Health System Transformation Lecture
The Missing Link in Health Reform
Lecture

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Well, thanks for that kind introduction, Lydia. I'm going to have to review the pay increase—probably not quite enough. But good afternoon, everybody. Come on, you can't be that tired, it's only 4:00. You got to be kidding me. No, it's great to be here to talk about this issue of chronic disease in the context of health care reform.

We hear a lot about change and experience and new directions on the campaign trail, and I think, if we're going to reform health care or do anything on health reform, we're going to need all of the above.

Senator McCain has made this week his Health Week, which, again is, I think, an interesting phenomenon in the context of a Republican candidate moving ahead on this issue even before the convention. So I think it does speak to the fact that health care is a major issue facing the American public, and certainly, it's a major issue that is going to be debated, I think, even more vigorously during the general election. My sense—and I'm just thinking forward here, moving into 2009.

As Lydia mentioned, I had the pleasure and opportunity to work, in 1993 and '94 in the White House and with President and Mrs. Clinton on developing a health care reform effort. I was primarily involved in the financing parts of it. But I can tell you—obviously, that didn't work. And second is that I think there's a lot of lessons, a lot of takeaways from that effort.

And one thing I do know is that the interest groups—both on the business side, the consumer side, the labor side, groups that deal with disease groups, and others—I think, are anxious to find some common ground, going into 2009, about how to proceed with health care reform.

I think that there is certainly a weariness of combating on this and beating each other up over elements of health care reform that, as you can see, we haven't been successful at this for sixty, seventy, eighty years. This goes back to Teddy Roosevelt in the early part of the 20th century and literally, virtually every administration has proposed one form or another of health care reform effort, largely defined around the financing issues of health care.

The most politically contentious parts of the debate. And I can tell you, they are vigorously debated. One thing that Lydia didn't tell you—before I went into government—I'm now 5'11", I used to be 7'3". So you do get your knees taken out from under you quite often there. And so my focus here is to think through what can we learn from this eighty years of not getting it right?

And I think, obviously, that, moving into 2009, we need three things. We need a different message, a different strategy, and it's got to be bipartisan support.

It doesn't really matter what happens, that much, in the Senate or the House—the Democrats are going to do very well. Whether they really get to a supermajority in the Senate is perhaps doubtful, which means that anything we do on this issue has got to be a proposal that engenders support from both sides of the aisle.

Firstly, all the debate, if you think about it, that you've seen happen over the last forty or fifty years, and some of the recent activities at the state level—California being perhaps the most notable one, that was an incredibly contentious debate about how to proceed with health care reform.

But most of that debate has largely centered and focused on the issues facing the uninsured. And those are issues that I've worked on for much of my career. It's something near and dear to my hear, it's a major part of what we need to do in terms of reforming health care. They count for about 15 percent of the population.

The flip side of the uninsured, of course, is that 250 million Americans have health insurance coverage, so 85 percent have some type of public or private coverage. My favorite line that I talk to some of the politicians when they're thinking this through about how to craft a message in the context of a political campaign is that 96 percent of people who voted in 2006 had health insurance. And their number one issue by far is that it costs too much.

So there's a tremendous amount of anxiety out there among, particularly, small-business owners and workers and families, parents worried about the states pulling back eligibility for the SCHIP program, about how much health care costs.

So it seemed to me that one opportunity that we may have this time going around is to start the debate in a different place. That rather than starting the debate in the most difficult political aspects of this issue over health financing reform, which is really the politics of how we're going to move money around the system, how we're going to raise money to pay for the uninsured, is it a public or private system.

Issues that, frankly, for a long time, we don't have a plurality of support for any one proposal and, indeed, we've got groups of, I think, three that would like to see a private-sector solution, a mandated solution, a single-payer solution, but none of them have enough votes to really move their agenda forward. And the unfortunate truth about it is that everybody's second choice in this game is the status quo. So the ability to compromise and move toward some common ground, obviously, has not worked.

So I'm thinking, going into 2009—this is not rocket science—don't do that. Don't start there, let's try something different and see if we can't build some type of a coalition around something. And my story here is going to be let's do it around health. And not just health care financing reform, but really about health reform.

