

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

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*This is a slightly abbreviated version of an adaptation from an address given by Dr. Kitzhaber at the Oregon Health and Science University. The full text is available at [www.ohsu.edu/som/alumni](http://www.ohsu.edu/som/alumni).*

In this article, I would like to accomplish four things: impress on you the urgency of the growing crisis in our health care system, provide a context for why our current system is so dysfunctional, suggest what we need to do to fix it and discuss how you might assume a leadership role in meeting this challenge.

Are you between 43 and 61 years old? We are the Baby Boom generation, the 30 percent of the U.S population born between 1946 and 1964. Most of us are the children of those who weathered the Great Depression, served in the Second World War or who helped rebuild the world in its aftermath. They built our system of higher education, created the interstate highway system and the transmission grid, went to the moon, cured polio, eradicated smallpox and put in place the great social programs of the 20th century: Social Security, the GI Bill, Medicare and Medicaid. As a result, our generation has enjoyed more promise and more opportunity than any other generation in the history of our nation.

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I want you to think about what *our* legacy is going to be—about the kind of world we are leaving to our children and grandchildren. And on our current trajectory it is not a pretty picture.

Consider the fact that last year Congress voted to raise the statutory debt ceiling to accommodate a \$10 trillion national debt. Do you know how much a trillion dollars is? The number is so staggering that it is impossible to comprehend without some frame of reference: A *million* seconds ago was last week. A *billion* seconds ago, Richard Nixon resigned the presidency. A *trillion* seconds ago was 30,000 BC. Our national debt now exceeds \$9 trillion and is escalating even as the population ages.

## Health Care to Health (cont'd)

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And while Congress is worried about Social Security, the real problem is Medicare. Social Security represents around a \$5 trillion problem, but when the Baby Boom generation fully reaches the age of 65—starting less than three years from now in 2011—the unfunded entitlement in Medicare is estimated to be over \$67 trillion. And we are financing this huge debt by selling securities to China and to other countries still willing to purchase them, *not only* threatening the fiscal stability of the American government and giving enormous leverage to some of our major international competitors (who at some point may simply refuse to continue underwriting U.S. deficit spending), but also casting a dark cloud of debt over our children's future.

If we fail to address this—if we fail to act boldly—this *will* be our legacy. We have been the major beneficiaries of the investments and sacrifices of the greatest generation and now it is our turn to give back, to ensure that we leave our children not a legacy of debt and degradation but a world of promise and opportunity and hope. How we meet this challenge will be the defining issue of our time. It is the unfinished business of the Baby Boom generation and it is inescapably intertwined with the future of the U.S. health care system.

To resolve this crisis, two things are necessary. *First*, we need a shared vision, a set of agreed upon objectives that capture the desired purpose of the U.S. health care system. *Second*, we need an accurate diagnosis of the underlying problem in our current system.

Let's start with objectives by reminding ourselves that *the purpose of our health care system should be to help produce healthy citizens, not simply to finance and deliver health care. In other words, health care is a means to an end, not an end in itself.* It has no intrinsic value beyond its relationship with health except as an economic commodity. Shifting the focus of our system from health care to health, however, involves a huge shift in paradigm—especially for providers and consumers. It will also require a fundamental change in our priorities; in our patterns of investment; and in the structure of our current system.

To understand the magnitude of this challenge, we need only look at those factors which have the greatest influence on a person's lifetime health status. Fully 40 percent involve individual behavior and lifestyle choices; another 30 percent is accounted for by genetics; 15 percent are social factors (educational level, where you live, the stability of your family; whether you have a home, a good job, etc.). Only 10 percent has anything to do with involvement with the U.S. medical system. In other words, 90 percent of what keeps people healthy has nothing to do with health care. What this tells us is that we do not have a health care system, we have a sick care system; one that does not do a very good job at keeping people well.

## Health Care to Health (cont'd)

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And here's why. As Neal Halfon, Helen DuPlessis and Molra Inkelas point out in their *Health Affairs* article "Transforming the U.S. Child Health System": Because the scaffolding for physical, cognitive and socio-emotional health is built in the early years of life, early investments in prevention and health prevention can greatly improve long term health, behavior, economic and civic outcomes.

We know that lifestyle contributes as much as 90 percent to the development of diabetes and 80 percent to heart disease, and that the lifestyle patterns and behaviors that lead to obesity, diabetes and heart disease are locked in during the early years of a child's life. Likewise we know that there are certain social and medical risk factors to which children are exposed in their early years which have an almost linear correlation with school failure, social dependency and involvement in the criminal justice system. And the longer we wait to address these unhealthy patterns, behaviors and risk factors, the harder it is to deflect the children back toward a healthy life trajectory.

And that is one of the fundamental truths which we must confront if we hope to shift our paradigm—and the focus of our political debate—from health care to health. It is relatively inexpensive and very effective to make a small course adjustment in the early childhood period to create a healthy life trajectory. By ignoring the early childhood investments necessary to do so, however, we harvest serious, expensive and tragic social and medical consequences later on.

Now I doubt if many people would disagree with these three basic system objectives: 1) improving population health; 2) reducing per capita costs; and 3) improving the patients' experiences. But the fact is that they cannot be achieved by operating within the context and the constraints of our current system because both its financing component and its delivery component are structurally flawed.

