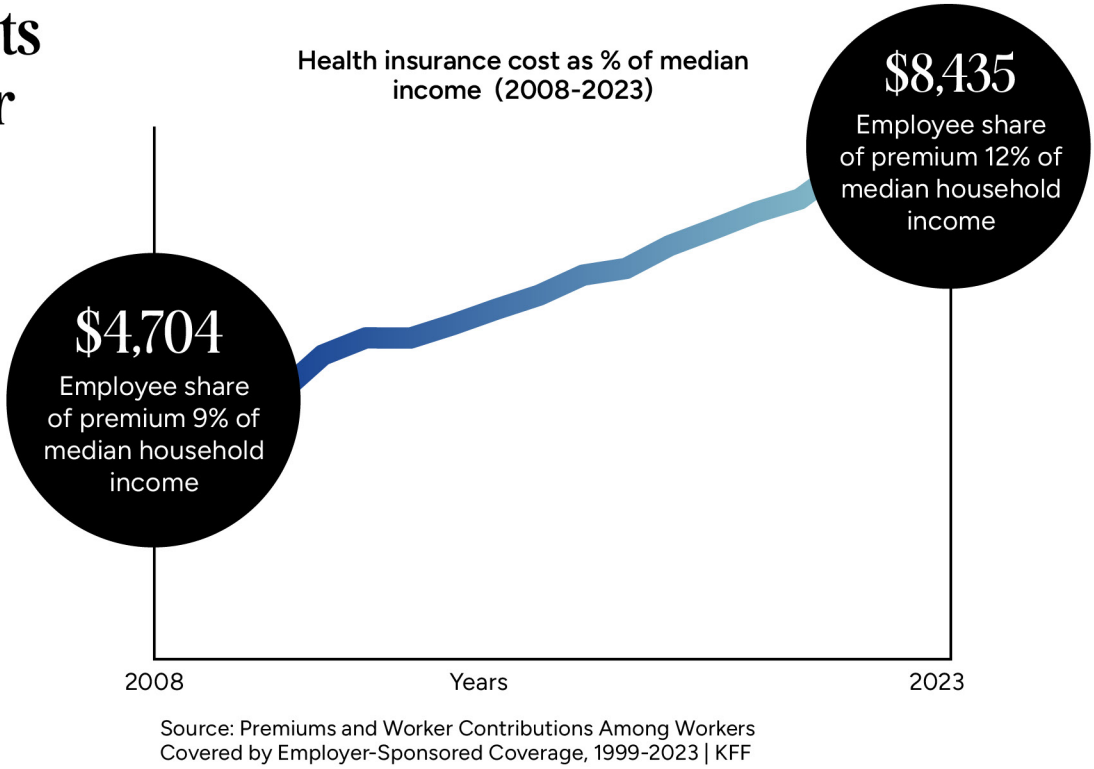
Average cost of health insurance vs. other priorities (2024)



Source: Axios, USDA, Business Insider, CNBC, Census, NYTimes

Fortunately, most Americans do get a subsidy for health insurance premiums from the federal government, the state government or their employer. That's what allows many of us to afford health insurance today. But, for every year healthcare inflation is higher than general wage inflation, the cost of that subsidy increases (see chart below)

Health care costs are rising faster than wages.



Source: Premiums and Worker Contributions Among Workers Covered by Employer-Sponsored Coverage, 1999-2023 | KFF

Entities providing subsidies to individuals and families do not have the financial means to keep growing those subsidies. Put another way, the money just is not there to keep paying for high increases in healthcare costs, and yet all the major participants in the industry are effectively expecting and demanding that this will continue.

I hope from this analysis you can see that the current state of our healthcare system is financially unsustainable, and we are approaching — if not already at — a critical tipping point.

The status quo has to change.

⚠ Nerd Alert Complete

READ MORE

Next: The cost and quality equation →

The cost and quality equation

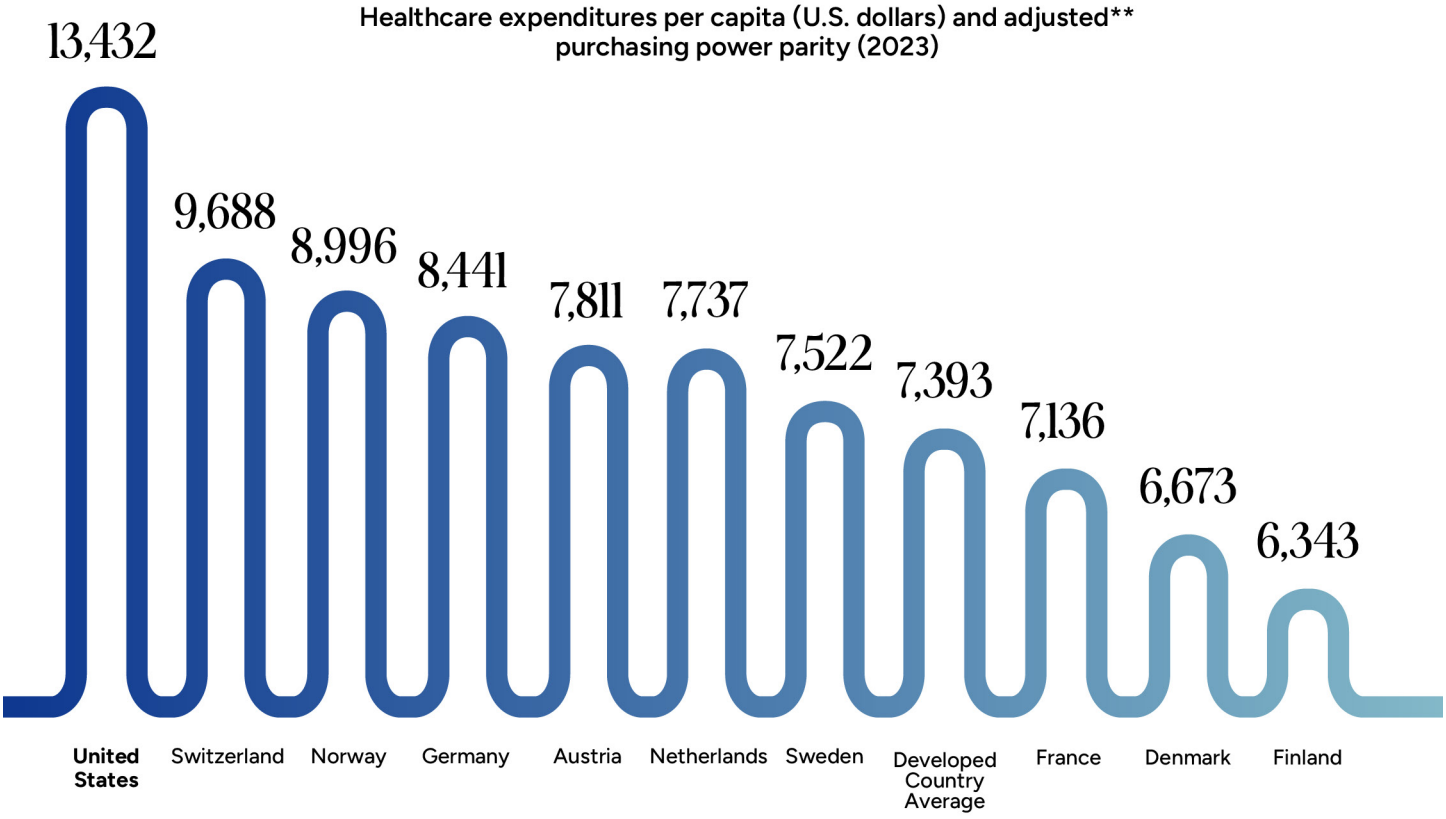
Americans pay the most for health care in the world, but don't get the best value.

