

Testimony Before the House Committee on Energy and Commerce
Subcommittee on Health

A Framework for a Better Health System

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Chairman Pallone, Ranking Member Deal, and Distinguished Members of the Subcommittee, it is an honor to be speaking to you today about repairing our ailing health care system. As a clinician, public health researcher, and medical-watcher, this is what I see: *our health system is failing—on cost, coverage, safety, and value—because the complexity of health care itself has exceeded our abilities as individual clinicians.*

The Nature of the Problem

Let me explain. The new edition of the International Classification of Diseases identifies more than 68,000 diagnoses¹—68,000 different ways in which the human body can fail. And over the last half century, science has given us beneficial remedies, if not outright cures, for nearly all of them. But these remedies are rarely simple. Each involves different steps in care, vexing uncertainties, often expensive technologies, complicated systems, and coordination. We have relied on training and ever greater specialization of individuals, but no industry in the world has to deliver on so many different service lines. We have some 6,000 different drugs² and more than 4,000 different kinds of procedures³, and providing them currently entails 35 million hospital admissions⁴, 120 million ER visits⁵, 400 million imaging procedures,⁶ almost 1 billion office visits⁷, and 3.5 billion prescriptions each year.⁸ What science has given us is extreme complexity. And our system cannot handle it.

In our current health care structure, this extreme complexity has produced **three kinds of failures**:

- Failures of coverage: Whether uninsured or inadequately insured, fifty-seven million Americans reported difficulty paying medical bills in 2007, up 14 million from 2003.⁹ On average, they had \$2,000 in medical debt¹⁰ and had been contacted by a collection agency at least once about it.¹¹ Due in part to underpayment, half of American hospitals found themselves operating at a loss in the third quarter of 2008.¹² And all this was before the worst of the recession. Today, employers we could never have imagined are dropping insurance coverage to stay afloat, or simply going out of business—even hospitals are folding.

- Failures of decision-making: Over and over again, studies find that medical decision-making is not nearly as consistent or reliable as people deserve. To take just a few examples: Forty percent of patients with coronary artery disease receive incomplete or inappropriate care; sixty percent of patients with pneumonia do; and so do ninety percent of patients with alcohol dependence.¹³
- Failures of execution: Even when good diagnosis and treatment decisions are made, our execution is inconsistent. The failures can be of the simplest kind imaginable—each year, almost 2 million patients pick up infections in hospitals, and 99,000 of them die, most because someone failed to just wash their hands.^{14, 15} And they can reach realms of care that are extraordinarily complex: each year, we estimate that at least one million Americans suffer disabling complications from surgery, and more than 100,000 die—and at least half of these cases are known to be avoidable.¹⁶

These failures should not be separated from one another. They are a reflection that the structure of our health care system is not suited to what we now know is required for our health.

- The system has left gaps. We need lifelong care and prevention to maintain productive, independent lives, with virtually all of us requiring costly medications, major surgical and medical procedures, and hospitalizations at numerous times during our lives. Yet our system leaves major gaps in coverage for that care for significant stretches of time. As the Institute of Medicine has shown, this is causing substantial rates of death and disability.¹⁷
- The system has left failures invisible. Even for the well-insured, we in medicine do not measure or monitor how often we succeed or fail. And—as any business can tell you—you cannot improve what you do not measure. For example, despite doing more than 100 million surgical procedures for people annually,¹⁸ we do not know how many of them died due to surgical complications last year or whether our results are getting better or worse. We do not know if the 17 million new patients with major depression are better off being treated in 2009 than 1999.¹⁹ Half of our states have no monitoring of hospital infections.²⁰ Not knowing these kinds of results is like not knowing what our unemployment or inflation rate is. We are spending one-sixth of all the money in our economy on health care.²¹ Yet we have no idea how we are performing from one year to the next.
- The system has no reliable mechanism for deploying practical knowledge. Health care is without any reliable tools to insure new, important discoveries will reach the average American. Here, for example, are just two discoveries of the last few months: People with normal cholesterol levels but high levels of a protein called CRP can reduce their likelihood of cardiac disease by half if they take a statin.²² And working with the World Health Organization, my

team at Harvard devised a simple, 90-second safe surgery checklist that we showed reduced complications and deaths by more than a third in eight hospitals around the world.²³ But how long will it take for hospitals and doctors to apply this knowledge in the actual care of most Americans? More than a decade.²⁴ And even then it will not reach all of them. This is because there is no one in health care taking responsibility for deployment of lifesaving knowledge.