The *financing component* was not built around a broad and equitable commitment to access, but rather around the concept of *categorical eligibility*. And these categories were established through three unrelated acts of Congress in the middle of the last century. The first was the decision in 1954 to allow employers to deduct from their taxable income the cost of their contribution to their employees' health insurance coverage—which amounts to a publicly financed tax benefit for employer-sponsored health insurance coverage. The other two acts were the creation of Medicare and Medicaid.

Today, Medicare accounts for about 9 percent of all federal income taxes, a number which is expected to rise to 19 percent by 2015 and 32 percent by

## Health Care to Health (cont'd)

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2025. It is the cost of this program as the Baby Boom Generation reaches the age of 65 which threatens the fiscal stability of our nation.

All three of these programs made sense at the time they were enacted, and all grant a public subsidy not to all citizens, but only to certain *categories* of citizens. The problem is that the economic and demographic environment in which they exist has changed dramatically over the past 50 years while the programs themselves have not. Maintaining this outdated structure increasingly depends on the relentless and unsustainable consumption of resources which rightly belong to future generations.

Because this system was built around categorical eligibility rather than around a broad commitment to access, a growing “coverage gap” has developed between its public and private arms. And into this gap fall those who do not fit into a category. As a consequence, the United States has avoided answering perhaps the most fundamental of questions—one that has been answered in some form or another by all other industrial nations in the world. And the question is simply this: In the U.S. *who has the responsibility to pay for the health care needs of the growing portion of our population which cannot afford to do so themselves?*

And because we have not explicitly answered this question as a matter of public policy we have, by default, left the economic market to answer the question for us. It should come as no great surprise that no business goes out and competes for people who will not pay them.

So cost-shifting results, which makes no sense as either a business plan or as a social policy. In effect, we have adopted a *de facto* policy: We won't pay to manage your hypertension in the community, but we will pay to treat your stroke in the hospital; that we will not pay to provide all pregnant women with good prenatal care, but we will pay to resuscitate their 500 gram infants in a neonatal intensive care unit. And that should not be acceptable to any of us.

The fundamental step we must take in the financing component of our system is to explicitly answer the question: Who has the responsibility to pay for the health care needs of that growing portion of our population which is unable to do so themselves? I believe that this responsibility will inevitably fall to the public, just as it is a public responsibility to ensure that all of our children have financial access to an education; just as it is a public responsibility to finance law enforcement, fire protection and to provide for the national defense. It is a public sector responsibility to ensure that all Americans have access to some effective level of health care.

## Health Care to Health (cont'd)

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But—and this is very important—it cannot be an open-ended responsibility for the simple reason that public resources are ultimately finite. In other words, the “floor”—the level of care to which everyone will have access—is, by definition, what we are willing to pay for with public resources. One of the flaws in the current debate over universal coverage is that no one seems to want to address the pivotal question of “coverage for what?” It is here that we will need to come to terms with the reality of our fiscal limits.

So the fundamental challenge, then, is not how to find more money to pay for health care, but rather how to ensure that the shared public dollars we are *already* spending on health care are allocated in a way that benefits all of us, not just some of us *and* that we are actually getting an improvement in population health for this extraordinary and growing expenditure.

And this brings us to the second structural flaw in our health care system: the *delivery component*. The problem is not how we pay for health care; the problem is what we are *buying*—and how that care is organized and delivered. The inefficiencies and poor performance of the U.S. health care system are built into that system.

If we look at where most of the money in the system is being spent, we find that, in any given year, 70 to 80 percent is spent on people who have one or more chronic diseases.

Furthermore, the spending is concentrated on a small portion of the population. In any given year 10 percent of the population accounts for 70 percent of health care spending.

Now we know that most chronic diseases are preventable, particularly when prevention measures are applied in early childhood. We know that chronic diseases are progressive. And we know how to intervene in order to prevent these complications. Doing so, however, requires an integrated care system—a team approach that can coordinate care and share information; it requires well-educated patients who can recognize the early warning signs of a complication leading to a quick and coordinated response.

Our system evolved around an acute care “infectious disease” model which made sense and still makes sense for acute life threatening conditions as well as for many common non-life threatening conditions. The problem is that this acute care model has come to serve as a “one-size-fits-all” approach to the provision of medical care in the face of a range of very different delivery challenges—not the least of which is chronic care.

## Health Care to Health (cont'd)

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In addition, only 4 percent of physicians in this country are in group practices of more than 50 physicians. Most physicians do not operate as a part of a team, which creates a problem given the fact a person with one chronic condition is being cared for on average by seven to eight different physicians who are often not in close communication with one another.

Moreover, the system suffers from a lack of data. Most patient information is in paper medical records stored in hospitals and in hundreds of thousands of physician offices across the country. These factors are largely why most people with chronic conditions interact with the care system only in crisis and get the appropriate care for their condition only about 50 percent of the time. And that is exactly why so many people with chronic conditions continue to progress to ever more serious complications which require more complex and expensive treatment.

Finally, our system evolved around a set of financial incentives which reward acute care interventions and actually discourage a focus on prevention and on the kind of reorganization around care management—especially chronic care management—that is required to resolve the growing crisis. Of the 9,000 different billing codes which providers use to get paid, there is not a single billing code for a cure; for prevention; for health improvement. These are simply not billable events.

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