While some people in our country do have the means to spend more money on health care, and there are certainly some amazing innovations happening in the U.S., the population-wide measurements for quality of care and consumer satisfaction tell a very different story.

Let's go through some comparisons between the U.S. and the rest of the world when it comes to healthcare costs and quality.

According to data sourced in the chart below, we spend nearly twice the amount of money per person on healthcare costs than the average developed country.

The U.S. spends twice as much on health care as other developed countries.



Source: OECD, KFF, OECD

[1.] Top 15 Organisation for Economic Co-operation and Development (OECD) countries with highest per-capita health spend selected to increase comparability to United States ranked in descending order in addition to developed country average

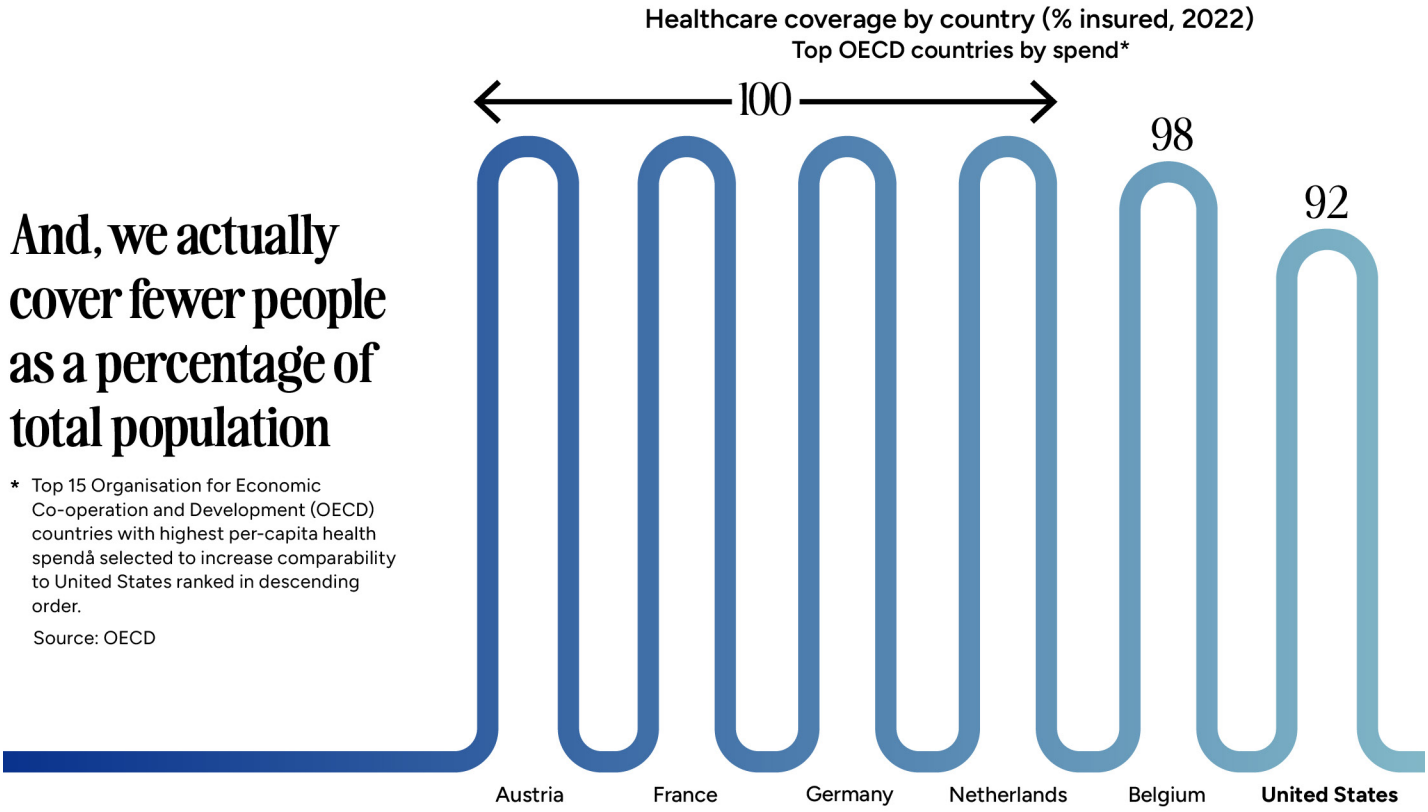
[2.] Using current estimated base prices as of 7/1/2025. Adjusting for purchasing power parity allows for better comparison between countries by eliminating differences in price levels and currency exchange rates between countries

Unlike other countries, we have a large population of people who do not have health insurance coverage, in large part because it is just too expensive for them. So even though we spend a lot more per person, our U.S. system actually covers fewer people.

