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Discovery: defining health and discovering progress

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In an article in the January 26, 2009 issue of The New Yorker, Dr. Atul Gawande provides an insightful analysis about how industrialized nations, except the United States, have come to reform health care, and provide coverage for all their citizens. "In every industrialized nation, the movement to reform health care has begun with stories about cruelty… the stories become unconscionable in any society that purports to serve the needs of ordinary people, and, at some alchemical point, they combine with opportunity and leadership to produce change."

The question for America is: Has that alchemical moment arrived? Certainly a mountain of facts has convinced almost all major policy makers that something must be done to correct a medical care system greatly out of balance. But we must begin any discussion by finding the most common of grounds: How do we define health?

The Institute of Medicine has a definition that is widely used and accepted which is: "Health is a state of well-being and the capability to function in the face of changing circumstances." With this definition we have a much richer understanding of health and break away from the limits of simply "sick" or "well." More than a third of our citizens who are overweight may not be "sick" in the active sense of the term, but they are also not healthy as they are at much higher risk of chronic disease than others. The 45 million Americans who do not have any form of health insurance may not all be "sick" each day, but their health is threatened each day because if their circumstances change they will not have the capability to function in the face of those circumstances as well as someone who does have health care coverage.

I have been involved in Health and Health Policy professionally since 1971. Over those many years there have been times I thought that the moment had arrived when we would produce fundamental change to our health and health care system. I thought that the fact that half of the personal bankruptcies in this country are triggered by health bills would offend the leaders of the wealthiest country in the world. I thought that the United States ranking 19 out of 19 countries in the category of mortality amenable to health care (that is, lives that could have been saved if treatment was given) would stir us to action. I thought that the fact that about half of American adults have reported some type of poor care coordination that affected them would move us to action. I have been wrong each time. I believe, however, that our time may have come. In part it is a combination of many of the things mentioned above with the added reality of the sheer weight of the cost of care. Here in New Hampshire as an example, the average family premium for private sector employees is the highest in the country.

This movement toward reform has been a very complex and winding path, but there are actually a few very simple principles in place this time that will combine to allow true effective reform to happen. As we follow the debate, the discussion, the polemics, and the posturing that will be a part of any potential transformation, there are five basic parts of that discussion that must be understood.

one: *We can achieve universal coverage.*

After all, every other industrialized nation on the face of the Earth has done it. They have not all done it the same way, but they got it done. Those who would argue that we don't have the capacity as a country to accomplish what everyone else has will find themselves left behind. Ironically, the three basic ways other countries provide coverage all exist to a degree in America. In some countries all health care providers, facilities, and the financing is run by the government. If you are a member of the Armed Forces in the U.S. that is how you get your care. In some countries the providers and the facilities are all private and only the funding is run by the government. If you are on Medicare in the U.S. that is how you get your care. In some countries, providers, facilities, and the funding is all done by private companies. If you get your insurance through work or buy it individually, that is how you get your care. The difference is other countries don't leave 20 to 25 percent of their citizens without any coverage. We do. And just

as a final point, they cover everyone; they spend about 8 percent of their GDP. We spend 16 percent but they have better health outcomes. As Dr. Gawande asks, has the cruelty reached a point where we must act? There is a difference between not being able to do something and not wanting to do something. We are able.

TWO: *To accomplish the goal of coverage in an effective and affordable way, we don't have to do something that we have never done before.*

Rather, we have to replicate what high-performing health systems here in the U.S. are doing today. Two recent studies underscore this critical issue. A Milliman Research Report published in February 2009 shows that if all our health care delivery systems were run as well (from financial and quality perspectives) as the country's best, we would reduce our health spending from 16 percent to 12 percent of GDP (still the most of any industrialized country) and be able to cover the 50 million Americans who go without coverage today. They lance the myth that we can only do this if we "ration care" by saying clearly: "We consider 12 percent a target for what is possible, not a budget. We believe rationalizing care is far superior to rationing it." Another study done by Dr. Elliott Fischer and his colleagues at Dartmouth and published in the *New England Journal of Medicine* in February 2009 notes that if we reduced the annual growth in per capita spending for Medicare from its current national average of 3.5 percent to 2.4 percent (which is the actual rate in the San Francisco area) by the year 2023, rather than having a $660 billion Medicare deficit, we would have a $758 billion surplus, a $1.42 trillion savings. So again to those who say, "It can't be done" the proper response is, "It is being done; find out where and how, and replicate it."