What we have is the picture of disorganization. It has occurred because medicine has changed fundamentally without our quite adjusting to it. Just a few decades ago, our knowledge was limited and provided by mostly single clinicians, given a prescription pad or an operating room and a few people to help. So we built a structure in which clinicians generally function and are rewarded as solo agents. But today medical knowledge is vaster than any one of us can manage or even grasp; success now requires well-organized teams and systems. The result is a painful and problematic mismatch: we are an industry of highly trained, highly specialized, and extraordinarily hardworking individuals; but we have no one who is aware of, let alone responsible for, the overall effects of what we do—whether for individual people or the economy.

This reality comes home to me as a clinician every week. Recently I helped care for a critically ill woman in her sixties with a severe abdominal pain. Insurance coverage troubles may have played a role. She hadn't seen a doctor in fifteen years and she proved to have multiple preventable problems. To save her, I operated to repair a ruptured colon, a cardiologist treated her subsequent heart attack, an intensivist managed her pneumonia, and a vascular surgeon worked to rescue her foot, which became gangrenous and would have to be amputated. She didn't make it. It was all simply too much for her. But there was a moment when it seemed like she would pull through. And as we contemplated it, and considered that when she went home, she'd be left unable to walk, unable to eat for months, and with a large open wound, someone asked: "Who's going to be her doctor? Who's going to take care of her?" The silence was deafening.

The answer, of course, was that we all needed to be her doctor. Each of us would see this woman in our clinics for one of her problems. But we had no real mechanism, let alone incentives, to spend time as a group insuring that nothing fell between the cracks, that we were all working in a common direction for her.

The great satisfaction of medicine is to have skills that help people and to be rewarded for using them. But there is also a constant demoralizing recognition that you are but a white-coated cog in a broken machine. Our present structure of health care—with its systemic gaps in both coverage and value—has set us all up for failure. It has given us a crisis of health care safety and public health; it has contributed to an economic disaster; and it has left us incapable of serving our patients as we should.

Structural problems like ours cannot be fixed with a flip of a switch. As the President has said, it took a long time for us to get into this trouble. It will take a long time to get out of

it. But there is good reason to believe that the problem, once understood for what it really is, can be remedied.

A Framework for Change

The mission for coverage. We all now recognize that we must create a system that closes our gaps in coverage. As has often been pointed out, every other major industrialized nation has successfully done so. Less often pointed out, they have done so in an enormous diversity of ways—ranging from Switzerland’s system of subsidized private insurance choices to Britain’s system of nationally run hospitals.²⁵

This diversity is not because of differences in political opinion. It is because each country built its system upon the programs they had experience with. In order to avoid mistakes and terrible harm, that is what we will have to do. That precept sounds as if it would severely limit our choices. But our health care system has been a hodge-podge for so long that we have experience with all kinds of systems.

On the start date for our new health system—on say, January 1, 2011—nothing noticeable has to change for the vast majority of Americans who have dependable coverage. But we want to construct a kind of lifeboat for those who are left out or dumped out of what exists, a rescue program for the people of our country. And we have a number of choices for what that can look like. We have programs like Medicare, Medicaid, and the veterans’ health system that could expand to provide a public option for people. And we have a benefits program for federal workers across the country that can expand to provide a system of private insurance choices.

All of these are established, working programs. Each of them has advantages and disadvantages. And over the next few months we are going to argue about them until we’re blue in the face. But, as other countries have shown, all of them can be made to work. Once we decide to do it, the gaps in coverage can begin closing within weeks. We must simply take the step.