And, we actually cover fewer people as a percentage of total population

* Top 15 Organisation for Economic Co-operation and Development (OECD) countries with highest per-capita health spendå selected to increase comparability to United States ranked in descending order.

Source: OECD

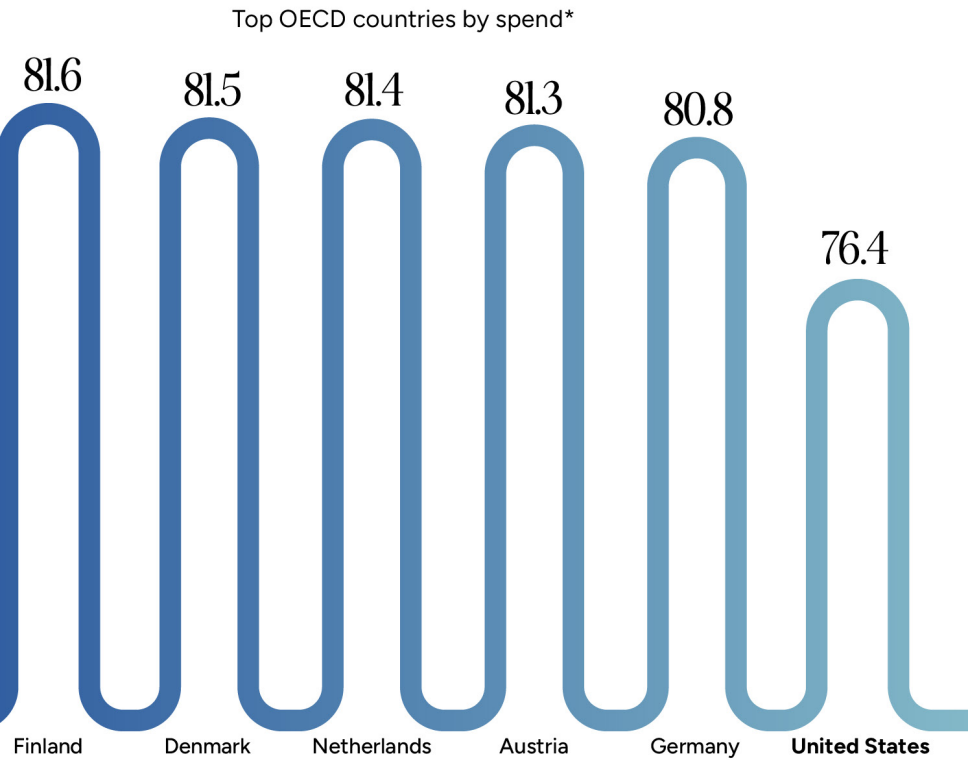


Unfortunately, our key healthcare quality measures also trail behind similarly developed countries, and so we are not getting the same proverbial “bang for our buck.”

Americans spend more on health care but live shorter lives than peers in similar countries

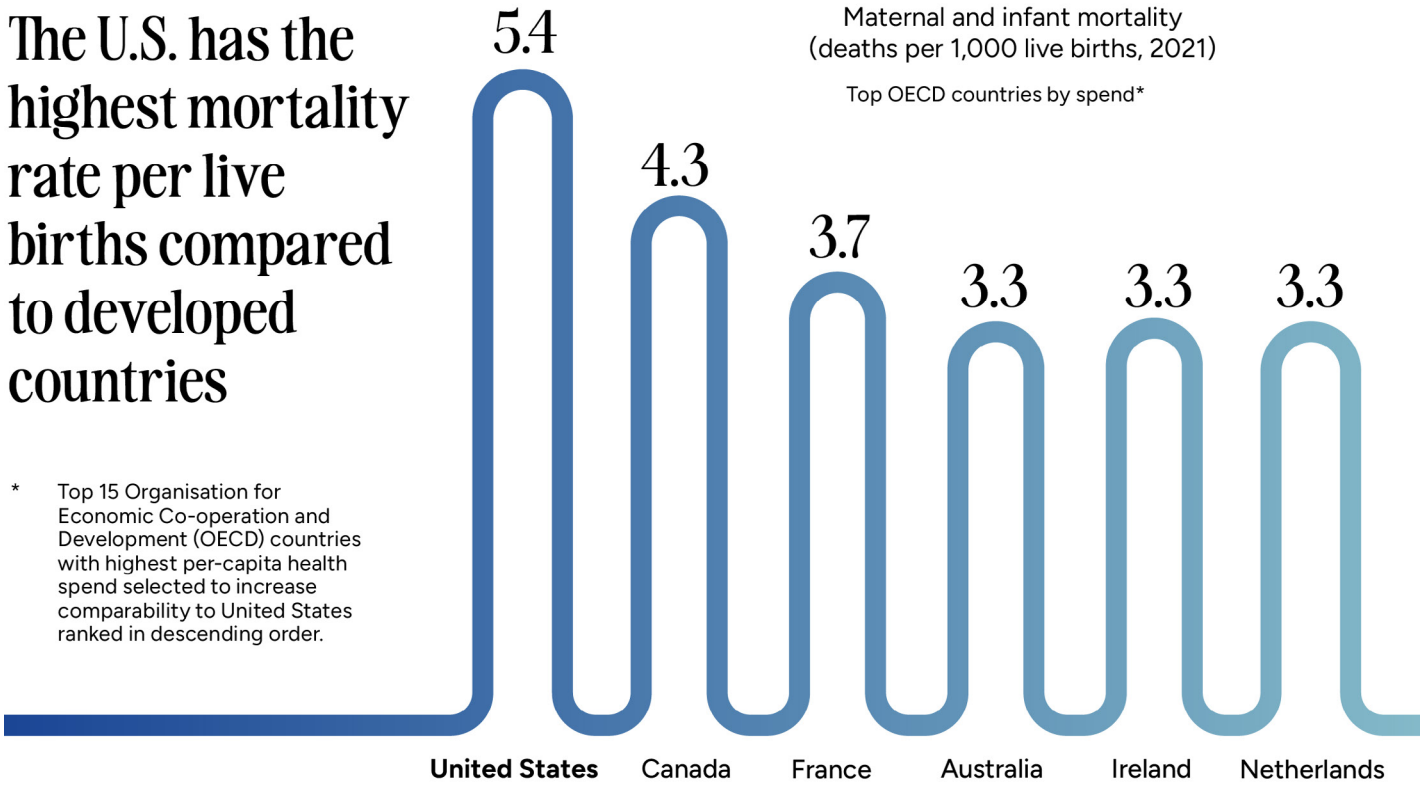
*Top 15 Organisation for Economic Co-operation and Development (OECD) countries with highest per-capita health spend selected to increase comparability to United States ranked in descending order.

