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Health Care Reform Now!

A Prescription for Change

John Wiley & Sons, Inc.

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Published by Jossey-Bass
A Wiley Imprint
989 Market Street, San Francisco, CA 94103-1741 www.josseybass.com

Library of Congress Cataloging-in-Publication Data

Halvorson, George C.
Health care reform now! : a prescription for change / George C. Halvorson. — 1st ed.
p. ; cm.
Includes bibliographical references and index.
ISBN 978-0-7879-9752-6 (cloth)
1. Health care reform—United States. 2. Medical economics—United States.
3. Insurance, Health—United States. I. Title.
[DNLM: 1. Health Care Reform—economics—United States. 2. Economics, Medical—organization & administration—United States. 3. Insurance—organization & administration—United States. WA 540 AA1 H118h 2007]
RA395.A3H3449 2007
338.4'33621—dc22

2007011636

Printed in the United States of America
FIRST EDITION
HB Printing 10 9 8 7 6 5 4 3 2 1
PB Printing 10 9 8 7 6 5 4 3 2 1

Contents

This book is dedicated to my four sons and four grandchildren: the reasons we need to make care wonderful and affordable for a very long time ahead.

Acknowledgments

A number of people helped me with this book, offering thoughts, feedback, insight, counsel, and support. I'd like to thank Jay Crosson, M.D., Arthur Southam, M.D., Lon O'Neil, Paul Wallace, M.D., Raymond Baxter, Ph.D., Steve Zatkin, L.L.D., Patricia Lynch, Robert Crane, Diane Lofgren, Lorie Schaible, Nicole Kohleriter, Candice Key, Jennifer Green, Jo Ellen Green Kaiser, and Louise Liang, M.D., for helping me think these issues through. I'd also like to thank George Isham, M.D., for his thought partnership around health care reform. Paul Wallace, M.D., deserves special thanks for his help with Chapter Four, the chapter on chronic disease treatment. He and the Care Management Institute team added value that was beyond the call of duty.

I thank you all.

Introduction

If current rates of health care spending continue, the cost of family health insurance coverage in America will exceed $17,000 per family within four years.[1] Many families will pay over $20,000 per year within five years.[2]

Family health insurance rates in California already exceed the complete per capita income of 147 countries.[3] The cost of family coverage already exceeds the full minimum wage for a single worker in the United States.[4] General Motors now spends more money on health care than it spends on steel.[5] Starbucks spends more on health care than it does on coffee.[6]

We spend more money on health care by far than any other country, and yet more than forty-five million Americans are uninsured at least part of the time each year.[7] To make matters worse, well-documented studies show us that nearly 50 percent of the time American patients are receiving less than adequate, inconsistent, and, too often, unsafe care.[8]

We have reached the point where both health care delivery and health care financing in America need new directions. The old approach isn't technically broken—because it continues to function—but it performs at unacceptable and unaffordable levels in far too many ways for far too many people. Our current approaches to care delivery and health care financing are sadly inadequate for what we need health care to do in this country today.

We don't really have a health care delivery system in this country. We have an expensive plethora of uncoordinated, unlinked, economically segregated, operationally limited microsystems, each performing in ways that too often create suboptimal performance both for the overall health care infrastructure and for individual patients. We have, at best, a nonsystem of care and, truth be told, the current nonsystem of care is inconsistent, massively expensive, sometimes dangerous, operationally inefficient, and dysfunctionally and sometimes perversely incented. Our current approach to financing both care and health care coverage too often leaves us with major operational problems as well as serious ethical issues relative to resource allocation. Our current approach to health care resource consumption can lead to unconscionably inadequate access to quality care for far too many Americans. Those problems are exacerbated for minority Americans. When it comes to racial and ethnic disparities in care and coverage, we very sadly have grown to accept as the status quo in America what should be seen as completely unacceptable differences in care delivery and care outcomes for our various minority populations. Our current nonsystem is expensive, frequently ineffective, and the distribution of care resources is often dangerously and shamefully inequitable.

