

Health Care to Health: The Unfinished Business of the Baby Boom Generation—Part II

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Clearly, this is not a system that can achieve the three objectives listed [in Part I of this article (*CSA Bulletin*, Summer 2009) which are 1) improving population health; 2) reducing per capita costs; and 3) improving patients' experiences], no matter who pays for it. Addressing this challenge will require *transformational change*, change that cannot be accomplished by limiting ourselves to incremental tinkering within the context and constraints of the deeply flawed structure of the current system. So let me offer what I believe would have to be the key elements of a system that *could* achieve our objectives.

First, we need a more equitable and sustainable financing structure. Categorical eligibility should be eliminated and replaced with a publicly financed floor with eligibility for a public subsidy based on financial need, not on arbitrary categories.

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Because of the reality of fiscal limits, however, this would require the development of a *defined benefit* through a transparent public process in which priorities are established among health services based on their relative effectiveness in producing health for the entire covered population—very similar to the prioritization process used in the Oregon Health Plan. This “basic level of care” could serve as a floor for everyone—which is the most efficient approach from an administrative standpoint—or only for those below a certain income level with a system of sliding-scale subsidies which gradually phases out as income goes up.

Second, this financing and eligibility structure must include “value-based cost sharing,” in which copayments are used not just to shift costs to individuals, but to help drive individual behavior and accountability within the context of the agreed-upon system objectives. This means that there might be little or no cost sharing for those services that are extremely effective and rank higher in priority, in terms of their impact on improving population health, and higher cost-sharing for elective, discretionary services and those that are lower in priority.

Health Care to Health (cont'd)

Value-based cost-sharing acknowledges the reality that those with more disposable income will always be able to purchase additional services beyond those financed with public resources. It acknowledges that there will inevitably be at least two tiers based on income—but there should not be *qualitative* difference between them in terms of health outcomes.

Third, care within this “floor” must be organized in a way that moves beyond the “one size fits all” acute care model which underlies our current system—and in a way that recognizes the range of very different delivery challenges we face. I believe that we must redesign our delivery system around at least those five families of conditions which currently account for the vast majority of cost in the system and the vast majority of patient encounters, but which—if properly managed—could significantly reduce cost and improve health. These families of conditions include:

- Pregnancy, Childbirth, and Early Childhood Care
- Acute Fatal Conditions (e.g., acute MI, major trauma)
- Chronic Fatal Conditions (e.g., diabetes, CHF, asthma)
- Acute episodic nonfatal conditions (e.g., cystitis, minor URI)
- End-of-Life Care

Fourth, revenue must flow to risk-bearing entities organized at the regional or local level, each of which would bear economic risk and *assume responsibility for the health of a defined population*. This entity could be:

- A hospital or health system with an affiliated physician group
- A large primary care group practice in partnership with payers
- A powerful, visionary health plan
- A “Health Development Organization”
- ***An entirely new entity***

This concept is perhaps the most radical—yet in my mind the most essential—component of a new system if we hope to change our focus from health care to health. Organizing the delivery of care at the local and regional level recognizes the reality of local and regional differences and it provides a “single point of contact” for each individual within the defined population. And it serves as an “integrator”—to ensure that the necessary investments are made to establish trajectories for health—focused on prevention, health promotion, and improving the conditions of children’s lives. These investments include not only medical investments, but the wide array of social and civic programs and services which are currently under-funded and uncoordinated.

Finally, payment for the basic level of care in the floor would take three forms. The initial form would be a monthly/annual risk-adjusted “subscription”

Health Care to Health (cont'd)

payment to cover the cost of maintaining the relationship with each individual and fulfilling the integrator function I just described. This payment would cover:

- Patient education
- Maintaining an electronic medical record
- Individual case management
- Coordinating care and services
- Office visits, home visits
- 24/7 consultation

The next form would be a bundled payment—also risk adjusted—to cover the cost of managing complex conditions, especially those requiring hospitalization.

The final form would be an annual performance bonus payment for high quality care (i.e., improving the health of the population, reducing complications, hospitalizations, etc.).

Traditional fee-for-service reimbursement would continue to flourish in the secondary insurance market for those services not covered in the floor.

Obviously, what I have just described does not even remotely resemble what we have today. And moving to such a system poses a huge challenge because of the sheer number of economic stakeholders invested deeply in the status quo. When any proposal to change the system is introduced within the legislative process, each stakeholder does a quick bit of mental calculus and often concludes that moving from the current system to the proposed system would disadvantage them economically. Thus, each of these stakeholders becomes a political advocate for or against a proposed vision for a new health care system based on how they think it will impact them economically in the short term.

These competing economic interests have thus been able to effectively block any serious consideration of a solution to a problem that poses a clear and present danger to our nation.

The point is that it is not only *politically* impossible, it is also *economically* impossible to move from our current health care system to a new one overnight. It is going to take some time and will therefore require a transition period. The problem is that, because of the significant trapped equity in the way our current system is organized and financed, the economic burden will go up for many stakeholders during the transition period. And these stakeholders, all of whom have a significant influence over the political process, are able individually and/or collectively to block anything that will affect their

Health Care to Health (cont'd)

short-term economic interests adversely. Furthermore, our political process tends to invest in crisis rather in prevention.

In order to successfully put together the politics of health care reform, we must be able to transcend the transactional stakeholder politics that anchor us to the past by *shifting the focus of the debate* from where we want to end up to how we are actually going to get there.

The challenge here is to make the politics of the transition period explicit by acknowledging and legitimizing the economic interests involved, by shifting the focus of the debate away from the narrow question of how a given stakeholder may be impacted adversely in the short term, to the much more productive question of how the economic impact on all stakeholders can be mitigated during the transition state.

But without first agreeing on the future state, there is no political pathway by which to get there. As the Roman Senator Seneca said, “No wind is the right wind if you don’t know what port you’re sailing for.”

Unfortunately, there is no evidence that this shared vision will emerge from our current political leadership—or from many of the economic interests so deeply invested in the status quo. But I believe that it can, and indeed, that it *must*, emerge from us.

Meeting this challenge requires three steps. The first step involves laying the foundation for reform. We need to agree upon a set of clear system objectives, an accurate diagnosis of the problem, and a description of the key design elements necessary to achieve objectives. Unfortunately, this key step has been bypassed by the mainstream debate over health care in America today.

The second step involves managing the transition. Doing so requires not just regulation, but intentionally engaging the economic market—particularly entrepreneurial capitalism—to create an enterprise that becomes ever more profitable by promoting wellness and prevention and reducing avoidable acute care.

The third step involves creating test sites—for example, a hospital with an affiliated physician group that decides it wants to transform itself along the lines of the key design elements we have been discussing. Because of the deep structural flaws in the current system, this effort will inevitably run into a variety of statutory, regulatory, and structural barriers that will prevent it from moving to scale. Exposing these barriers, however, creates an important tension between the current system and the new model, thus providing a clear avenue through which to seek specific legislative relief.

Health Care to Health (cont'd)

We need not be victims of the changes taking place around us. Doing so, however, requires the courage to stop clinging to the past and to start shaping the future. The challenges we must overcome in doing so may be less tangible than the menace of WW II. But they are just as deadly, in part because they are less tangible, less obvious, than a Pearl Harbor. Yet the challenges we face today, if we can meet them successfully, will have every bit as much impact on the lives of our children as did the winning of WW II on my generation.

That is our challenge today. To plant the seeds of tomorrow; to change the parameters and the context of this debate by acting, by leading, by personally engaging in this struggle—not as captives of the past, not as victims of the status quo, but as the proud architects of a new future.

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