Source: OECD



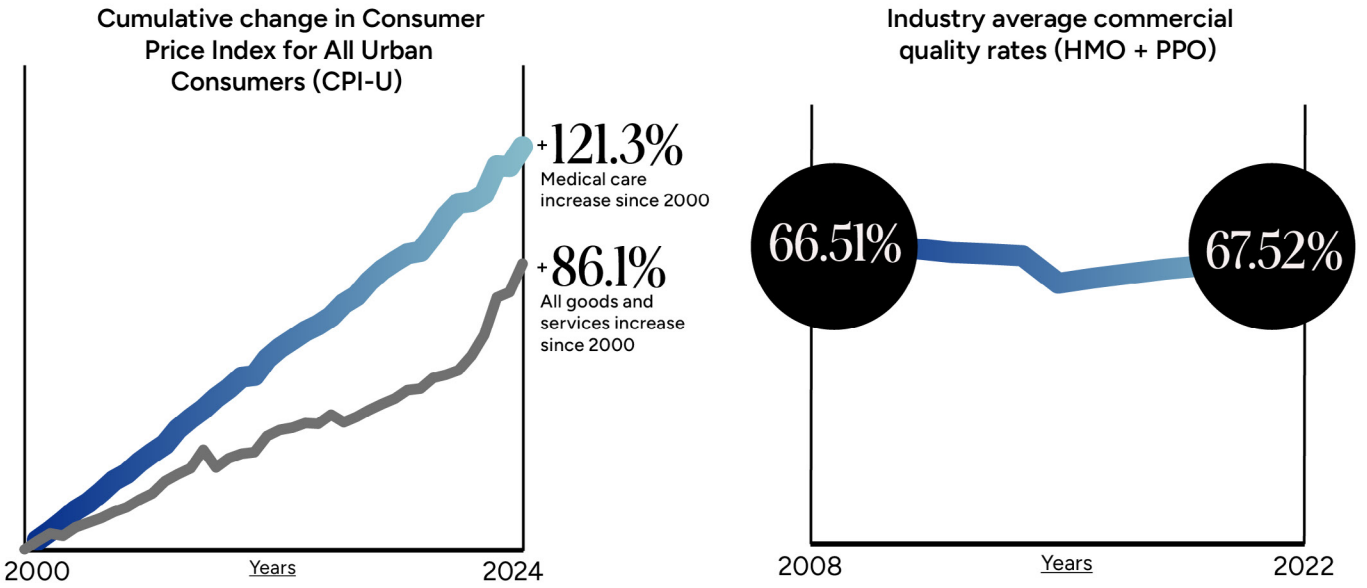
The U.S. has the highest mortality rate per live births compared to developed countries

* Top 15 Organisation for Economic Co-operation and Development (OECD) countries with highest per-capita health spend selected to increase comparability to United States ranked in descending order.



While we have been pouring more and more money into health care every year for decades, as the following chart shows, our quality scores have not been meaningfully improving.

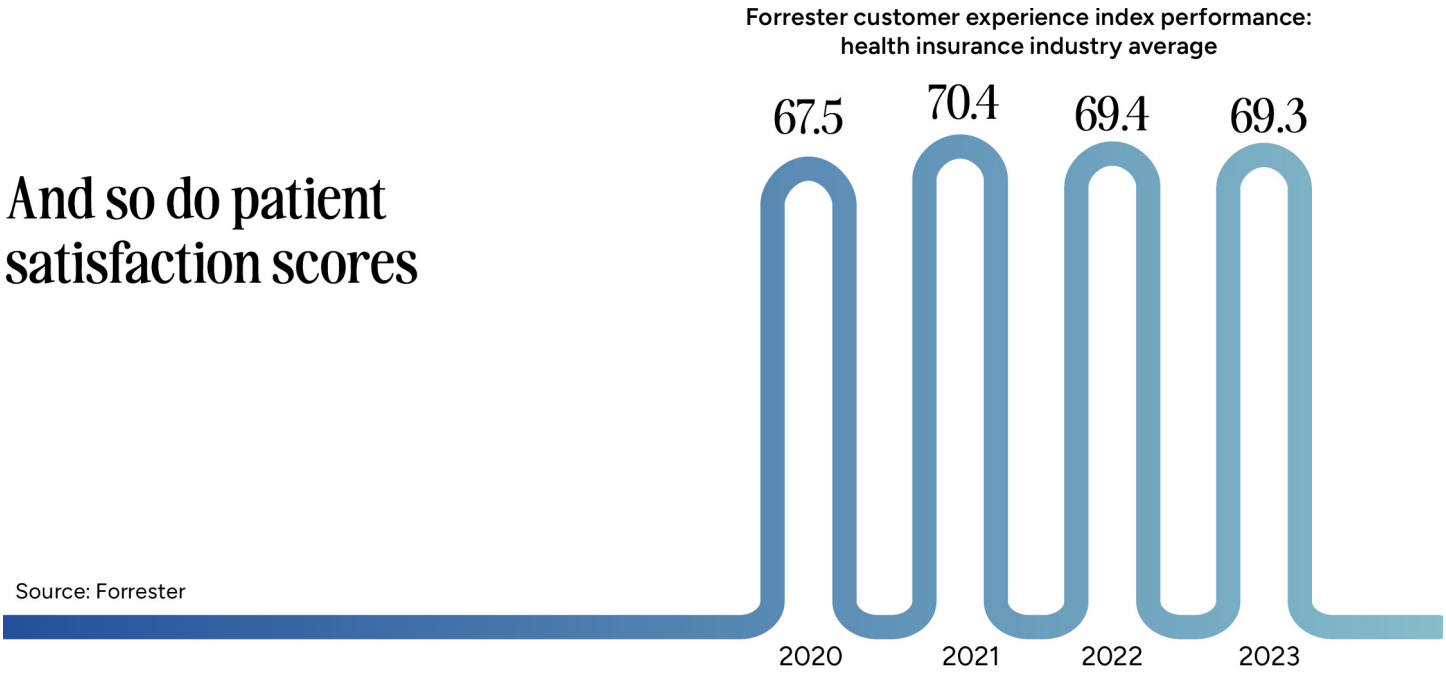
While we continue to pay more for health care, average quality rates remain flat



Source: KFF analysis of Bureau of Labor Statistics (BLS) Consumer Price Index (CPI) data , NCQA HEDIS Measures and Technical Resources.

