Health policy

Our health care system is not broken—it's obsolete!

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We often hear that our health care system is "broken." Indeed, it's become a pat refrain among policymakers and the media. But thinking the system is "broken" implies that it can be "fixed"—patched up to make it work like it used to. That's what would-be health care reformers seem to think when they tinker with "fixes" like expanding insurance coverage with mandates and subsidies, guaranteeing insurance despite pre-conditions, crafting pay-for-performance incentives to change provider behavior, and expanding use of electronic medical records. All of these "fixes" would undoubtedly be helpful and should be implemented without delay. But unfortunately, even in the aggregate, these and other attempts to tinker with the current system cannot get at the fundamental problems we have to solve and, hence, are a far cry from true health care reform.

Why? Because our health care system is not "broken." Rather, it's outmoded. It's archaic. It's a legacy system that is simply incapable—inherently incapable—of meeting today's health care needs, no matter how much we tinker with it. Imagine trying to fix a Model T Ford so that it could fly. You could put in a more powerful engine, take off the fenders, strap on wings, and put on a pair of aviator goggles. But you still couldn't get the darned thing off the ground!

The hand-me-down system we've inherited is just like that old car, the product of a bygone era that was well designed for yesteryear but is no longer serviceable. Yesteryear was when the health care system needed to deal primarily with acute, often self-limited illness and injury; when medical technologies were much more limited in scope and much less complex; when we thought "the world's best health care system" delivered uniformly high-quality care to everyone; and when the overall cost of health care was still in the single digits as a percentage of GDP.

In times like those, our country could get along quite well with autonomous doctors working solo or in small groups. And we rather liked having our doctors in total control, with all other health care professionals playing supporting roles. We could tolerate independent hospitals competing with one another for patients. We had a fee-for-service payment system that was well designed to deal with isolated episodes of illness and discrete encounters with individual providers. And paper-based medical records kept separately by each of our providers worked well enough.

Today, we face an entirely different set of realities, realities that our legacy system was never designed for, and can never be retrofitted to deal with satisfactorily. Chief among them are rising costs, an increasing burden of chronic, unrelenting disease and disability, way too many medical errors, inexplicable variations in the way medicine is practiced across the country, profound lapses in quality, and wide disparities in health and health care even among those with adequate insurance.

The fragmented, uncoordinated, fee-for-service conglomeration we have inherited cannot hope to cope effectively with these twenty-first-century challenges.

If policymakers would shift their mental model from "broken, let's fix it" to "obsolete, let's redesign it," I doubt there would be much disagreement about the features a new system should have. We'd want "units of accountability" big enough to be held responsible for delivering comprehensive, high-quality, cost-effective care to large groups of people. These units of accountability would be required to develop systematic approaches to weeding out waste, to coordinating the care of the chronically ill, to avoiding redundant tests, to guaranteeing that preventive strategies were broadly implemented, and to fully utilizing the skills of all health care workers in high-performing teams.

Moving from our dysfunctional, fragmented legacy system to an integrated, accountable system will not be easy and will not happen quickly. The barriers to achieving the fundamental transformation required are enormous. An entirely different financing scheme will be needed to release the system from the paralyzing constraints of our current fee-for-service arrangement, and a new cultural paradigm among providers will be needed to foster collaboration, teamwork, accountability, quality improvement, and patient safety. Even before clearing those barriers, however, a way must be found to overcome the resistance from entrenched stakeholders who are profiting handsomely from the current system and who have powerful political allies.

But the risk of trying to preserve an obsolete system is simply too great to let these obstacles stand in the way of needed reforms. Fortunately, a window of opportunity has opened up. Buried in the myriad "fixes" included in the Patient Protection and Affordable Care Act is a call for CMS to promote demonstration projects to implement and evaluate innovative approaches to organizing and delivering health care. Such demonstrations could allow for the creation, on a large scale, of what Stephen Shortell and Lawrence Casalino have called *accountable care systems*, systems that are "capable of implementing organized processes for improving the quality and controlling the costs of care, and of being held accountable for the results."[1] Being "accountable" would entail both

demonstrating appropriate clinical outcomes and taking on significant financial risk. It's hard to imagine how these expectations could be met in the absence of a fully integrated system of providers in which doctors, nurses, hospitals, public health professionals, nursing homes, pharmacists, home health agencies, etc. join forces to manage *cost-effectively* the care of individuals and to deal *systematically* with the known health needs of a region or population.