This is clearly the wrong place to be. I am definitely not the only person who believes that to be true. Far from it. Just about everyone who thinks seriously about American health care today is coming to that same conclusion. It's obviously time for a change—and multiple change agents in our society are increasingly ready to move to a better approach. In my job as CEO of a fairly large health care organization, I've talked to the heads of major unions, senior political leaders, senior community leaders, and the heads of more than a dozen major U.S. corporations. Over the past couple of years, I've talked to industry consultants, to the human resource leaders for a lot of companies, and to senior executives from quite a few leading health care institutions. I've also talked to friends, neighbors, consumers, patients, and various people

involved in community activities. Without exception, I hear a call for change. Now. People have lost patience. The time for change truly is upon us.

The problem is—change to what? There isn't a consensus about what we should change to. Everyone knows the problems. No one knows the solution. So we have an incredible tsunami for change building up massive levels of societal energy, with nowhere for that powerful—but currently undirected and unfocused—wave to go.

That's one purpose of this book—to point in one possible direction toward a total package of health care reform that might actually solve major portions of the quality problem, mitigate and significantly improve the cost problem, resolve much of the societal inequity that results from having so many people uninsured, and help solve that full set of economic problems in a way that is uniquely American. Moving to universal coverage has to be part of that solution.

Every Country Takes Its Own Path to Universal Coverage

I've looked at the universal coverage plans of twenty other countries and talked directly to the health ministers of half a dozen to learn how other countries have dealt with those same issues. What I learned was that even though every other industrialized country has achieved universal coverage, they have each taken their own unique path to get there. The Canadian system, British system, and German system are not identical. The approach each country has chosen to get to universal coverage—and much lower overall health care costs than our costs in this country—all fit the specific local logistics and the unique economic and cultural needs, values, belief systems, and characteristics of each country. I have learned that each and every country has designed its own unique version of universal coverage based on the local economic and political characteristics unique and relevant to each country.

I mention that because I believe we need to do the same thing here—evolve to an American system that achieves universal coverage for this country using those specific characteristics of care delivery and financing that are most valued by the American public and the American electorate.

Simply cloning and transplanting Canadian health care is not a viable option. Doing significantly better than Canada is. Stealing a few good ideas from Canada makes a ton of sense. But in the end, if we want to truly succeed, we need our own approach to getting coverage for everyone in America.

A major portion of this book is written to offer a series of facts, data points, observations, and functionally practical suggestions about how we can create a more patient-centered American health care marketplace that offers patients truly well-informed choices, affordable coverage, and an array of fully accountable health care providers competing for patients in the context of value, performance, and cost. We need an American approach that builds effectively and directly on the principles of continuous process improvement to enhance American care delivery while making care more accessible and affordable.

I don't approach these problems from an academic perspective. From a purely functional point of view, I've been directly involved in or worked closely with pretty close to every level and category of health care financing and delivery over the past three decades. Over those years, I've worked in health insurance, health plan management, care system management, and direct care delivery operations. In my current job, I'm the chair and CEO of one of the larger hospital systems in America and the third largest health plan in the country. Over the past three decades, I've worked with the private market, Medicare, Medicaid, and various other governmental programs. I've also had some experience in other countries, starting a health plan in Jamaica quite a few years ago and helping start twenty small health plans in Africa only a few years ago. I'm currently board president for the International Federation of Health Plans—an association of seventy-five independent, operational

health plans from twenty-five countries, ranging from Botswana to the United Kingdom to Hong Kong.[9] So I have not limited my thinking about possible approaches and solutions to purely American experiences or purely local thought processes.