Now, to do this right, if affordability is really the major issue—which I think it is, and it's certainly the major issue among voters, who are worried about the cost of health insurance.

If you're going to craft effective solutions to this problem, you've got to start with a clear understanding of the issue, and you have to come up with a common definition of the issue. It's not that we haven't worried about health care costs over the last fifteen, twenty years or beyond, I think the dilemma has been, is that everybody's been solving a different problem. Everybody has a different premonition and notion of why health care spending is too high.

Some think it's malpractice expenses, some think it's defensive medicine, some think it's rising rates of waste. So there's an explosion in this country of recreational colonoscopies, and that's really driving the growth in spending. [Laughter]

So, you know, if you start with everybody having a different opinion about the problem, you're unlikely to (a) craft anything that's effective or (b) to really come together on a common set of proposals to really deal with this. So one of the things I've been working on for the last year, whether it's at the state level, and certainly, with all the presidential aspirants, is putting in front of them just some very simple statistics.

Just as a quick aside here—one of the things on health care reform that I've found, and as you listen to politicians and candidates debate this over the years, this is very complicated. The health care system's complicated, these health care reform proposals are complicated.

I remember working with Senator Kerry, thinking his plan through four years ago. I've looked to the guy as very thoughtful, he knows this issue inside and out, he put together, I think, a very innovative plan. He couldn't explain it to anybody—it was too complicated. So I sat with—my target audience on this issue is my Mom. So if my Mom can't understand what somebody's saying in 15 seconds about their reform proposal, you might as well not say it at all. It's just not getting any traction.

So I made her watch the Kerry speech, I made her watch the Bush speech on health care. I just sort of asked her what her takeaways were. She didn't understand any of it. So this time around, I said, Mom, I got a very simple way to frame this. Why don't you listen to the pitch?

After I pulled her out from underneath the bed, because she had about had it with health care reform proposals, I went through this presentation and, to her, it made some sense about what we're trying to solve.

So I call these the Six Unhealthy Truths about the Rise in Chronic Disease and what impact and role it plays in the health care system. Truth 1 should not be, and it is not, a surprise to most people in this audience, and certainly people on the panel with me. But remember, I'm speaking to a general audience here, which includes politicians.

And I'll show you some slides at the end, which are kind of intriguing and perhaps disturbing, about the awareness of this issue in political circles. But we know chronic disease is the number one cause of death and disability in the United States. It accounts for about 70 percent of mortality in a particular year. That's 1.7 million deaths a year linked to this disease.

So it is a major impact, as we well know, on underlying morbidity and mortality in our health care system. This second one is my favorite one, though, because if you—after I get through talking about this, let's just think about the implications for it just a minute.

About 75 percent of what we spend on health care is associated with patients that have one or more chronic health care conditions. That means we're talking about patients with established, longstanding medical conditions, where the health care challenge is one of more effective self- and more effective clinical management of those diseases and conditions.

This isn't necessarily an issue, per se, of insurance and people who are sick, that we can affect through benefit design by raising copays and deductibles and, indeed, as we'll talk about, many of the solutions to this issue are exactly the opposite. Moving copays and deductibles down and then perhaps even to zero for medical maintenance services such as annual eye exams, extremity exams, and so on.

So this is not something in the context of managing health care spending that we are going to easily solve just through high-deductible health care plans. They're a great addition to the product mix, it's certainly a good innovation in the marketplace, but if you think about it, the typical patient that's driving these spending dollars is a hypertensive diabetic with elevated cholesterol, bad triglycerides.

They're obese, so they got some pulmonary issues, bouts of asthma, some back problems, and they're depressed. That's what a primary care doc gets to deal with in a 15-minute established office visit as that physician waits for the patient to show up and explain all their problems that he or she may have. That is not something that we're going to effectively manage through a $2,000 deductible plan and, indeed, the last thing you probably want to do is run that person through a $2,000 deductible plan. Medicare owns this population. Well over 90 percent of spending in the Medicare population is linked to that type of clinical profile that I just talked about.

What about the growth in spending? Well, this is something we've been working out with my colleagues here for a couple of years now. I got into the growth in spending piece about four years ago only because the only base of information we had about spending increases came from the National Health Accounts data that came out every year.