And patient or member satisfaction hasn't materially improved during this time period, either.

And so do patient satisfaction scores



Source: Forrester

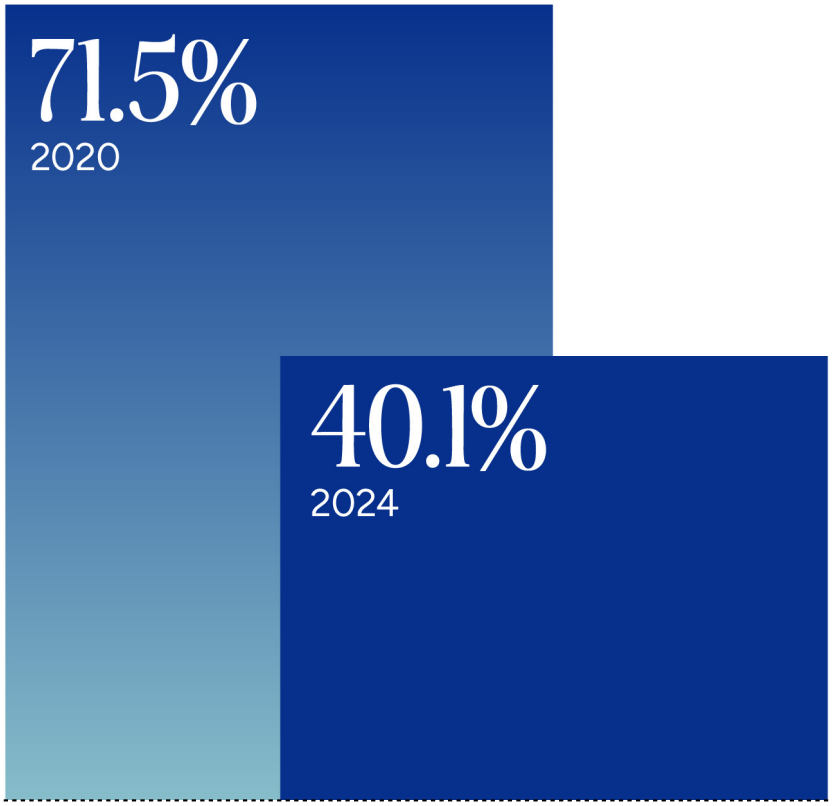
As these trends continue, trust in our healthcare system has been falling to very low levels. It's hardly surprising: The participants in our healthcare system keep collectively demanding so much more money every year, but they are not fundamentally improving the product and service that they offer.

As such, American's trust in the U.S. healthcare system is eroding

* Compiled from 24 waves of internet surveys administered across ~443,455 unique respondents. Survey utilized data from 24 waves of nonprobability internet surveys. Data were self-reported in response to the question, "How much do you trust the following people and organizations to do what is right?" Available choices in survey representing trust included "a lot" and "some." Available choices in survey representing no trust included "not much at all" and "not at all".

Source: JAMA, Qualtrics XM Institute, Gallup

Overall trust in our healthcare system is significantly low



To sum it up, **our healthcare system is both bankrupting us and failing us.**

We shovel huge, growing sums of money into this system every year, but don't get meaningful improvement from it — let alone hitting a standard worthy of our family and friends. Meanwhile, the healthcare industry explains why even larger sums of money are needed each year, and points fingers at others as to why our healthcare system is so troubled.

Now that we know how poorly our healthcare system is performing, the question is, why is it performing so poorly?

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Next: Houston, we have a system problem →

Houston, we have a system problem

A former colleague told me a story about how he encouraged his children to help around the house. The family had a few dogs who roamed around a relatively large, fenced backyard. Naturally, the dogs often relieved themselves, which led to a messy backyard that the family was hoping to use for other purposes as well. So, my colleague made a deal with his kids: I'll give you a dollar for each piece of poop that you clear out of the backyard. (I'm not quite sure how the pieces were counted and didn't have the stomach to ask.)

The system seemed to work well for the first little while, as the children enthusiastically scoured the backyard and then happily collected their money, from an equally happy father who looked out on the cleared backyard.

Then something unexpected started to happen. The amount of poop the kids were collecting each week was growing, and not just by a little, but by a lot. It finally led the father to start trying to figure out where all the crap was coming from.

It turns out he has fairly clever children, who decided to feed the dogs relentlessly (pretty much all day long), to produce more poop profits.

My colleague had discovered the problem, but then he had to decide what to do about it. One option would be to aggressively supervise the feeding of the dogs. There were multiple problems with this approach, including but not limited to the fact that he had a full-time job; very resourceful, highly motivated children; and willing accomplices in the dogs.

So instead, he decided to pay the children a flat amount for keeping the backyard clean, rather than paying by volume. Not surprisingly, the excess feeding stopped immediately, and the backyard still stayed clean.

While this may be considered an inappropriate metaphor for health care, I beg to differ. It really is this simple. In health care, we generally pay by the piece rather than for the result, and therefore the resourceful and highly motivated participants figure out how to generate **a lot** more pieces. The difference between health care and my colleague's backyard is that there are many times where healthcare results and patient satisfaction get worse when we add more "pieces." So, we end up with the worst possible outcome — we pay more but don't get the optimal results we're seeking.

Unfortunately, thus far, instead of following the path of my colleague and paying differently to address the problem, we've been trying to do the healthcare equivalent of supervising the feeding of the dogs. This has led to a long-running back and forth between physicians, hospitals and pharmaceutical companies trying to provide a higher volume of more intensive services and treatments, while health

plans attempt to put rules and oversight in place to identify and manage inappropriate or excess services. (Anyone ever heard of prior authorization?)