The organization I work for in my day job is a special entity. Kaiser Permanente is a vertically integrated organization of medical groups, hospitals, and health plans. We have over 140,000 total employees and involvement in every level of care delivery. Our health plan has nearly nine million members and annual revenue of roughly $35 billion. I love our approach and our model. It truly is a special organization. We bring a lot of health care financing and care delivery functions together under our organizational approach. But I need to recognize here that Kaiser Permanente's vertically integrated organization model and our melded approach to care and coverage are relatively unique within the United States—though there are fairly similar organizational units embedded in the national health systems of several European countries.

Within our vertically integrated organization, we are actively pursuing an aggressive agenda to implement a completely automated medical record system with all care digitized—from scans and X-rays available everywhere through hospital lab test ordering, care delivery best-practice reminders, and direct patient interaction with their medical records. Our goal is to be completely connected, easily accessible, and almost paper-free. It's a relatively unique multibillion dollar system and operational improvement agenda that we are pursuing in large part because of many of the points and perspectives you will read in this book.

This is not, however, a book about us or a book recommending that everyone else become clones of Kaiser Permanente—though I do love our model and believe it offers a wealth of value. So why don't I recommend that everyone else become exactly like us? Because there is no feasible way for the entire country to quickly become a fully vertically integrated system—like Kaiser Permanente—just as there is no feasible way for the United States to completely adopt the Canadian universal coverage system and then

move to direct governmental budget control over every single American hospital. There are just too many complications involved in both of those potential ideas for either of them to happen quickly or functionally in this country today. I do believe we would benefit by having more Kaiser Permanente clones in this country, but that is not likely to happen anytime soon, and that's not the point of this book.

So what I advocate in this book is a slightly different model from ours—a model of virtual integration rather than true vertical integration—that I believe can work for everyone else in American health care in a fairly quick time frame.

The model I recommend builds on and emulates some of the best features of a fully integrated approach using computers and care support technology to consistently and systematically improve care delivery and financing across the current American nonsystem of care.

The care delivery approaches, economic incentives, market infrastructure, and universal coverage recommendations proposed by this book are intended to include everyone—involving America's community clinics, our safety net hospitals, and all private and public care delivery systems, ranging from the Mayo Clinics, Geisinger Medical System, and other giant multilevel practices down to the millions of stand-alone independent caregivers who deliver most health care services in this country. The model I am proposing utilizes the best features of the private American health insurance system and incorporates full use of both Medicare and Medicaid infrastructure and financing. It's an American model aimed at building on the best of what America has available right now to deliver and finance care.

This Is the Right Time for Reform

My goal is for this book to be useful to you in thinking clearly with good information about some of these truly complex issues. I do believe it's time to reform American health care, and I believe that

if we put in place the right reform agenda, care will be better, more accessible, more universal, and significantly more affordable when we are done.

This is the time. The energy is here now, waiting to be focused. What we need to do at this point is bring everyone—labor, management, consumers, carriers, the uninsured, the underinsured, caregivers, government agencies, patients, and the community together to form a consensus on an approach that can truly get the job done. Then we need to turn that consensus into practical, functional, operational reality as soon as we can get that whole agenda in place.

I hope this book helps in that process. It's intended to be a simple conversation in practical and commonsense terms about some things we need to focus on and some things we need to do to actually reform health in America. *Epidemic of Care* and *Strong Medicine*, two books I wrote earlier, started down this road.[10] This book is the next step on that journey. It's a step toward action. Let me know what you think of the points and ideas that are discussed and proposed. I'd love to hear your reaction and your thoughts.

Be well.

The Author

George C. Halvorson was named chairman and chief executive officer of Kaiser Foundation Health Plan, Inc., and Kaiser Foundation Hospitals, headquartered in Oakland, California, in March 2002. Kaiser Permanente is the nation's largest integrated health plan, serving more than 8.7 million members in nine states and the District of Columbia.

Halvorson has more than thirty years of health care management experience. He was formerly president and CEO of HealthPartners, headquartered in Minneapolis. Prior to joining HealthPartners, he held several senior management positions with Blue Cross and Blue Shield of Minnesota. He was also president of Senior Health Plan and president of Health Accord International, an international HMO management company.