As possible points of departure for developing such truly accountable care systems, Shortell and Casalino suggest several current organizational arrangements including multispecialty group practices, hospital staff organizations, physician-hospital organizations, independent practice organizations, and health plan-provider organizations or networks. I'm concerned that none of these existing organizational arrangements is likely to be sufficiently scalable to meet the real challenges. What has more potential of doing so, in my view, are well-organized academic health centers.

Indeed, many academic health centers are uniquely poised to develop the kind of integrated health care systems that we need. Many already have organized faculty practice plans, a network of affiliated hospitals, community physician referral bases, a relatively robust IT infrastructure, a tradition of innovation, loyal patients, and the trust and respect of their communities. Modern information technologies could be used to stitch together the network of hospitals, doctors, home health agencies, pharmacies, and other community resources needed both to provide for the health and health care needs of a large population and to monitor the system's fiscal performance and to identify opportunities for improvement. Given their existing capabilities—and their avowed mission to serve the public interest—academic health centers, either individually or preferably in partnership with others, should lead the way toward solving what is arguably the most urgent health problem facing our county.

However we do it, if we want our health care system to fly in the twenty-first century, we've got to stop trying to repair a hodgepodge arrangement that is hopelessly antiquated and get on with the hard work of replacing it with a real system that can actually do the job. Now that Congress has provided CMS with substantial resources to fund more appropriate ways to structure and finance health care services, I believe academic health centers—as engines of innovation—should seize the opportunity to demonstrate what true health care reform might look like.

References

1. Shortell SM, Casalino LP. Health care reform requires accountable care systems. JAMA 2008; 300: 95–7.

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Memento Mori

The first one caught me by surprise.

I was doing my initial thoracentesis,
a task less daunting than the word implies.
A cheerful woman gasped from fluid in her chest,
a pleural effusion caused by rampant cancer.
There was no effusiveness in the somber needle
I guided carefully through her chest wall.
"I'm going to die now," she calmly said,
and, with nothing further, laid back dead.

It was the moment doctors dread;
full frontal with the enemy ahead
And I midwife to the highest drama.
This was no time for contemplation.
Coding, CPR, intracardiac adrenaline;
we were quick and forceful, but for naught.
Relatives were notified, and in intense detail
we probed each second, searching for a clue or cause.
None came, and nothing from a later autopsy.
We had no solution, no solace, and no one to blame.

While preachers celebrate the rising soul,
and mystics sense transfiguration, and
loved ones clasp one another, casting
hope against the loneliness of death,
we found no answer in her body,
no meaning in the metaphysics,
and nothing in ourselves to talk about.

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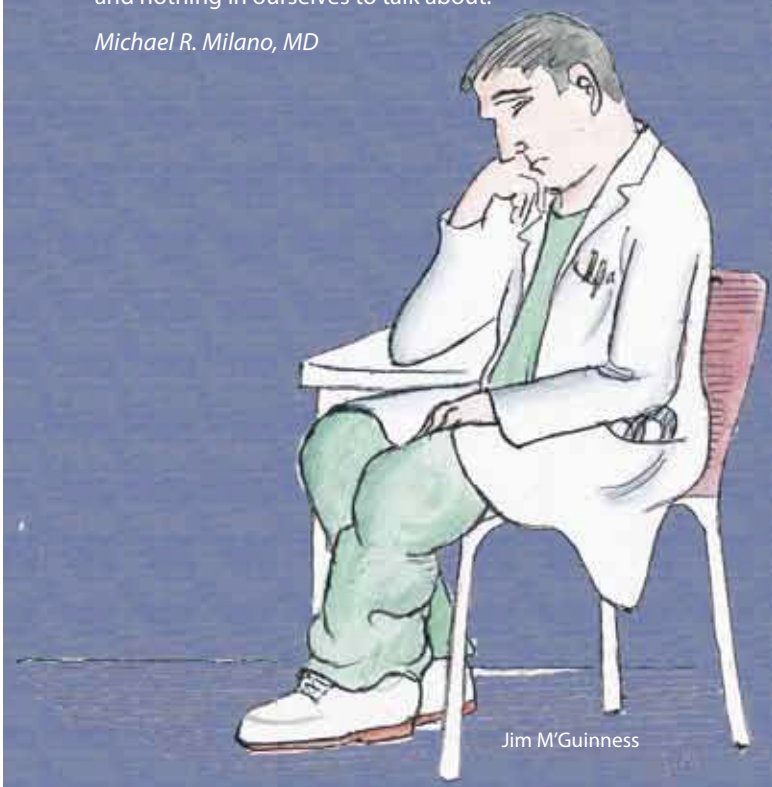

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