Patients can get stuck in the middle of this back and forth at the worst moments possible, because they're already not at their physical best (which is why they're seeking care) and probably quite stressed about their health situations. Who needs the additional stress of wondering whether a service is covered, or whether the words in the relentless pile of insurance documents saying "This is not a bill" are to be trusted?

The temptation in this situation is to call out the individuals and organizations doing this and try to "correct" their behaviors. But **one of the most important things I've learned in my more than three decades in health care is that you simply cannot fight financial self-interest effectively over a long period of time.** Much like my colleague's teenage children, the participants are just too motivated and resourceful — and, in the case of health care, the patient experience suffers when we try to do that. We need to change the **system** of payment, so that the participants have the <u>will</u> to use all their resourcefulness to deliver great, personalized care efficiently.

Let's walk through an actual example.

If you want to get the crap out of the healthcare system, start with colonoscopies.

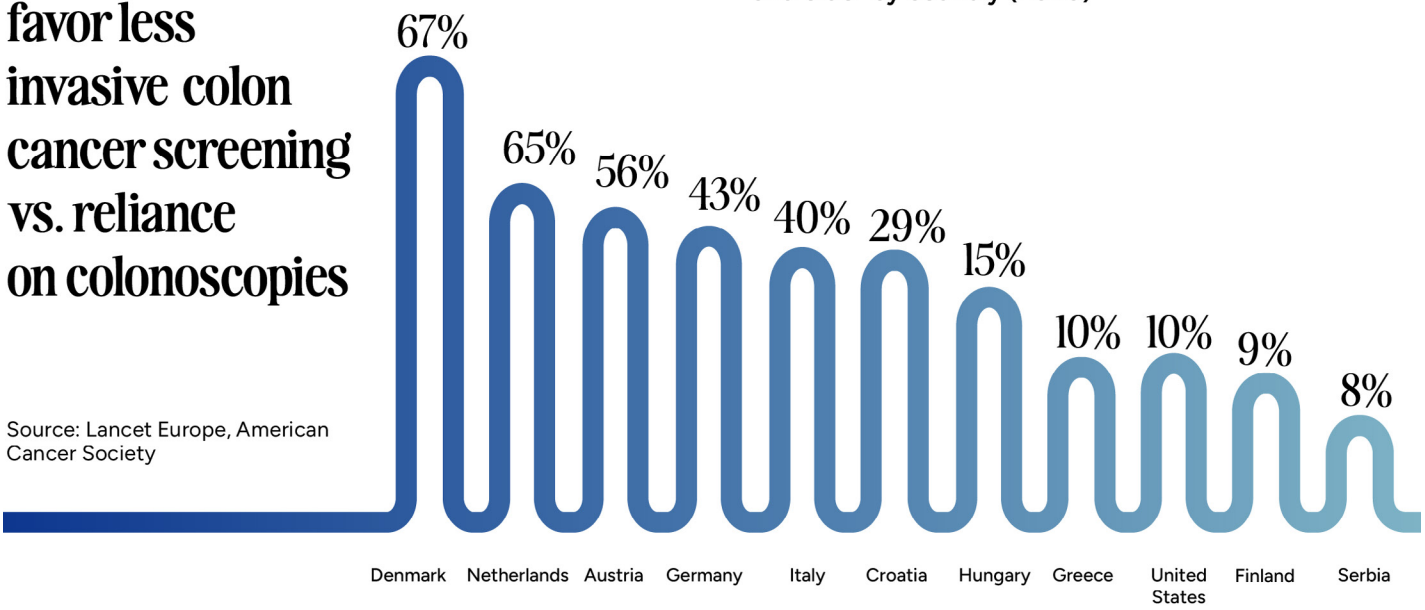
We have a series of preventive screenings that are recommended for otherwise healthy people of various ages and genders, largely designed for the early detection of cancers, like women of a certain age getting a mammogram on a regular basis. (By the way, I highly recommend that everyone follow preventive screening guidelines!) One of the preventive screens that we do is for colon cancer.

There are actually multiple ways to screen for colon cancer, including a colonoscopy or other device-driven interventions like a sigmoidoscopy, but also at-home fecal lab tests like a "FIT" test. As it turns out, clinical studies indicate that for individuals who have not been identified as high risk, the at-home tests are considered equally effective screening for cancer — plus they have the advantage of being a fraction of the cost, don't require people to take any time off work, and carry far fewer health risks (such as adverse effects of anesthesia).

This is one reason why developed countries all over the world have moved to using home testing, such as the FIT test, as a preferred method of colon cancer screenings for people who are not high risk. Look at just how prominent this testing is in nearly every country with a similarly developed economy to the United States.

Other countries favor less invasive colon cancer screening vs. reliance on colonoscopies

Utilization of fecal tests among eligible adults age 50+ and older by country (2020)



Source: Lancet Europe, American Cancer Society

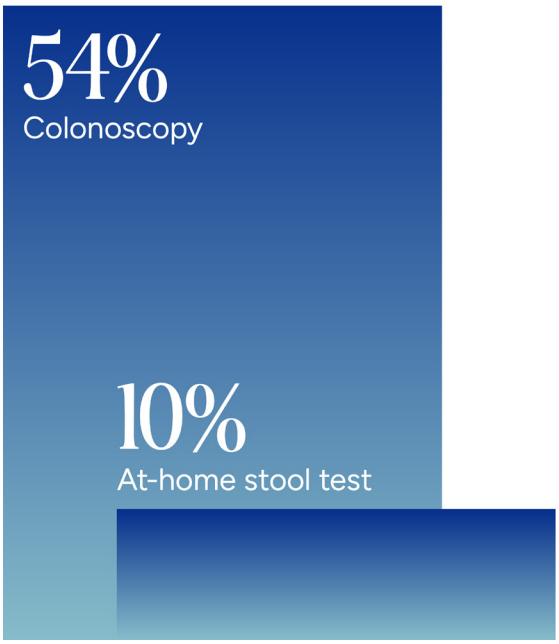
In the United States, as seen in this chart, only about 10% of people doing colon cancer screenings use the at-home tests, whereas over 50% get colonoscopies.

Why is that?