Halvorson serves on a number of boards, including those of America's Health Insurance Plans and the Alliance of Community Health Plans. He is the current president of the Board of Directors of the International Federation of Health Plans, and a member of the Harvard Kennedy School Healthcare Delivery Policy Program, the Commonwealth Fund Commission on a High Performance Health System, and the new Institute of Medicine Task Force on Evidence-Based Medicine. He also serves on the Executive Council of La Clínica, and on the Ambassadors Council to Freedom from

Hunger, an international development organization working in seventeen countries. He is a former board member and trustee of the National Cooperative Business Association.

In addition to *Health Care Reform Now!* Halvorson is the author of other books on health care, including *Epidemic of Care* (2003), *Strong Medicine* (2003), and *Health Care Co-Ops in Uganda: Effectively Launching Micro Health Plans in African Villages* (2006). He is currently writing a new book about racial prejudice around the world. He has written numerous articles on subjects ranging from health information technology to the changing marketplace.

Halvorson has interacted in a number of settings with academics, policymakers, and health industry leaders including the HR Policy Association, the World Bank, the European Health Care Congress, the National Business Group on Health, the Microsoft Annual Health Plan Executive Forum, the National Governors Association, the World Health Care Congress, and a number of universities and colleges. He has served as an advisor to the governments in Great Britain, Jamaica, Uganda, and Russia on issues of health policy and financing.

Health Care Reform Now!

1

A Few Hard but Useful Truths

If we truly want to reform health care in this country, we need to start by addressing four key facts about health care in the United States today. Unless we understand those four facts and deal directly with each one, I believe health care reform, universal health coverage, a consumer-driven health care marketplace based on actual value, and continuous and systematic quality improvement in care delivery will all be unattainable goals.

So what are those four fundamental facts? They are pretty basic, but they need to be clearly stated so we can incorporate them into our thought processes, discussions, and problem-solving approaches. The four key facts are that (1) health care costs are unevenly distributed in America, (2) care linkage deficiencies abound—and can impair or cripple care delivery, (3) economic incentives significantly influence health care, and (4) systems thinking isn't usually on the health care radar screen. Those four realities underpin our current health care dilemma. Dealing directly with each of them will point us toward a practical and achievable health reform solution.

Truth One: Care Costs Are Unevenly Distributed

The first key fact we all need to understand clearly is that health care costs are not distributed evenly across the American population. A very small number of patients spend most of our health care dollars.

Let me make this point in very clear and simple words: any attempt to reform or improve health care expense and cost levels that does not understand and then deal directly with that key cost distribution fact is doomed to fail.

So how skewed are our health care expenses? Very. The specific numbers vary a bit from population to population, but the patterns of spending are the same for every set of people in America.