The mission for value. Just providing coverage, however, will not remedy the failures of decision-making and execution that are hobbling American health care. A better health system will not be possible unless that system has components structured to serve one critical and singular mission: ***To measurably reduce failures and increase successes in health care delivery, and thereby increase the value for the country of our massive investment in health care.***

To achieve this, a reformed system must fulfill three new functions that our current system does not:

- Measurement of national statistics. We must have the capacity to measure in real time the results and value of actual care in America. This would include (but not be limited to) how many hundreds of thousands of Americans suffer hospital infections, death or disability from surgery, failures in mental health care, racial

disparities and whether we're reducing these numbers from year to year. (Our current data measurement, if present at all, is uncoordinated and at least three years out of date—which is useless for health system guidance. We spend less on measuring health care than we do on measuring agriculture.) The data should also include measures of efficiency (including how much insurance paperwork is required of clinicians), equitability, and benefit for workforce productivity, as well as how much these parameters are improving over time. These measurements provide the targets for our health care system, much the way our economic measures of employment and productivity provide the targets for our economic system.

- Discovery of practical know-how. We spend \$30 billion a year on new discoveries but virtually nothing on identifying the practical steps for how our hospital and doctors offices can put them all into effective, daily use.²⁶ This is lifesaving research. This neglected work would identify the systems innovations that improve American health care. It would focus on both simple solutions (such as the production of low-cost team checklists to improve performance for anything from cardiac disease to infectious outbreaks) and more complex investigations (such as how to organize teams, and bundle payments for them, to be most effective for health care and wellness).
- Coordinated deployment. My team at Harvard and the WHO is working with the Institute for Healthcare Improvement to deploy the safe surgery checklist across the country, as an instance of that kind of practical know-how. And in six states, it is proving remarkably successful—Washington, South Carolina, North Carolina, New York, Massachusetts, and Indiana. Why? Because their hospital associations committed to helping all of the hospitals in their state adopt it. Dissemination is not possible without coordination. And a reformed system should provide support for this kind of coordinated deployment of practical lifesaving knowledge in every state.

I would like to see this work consolidated in a National Institute for Health Care Delivery, standing alongside our National Institutes of Health. But this work can also be done through existing agencies—with the National Center for Health Statistics, the Agency for Healthcare Research and Quality, and our public insurers like Medicare, Medicaid, our a future public option for the uninsured.

As we embark on health reform, we are entering a debate that will inevitably fuel fierce antagonism over questions of public versus private coverage, how to contain health costs, and taxes. But along the way, we must not forget that our aim—whether we are policymakers, patients, clinicians, or citizens who must pay one way or another for health care—is a better health system. And we have within our grasp the practical possibility of a reformed system that can be better for both public health and our economy.

The Possibility: Health Care Transformed

If the health reform bill you seek to pass closes our yawning gaps in coverage for people, provides timely measurement of basic national health system statistics, supports discovery of practical organizational know-how, and supports deployment, the results will be life-altering for Americans. It will go down in history.

In the face of health care's extreme complexity, this possibility may seem beyond reach. But it's not. We have the know-how. Our goals are achievable.

By 2013:

- We can virtually eliminate personal bankruptcies due to health care debt.
- We can make health care measurably more effective, including:
 - Reducing the number of infections picked up in hospitals by 50%;
 - Becoming the first country in which cardiac disease is no longer the number one cause of death;
 - Reducing major complications and deaths from surgery by at least one-fourth.
- We can improve the ability of clinicians to do their jobs by reducing the burden of insurance paperwork by at least 50%.
- We can cut overall health inflation by half and insure that no business has to spend over 15% of payroll on ordinary health coverage.

Health reform is not going to produce a utopia. People will still face co-payments and premiums. We will still face agonizing disputes over drug and technology costs. Whatever the system's contours, we will still find it exasperating, even disappointing. We are not going to get perfection.

But we can have transformation—which is to say, a health-care system that works for all of us. And that will do more than just catch us up to other countries. If we follow through on this work, we can have the most effective health system in the world.

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