Only 10% of Americans doing colon cancer screenings are using at home-tests

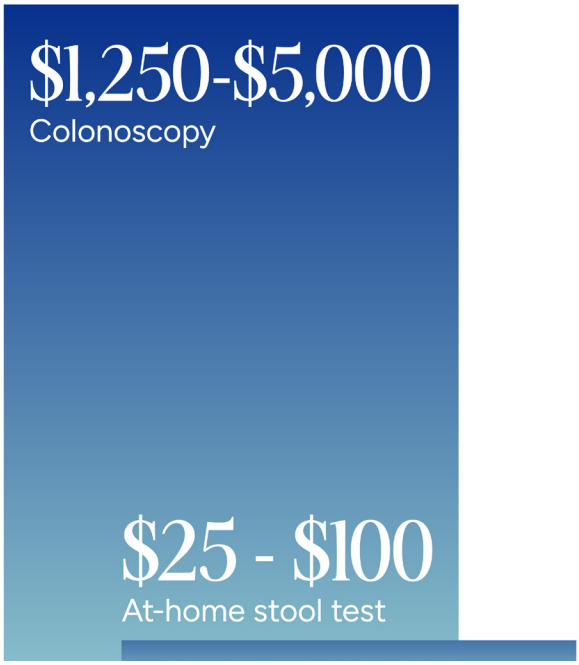
Source: American Cancer Society

Colorectal cancer screening rates among eligible adults age 45+ (2021)



One reason may be because a colonoscopy is way more profitable for the providers doing the screening than an at-home test. We are paying by the piece, and in this case the pieces are colonoscopies.

Average cost of at-home colon cancer screening tests vs. colonoscopies (2023)*



* National average cost incurred for these services by payers, including health plans and out-of-pocket costs for consumers. Price for colonoscopies affected by extent of pre- and post-procedure services; location; type of facility providing service, with hospitals generally costing more than surgery centers and other settings; and any polyp or biopsy costs
Source: Testing.com, GoodRX, Carecredit

There are plenty of additional examples of how the current payment system drives decisions that are more profitable and increase health care costs, but are not necessarily the best option for the patient.

All this demonstrates one of the major problems with today's healthcare system. The way participants within the system are paid does not give them the will or incentive to do the right thing for the patient every time. This is the driving force behind a lot of our health system's unsatisfactory performance, and yet, to date, we have largely tried to address the symptoms of that problem rather than its root cause.

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Next: Pay for value, not volume →

Pay for value, not volume

While there are a lot of different methods used to pay for health care in the United States, the most common way to pay for health care is based on "pieces" or what a lot of people call "fee for service." Physicians often get paid for each 15-minute visit, procedure and surgery that they do. Hospitals get paid when people stay in the hospital and/or access and use the services they offer, like colonoscopies. Pharmaceutical manufacturers get paid each time a prescription of their drugs are filled. Yet the healthier a patient is, the less of these "pieces" they require. Shouldn't our healthcare system incentivize health?

Here is where we start talking about the path forward.

Imagine if we paid participants in the healthcare system for the outcomes that our loved ones deserve, instead of paying by the minute, procedure or drug. Aligning compensation with improved health outcomes drives better health, enhances quality of care and lowers costs.

In general, the ideal way to pay health plans, hospitals, physicians and pharmacy manufacturers would be as follows:

- A per person, per month fee that is objectively adjusted for risk factors, e.g., the older and sicker a person is in general the more health care services they consume
- A per person bonus for health outcomes (clinical quality performance)
- A per person bonus for getting high customer satisfaction ratings
- A per person bonus for being cost-effective, e.g., what percentage of patients at low risk use a FIT test instead of a colonoscopy?

Under this model, doctors wouldn't need to be "on the clock" keeping all visits to 15 minutes; they would instead be incentivized to ensure you get the best possible care; they would treat you like the customer so that you give them high scores on the survey feedback; and they would be on the lookout for the most cost-effective and convenient care option for you.

Similarly, hospitals and pharmaceutical companies would see their services and products as ways to help patients get healthier and improve patient satisfaction while ensuring care is cost-effective. They would view the increased use of their services and products as a cost, rather than as an opportunity for more profit, and therefore would only use them if they believed it would lead to a better outcome and a more satisfied patient. The attitude would shift from "more is better" to "better is better."

Health plans would not have any incentive to try to insure only relatively healthy people, and they could significantly reduce the amount of time and energy required for prior authorizations. They would maximize their financial gain by pursuing higher quality and greater member and patient satisfaction, all while keeping their administrative costs and healthcare costs as low as possible.

Perhaps even more importantly, all these participants would quickly realize that in order to improve quality outcomes, patient satisfaction and costs, they would need to cooperate and work together much better than they do today. For example, there would also be serious motivation to dramatically improve the flow of information about a patient and coordinate efforts to ensure care needs do not slip between the cracks.

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Next: Digital health and automation →

Digital health and automation

Much of the inefficiency, delays and frustrations with the current healthcare system boil down to using outdated technology and highly manual processes to share information and complete basic transactions. It's astounding and completely unacceptable to discuss this in the year 2026, but even though patients have a legal right to their data today, most people have to piece together information from multiple sources (like different physicians, hospitals and health plans) to try to create a comprehensive record. It is a bit like having to contact the company where you made an on-line purchase, the local grocery store, the gas station and a host of other companies where you used your credit or debit card in order to pull together your monthly financial statement.

Creating this kind of record can easily be done, but is a perfect example of the healthcare industry needing to be told what to do. I spent over a decade trying to talk all the different participants in the California healthcare system into voluntarily working together to create these records, without success — and finally broke through when we helped convince the State legislature and the Governor to sign a law requiring the sharing of data. Now, Blue Shield of California members can access their digital health records on their phones or favorite devices.