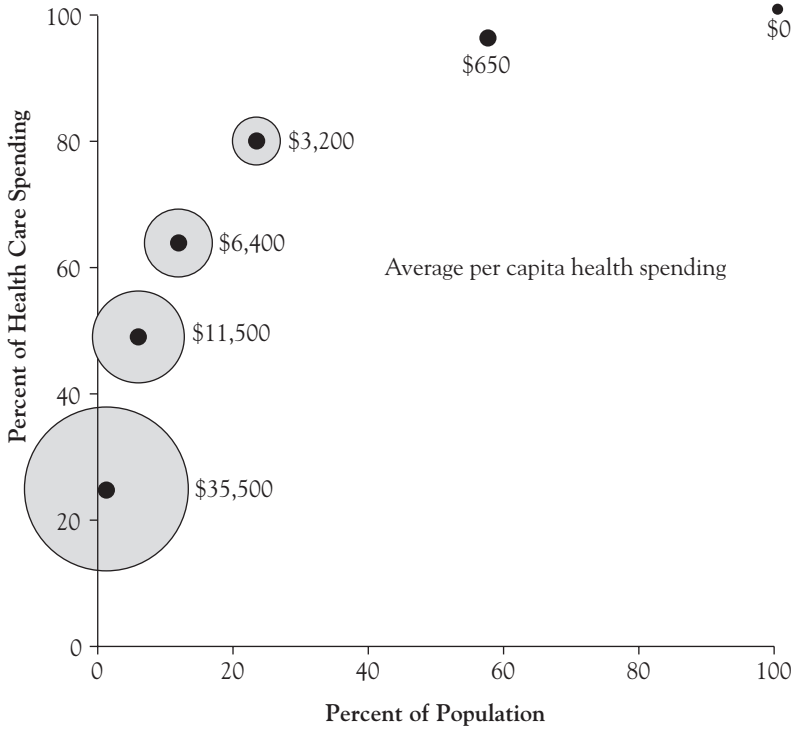
When we aggregate data for the U.S. population as a whole who have health coverage, 1 percent of the population spends over 35 percent of all health care dollars. Data compiled by our actuaries from various sources indicate that 5 percent of the population spends almost 60 percent. Ten percent spends nearly 70 percent of our care dollars. Our actuaries also calculate that a mere 0.5 percent of the insured population spends nearly 25 percent of all care dollars.[1]

You can see these numbers in Figure 1.1. So the truth is a fairly small number of people spend almost all of our available health care dollars.

On one end of the cost continuum spectrum, a very small number of people spend a very large percentage of our health care dollars. On the other end of that same continuum, there are a lot of people in this country who spend very few health care dollars. Half of the population spends only 3 percent of our health care resources. In dollar terms, the difference between health care spending for those who spend the most and the ones in the bottom 50 percent who spend the least is almost $35,000 per person per year. And 15 percent of our population spends no health care dollars at all in any given year.[2] Zero.

It's hard to reduce costs below zero—so that's obviously not where we should be focusing our attention. Nor should we focus on the folks who spend less than 3 percent of our health care dollars. We need to focus on the big spenders. Thinking strategically and systematically, the key opportunity for us in American health care is obviously to figure out how to have a real impact on the current and future costs of care for those few, very expensive people. Look at Figure 1.1 for some key numbers.

Figure 1.1. Distribution of U.S. Health Care Spending.



Source: Agency for Healthcare Research and Quality. "Medical Expenditure Panel Survey Statistical Brief #81: Concentration of Health Care Expenditures in the U.S. Civilian Noninstitutionalized Population." May 2005. http://www.meps.ahrq.gov/mepsweb/data_files/publications/st81/stat81.pdf.

Five Chronic Diseases Create the Most Costs

An equally important point of fact that we need to understand and focus on is exactly who spends those dollars. The total medical care costs for people with chronic disease account for more than 70 percent of the nation's health care expenditures.[3] Five basic diseases create the vast majority of American health care expenses, and they are all chronic conditions. Most people do not understand that basic fact of health care economics. Why? Because acute care cases tend to get more attention.

Acute (nonchronic) health conditions tend to get more public attention because each individual acute case can be very visible. Those diseases do not create most health care costs. Pure acute medical conditions like cancer, trauma, infectious diseases, and maternity care do create real expenses, but they are *not* our major cost drivers. Our dollars are overwhelmingly going to people with one or more of these five chronic conditions: diabetes, congestive heart failure, coronary artery disease, asthma, and depression.

That set of facts tells us that we need to think strategically and clearly about those five very expensive conditions if we truly want to impact health care costs in America. We need to learn to think systematically about the care we deliver for each of those diseases and then act systematically to improve the quality, outcomes, consistency, and cost of that care.

Chronic Diseases Progress

For starters, we need to recognize the very useful fact that each of those five very expensive chronic diseases tends to be progressive. They each tend to start with a relatively low level of needed care for each patient. If the patient does not receive proper treatment, his or her condition will worsen until the patient requires major additional amounts of money for his or her care. The expense climbs for each patient over time as his or her health status deteriorates and each person's disease progresses into its full-blown, highly expensive, acute care crisis stages.