THREE: *The current dominant form of payment—"fee for service"—needs to be fundamentally redesigned.*

Our current payment system is at odds with our goals for a reformed health care system. It fails to adequately incent or support quality and efficiency, and it ignores evidence-based practice and care coordination. As a result, we have witnessed an erosion of primary care and wellness; a continued, yet unsustainable, rate of increase in costs; a deeply fragmented system of care; and a worsening of health status indicators and levels of access.

The Citizens Health Initiative, which the Institute for Health Policy and Practice at UNH leads, initiated a project in February 2009 to address these challenges. We believe that stakeholders in New Hampshire are uniquely positioned to design and implement a payment system that values, prescribes, and rewards medical care that is tightly coordinated and of superior quality and efficiency.

Our goal is to move to a payment system in New Hampshire that lets us:

- Align payment, goals, and incentives across the systems of care: primary, specialty, behavioral, ancillary, and hospital;
- Align goals and incentives across employers, payers, and systems of care;
- Address the unsustainable rate of growth in health care expenditures;
- Reward explicitly defined quality care;
- Reward excellence in the delivery of evidence-based clinical practices;
- Incent the use health information technology;
- Recognize administrative best practices and lean processes; and
- Serve as a model of transparency.

Similar efforts are taking place in other states and will certainly be a central feature of the national reform effort. But true reform also requires that we look beyond the medical treatment system in our efforts.

FOUR: *This is health and health care reform, not just medical system reform.*

We must remember the definition of health to initiate true reform. Consider the following. From the year 1900 to the year 2000, life expectancy in the U.S. went up 30 years. Of those 30 years, 25 were the result of public health efforts like clean air, clean water, safe workplaces, immunizations, re-engineered roadways, and safer cars. Only five of those years were as a result of medical treatment advances. While we spend 90 percent of our health care dollars on the treatment of illness, the things that really affect our health are our behaviors, the environment, and heredity. As a result we need to assure that health reform takes place across all aspects of our community. In the city of Keene, N.H., the Cheshire Medical Center and the Hitchcock Clinic are leading a program called Keene 2020. The goal of the project is to make sure that Keene becomes the healthiest community in the country by the year 2020. The effort involves the Community Mental Health Center, community businesses, the school system, so-

cial service agencies, and a wide range of community players. Here at UNH we are launching not only this Discovery discussion on health but also a Healthy UNH effort, which will have as a goal to make UNH the healthiest university in the country by the year 2020. These are the kinds of efforts that will be critical to move beyond our current model of almost exclusive reliance on medical treatment and be about the task of creation of health.

FIVE*: There is one final part of reform that will allow us, in the words of the Institute of Medicine, to cross the quality chasm in our systems of care.*

Fifth and finally, the acquisition and deployment of Health Information Technology (HIT) and Health Information Exchange (HIE) throughout our system of care is critical. If offers a necessary tool on a path to making substantial progress in improving the health of our people through improved patient safety, enhanced quality, health cost reduction, consumer engagement and empowerment, expanding access, and improved monitoring and provision of public health. The stimulus package that has become law will be providing $19 billion for the expansion of Electronic Medical Records and other HIT. It will become critical that we spend these dollars not to set up individual electronic islands at practices around our state and country but to assure that we are able to connect those sites so that secure critical information can be available to patients and the many clinicians who help treat them. Done well, the application of these information tools can substantially improve our health and health care system.

So in sum, the opportunity for reform is before us, and it is well within our capacity to create a better system that serves all our people. We cannot stabilize our economic present or secure our economic future without reforming our current health and health care system and making it available to every one of us.

As I have observed, we are already doing it right in many places in this country. The time has come to do it right everywhere in America. The time has come to get on with that job.