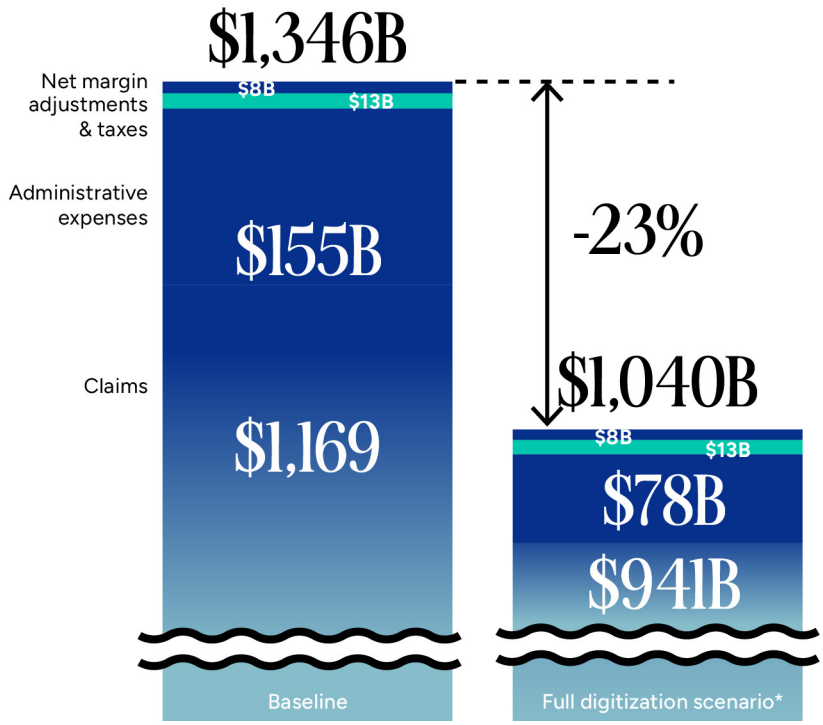
Once we have this record, we can take steps to eliminate or reduce administrative costs and burdens, and dramatically improve the experience of patients, doctors and other clinicians with automations and real-time support, such as:

- Completing prior authorizations in real time, just like credit card authorizations
- Supporting a highly personalized, shared decision-making process between the patient and the physician (see below for more on this)
- Highlighting steps the physician and/or patient can take to improve clinical quality (often referred to as "closing care gaps")
- Calculating clinical quality scores and submitting accurate data to regulators
- Processing and settling all claims and other provider payments
- Facilitating the appropriate use of technology, including artificial intelligence

Health plans can and must reduce their administrative costs by 30–50% as soon as possible. In order to do that, all health plans will need to automate the workflows listed above, among other things. With a digital health record and adoption of new technology and workflows, I would suspect that our physicians, hospitals and other clinicians could easily experience productivity improvements of 30% or more, as well.

In short, creating a comprehensive, real-time digital health record and fully and appropriately utilizing available technology, including artificial intelligence, to drive real-time automation could reduce healthcare system costs. As reflected in the following chart, this reduction would be around $306 billion, representing approximately a 23% decrease in health insurance prices annually.

By bringing health care into the digital age, we could save approximately $306B annually.



* Assumes 50% reduction in health plan administrative expenses and 20% reduction in claims as a function of 30% lower provider administrative expenses & labor costs, with 100% passthrough to reduced health insurance prices; assumes typical provider spends 65% of revenue on administrative expenses and labor; assumes adjustments & taxes and net margin remain constant from baseline
* Source: NAIC Exhibits, Payer 10-Ks & earnings calls

All these savings could happen without changing any of the health care that's being provided today.

The reality is that the industry is decades behind in using technology to make health care far simpler, more automated and able to function in real time — just like we operate in the rest of our lives.

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Next: Putting personal care at the center of health care →

Putting personal care at the center of health care

The human body is incredibly complex, and the pace of discovery is beyond the capacity of any individual, no matter how intelligent or well-trained. A study by PubMed in 2004 calculated more than 7,000 articles per month published in primary care journals that physicians trained in epidemiology would need to read to be fully up on all the latest research — which would require a physically impossible 29 hours per weekday of reading. This study demonstrates that it isn't possible for practicing physicians, or anyone else, to keep up with the speed our society is gaining important, fact-based insights on how to improve health.

In fact, a widely cited study published in Health Affairs in February 2018 estimated that it takes about 17 years on average for robust clinical research findings to be incorporated into routine clinical care by 50% of eligible clinicians.

In order to hit the standard of "worthy of our family and friends," that gap needs to be brought from 17 years to zero, and from 50% to 100%. If one of my loved ones needs care, I want to know that the clinical options offered are based on the latest available, credible research rather than a decades-old habit. I also want those options to be personalized to their particular circumstances. But there's no way to do this if the basic understanding of treatment options is outdated.

In addition, I want the physician to be fully engaged in listening to, speaking with and examining my loved one, rather than staring at a computer screen and typing. People complain all the time about how impersonal it feels when physicians are not making eye contact or otherwise engaging in a manner that helps patients feel heard, seen and understood.

How do we improve this? We need to personalize care.

- This means physically personalized care, e.g., determining the best therapeutic treatment for a cancer diagnosis based on the genetic profile of the cellular mutation. But it also means mentally and emotionally personalized care, ensuring there's a warm, trusting, human-to-human relationship and interaction happening between the patient and their caregiver(s).
- The technology exists to make personalized care a reality. With the comprehensive, real-time digital health record, patients and caregivers will have all health information accessible in a central hub. By appropriately using artificial intelligence, doctors and patients can find all the most recent, credible evidence available in the world regarding any particular health condition(s), including the pros and cons of different treatment options. This may very well include recent research the clinician has not had time to read.

- Patients and physicians can then discuss those pros and cons and land on the treatment option that's best for that individual, in a process the late Dr. John E. (Jack) Wennberg called a Shared Decision-Making Model.
- In addition, physicians and other clinicians are increasingly using "ambient dictation" and artificial intelligence to record their clinical notes and electronic medical record automatically by tracking a natural conversation with the patient during a clinical visit. The technology completes all the necessary documentation during the course of the patient visit, the physician reviews and confirms the records as soon as the visit is over, and the audio recording of the visit is destroyed. In addition to helping the physician be much more efficient, it also allows them to fully engage with the patient without having to do any typing or screen-watching.

By taking this "high-tech and high-touch" approach, we can truly personalize care for everyone.

A system worthy of us all

The American healthcare system is at a breaking point—financially unsustainable, structurally flawed, and emotionally disconnected from the people it serves. But this crisis is not inevitable. By shifting from volume-based payments to value-driven outcomes, embracing digital automation, and restoring the human connection at the heart of care, we can transform health care into a system that is not only affordable, but also compassionate, efficient, and deeply personal. The path forward demands courage, collaboration, and a commitment to change. Because our families, our communities, and our futures are worthy of nothing less.

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