Why do we all need to understand that particular fact? Because if we think systematically about that situation, then it becomes obvious pretty quickly that slowing or preventing the progression of each chronic disease from the relatively inexpensive early stage to the incredibly expensive, crisis-laden, and more complex late stage is a huge and obvious opportunity for us all. Successful interventions in the progression of chronic disease have the potential to significantly reduce health care costs and simultaneously improve the

quality of life for those chronic care patients. Do the math. If we want to reduce the amount of money we spend on health care, we need to start by recognizing who we are spending it on now, and then we need to improve outcomes and care for those patients so we can reduce the expenses of their care.

This is not just a hope or a dream. Medical science has now progressed to the point where we can effectively intervene in systematic and consistent ways to reduce the complications that drive so many of our health care costs. Any attempt at reforming care delivery or alleviating costs absolutely needs to address these issues directly and take advantage of these opportunities. Interventions are needed. They are possible. They just aren't systematically done in American health care today.

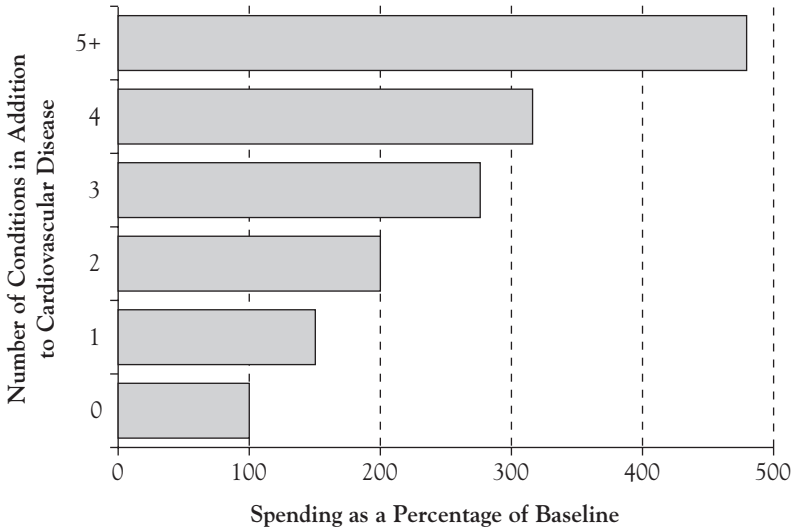
This is a very doable agenda. But it's not how the American health care infrastructure performs now, and this particular cost and quality opportunity is not where most health care reform thinkers currently focus their thinking.

The Impact of Comorbidities

So what else do we need to know about patients with chronic diseases? A key point for each of us to have on our strategic radar screen is the reality and impact of comorbidities. Comorbidities mean that a patient has multiple diseases. It is particularly important to clearly understand that the people getting the most expensive and heaviest levels of care in America today usually have comorbidities—two or more of those five chronic diseases—with an additional acute disease often creating further complex and extremely expensive problems for many of these chronic care patients. See Figures 1.2 and 1.3. Patients with comorbidities generally require the most care, and they often utilize many more caregivers than people with just one disease.[4]

As you will read later in this section, our health care infrastructure does a much worse job of taking care of people with comorbidities

Figure 1.2. Increase in Average Annual Health Care Spending with Comorbidities.



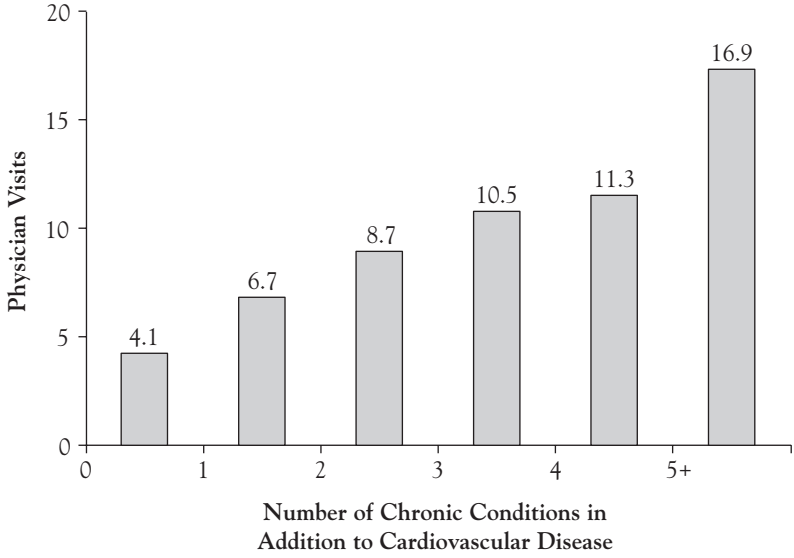
Source: Partnership for Solutions. "Cardiovascular Disease: The Impact of Multiple Chronic Conditions." Baltimore, Md.: Robert Wood Johnson Foundation and Johns Hopkins University, May 2002. http://www.partnershipforsolutions.org/statistics/issue_briefs.html.

than it does of taking care of people with only one disease. In other words, we do least well as an American care infrastructure for the very patients who need care the most.

Those are a couple of key facts about the distribution of health care costs in America that need to be at the foundation of our strategic and operational thinking about care and the costs of care.

Any plan for health care reform that does not deal directly and effectively with those five chronic conditions—and their comorbidities—is probably going to be an exercise in futility—very probably a waste of political, social, and economic energy and resources. Those five conditions are what cause us to spend the bulk of our health care money. It's almost silly to think about health care reform

Figure 1.3. Increase in Average Annual Number of Physician Visits with Comorbidities.



Source: Partnership for Solutions. "Cardiovascular Disease: The Impact of Multiple Chronic Conditions." Baltimore, Md.: Robert Wood Johnson Foundation and Johns Hopkins University, May 2002. http://www.partnershipforsolutions.org/statistics/issue_briefs.html.

that doesn't address each one of these conditions, problems, and opportunities very directly.

Significant Problems with Chronic Disease Care

So how well do we do now in America taking care of those chronic diseases? We don't do well at all.

A wonderful and important study done by the RAND Corporation took a look at the health care of 7,000 Americans, checking every aspect of their care for multiple years. That superb RAND study showed that Americans today receive appropriate care for their complete set of medical conditions barely half of the time[5]—and our

care delivery process was particularly inept in providing care to people with those five chronic diseases.

That's not the only research that has resulted in that finding. John Wennberg's wonderful work at Dartmouth Medical School[6] (see Figure 1.4) and a body of excellent work done by the prestigious Institute of Medicine (IOM)[7] both point us to equally dramatic and troubling conclusions. According to the IOM, there is a vast "chasm" between the care we know people should get and the care that patients in America actually receive. The IOM wrote a book titled *Crossing the Quality Chasm* that should be required reading for anyone advocating health care reform in America. [8] It's a brilliant piece of work. Easy to read. Well argued. Well documented. Absolutely clear in its message. If you haven't read it, please get a copy. The introduction alone is worth the price of the book.

Box 1.1. The Institute of Medicine on the State of U.S. Health Care.

Crossing the Quality Chasm makes the point that the current state of the health care delivery system is mismatched to the needs of U.S. citizens, particularly those with chronic disease. The Institute of Medicine (IOM) concluded that bringing state-of-the-art care to Americans in every community requires a sweeping redesign of the entire health care system for patients to receive care that is safer, more reliable, more responsive to their needs, more integrated, and more available, and for patients to count on receiving the full array of preventive, acute, and chronic services that are likely to prove beneficial. As a follow-up to this report, seventeen priority areas for transforming health care were identified. These include diabetes, coronary heart failure and coronary artery disease, asthma, and major depression.