So CMS does a great job with their actuaries and economists there in putting together a document that shows where we spend our money, what it goes to, and who pays the bill. And it's a very interesting study, gets the front page in USA Today, Parade magazine.

By the way, for those of you who want to influence the public, those are the only two things that matter, *Parade* magazine and *USA Today*. You think you're pretty special if you get something in the *Washington Post* or the *New York Times*. You missed your target. You know, you really got to get in *USA Today* and *Parade*. Well, it gets front-page coverage there.

And I kept looking at these numbers. This is interesting stuff, tells an interesting story, but if you think about it from a policymaker standpoint, either in the public or private sector, what do you

take away from that? What does it mean? Does it mean that, if you see drug spending going up, that somehow, we must more aggressively manage the drug budget?

Or if you see hospital spending rising a little bit faster, that we need to budget out all the hospitals in this country? Sort of begged the question to me that we really didn't understand what was underneath the trends. And, indeed, if you go back to the literature on this, we have virtually no information on what's really driving the growth in spending. Therefore I think a lot of the policy confusion that exists out there about how to proceed with effective interventions.

Well, what we did is basically say this is, you know, if you think about it, a fairly simple proposition. Spending goes up because we're either treating more patients with a particular disease or it's costing more to treat those patients due to technology and other things that are happening or some combination of the two. So we took the top 20 medical conditions and the 20 most expensive medical conditions that generate about 85 percent to 90 percent of total spending and decomposed the growth in spending over periods of time to see how much of it was due to a rise in the prevalence of treated disease and how much of it is due to an increase in spending per treated case.

And as it turns out, across that entire set of categories, about two-thirds of the growth is due to a rise in the prevalence of treated disease. So that led us into some more research on this issue because, obviously, treated prevalence can rise over time for a whole host of reasons, some good, some bad. The good ones may be better detection, our ability to have new technologies that can treat where we didn't have the capacity before, a better capacity—and depression is a great example of this—of people to recognize symptoms of disease and get them diagnosed and get people into earlier treatment.

Or the one that I was most interested in, which was on the bad side of this—how much of this is truly due to a rise in the clinical incidence of disease related to lifestyle factors? We started to look into some of the data like this. These are looking at the adult population, and this is just to make my point about the two-thirds. This is the percent of adults that are being—that have been diagnosed and treated for each of these medical conditions.

So if you look at the explosion in the share of the population under some sort of medical management here, this list of conditions and diseases should look pretty familiar with respect to their linkages to lifestyle, whether it's smoking or whether it's excess weight, diet, and lack of exercise.

I won't go through each of these charts, but this is a great visual. These are the state data on obesity. Regardless of whether it's self-reported or if they're clinical measures, it has doubled. You may find interesting that the self-reported data, the share that are reported as obese are about 10 percentage points lower than the actual clinical measurements, and that's probably not because people are lying about their height, it's probably a little under-reporting on the weight side.

So these numbers have doubled over time. Today, we have 34 percent of the population, give or take, that are clinically obese. What we found is that doubling of obesity since 1985, by itself,

accounts for 20 percent to 30 percent of the growth in spending. So it's not all technology. Technology is a piece of this, and a major piece of it, but it's not all technology that this rising rates of disease incidence is a major part of the story.

Another way of quantifying it—if, somehow, through a magic wand, we could've kept the rates of obesity in this country at 1987 levels, even with today's inefficiencies, treatment decisions, treatment rates, the way we approach patients, we'd spend about $200 billion or so less on health care. We'd take about 10 percent off the base. It's an amazing number, it's a large number. Now, this is an adaptation from Ed Gregg over at the CDC, who's done some terrific work on looking at some of these secular trends in cardiovascular risk factors.

But this growth—I'm just going to give you an idea on diabetes over this time period. It's gone up substantially, 5 percent to almost 9 percent. And if you decompose where that growth in the prevalence of diabetes is coming from and you do the math here, you'll see that virtually 100 percent of the growth in diabetes prevalence is due to rising rates of obesity.

So the contributions to this epidemic are virtually all driven by rising rates of obesity. Another way of saying it is that the prevalence of diabetes among obese adults is about 14%. It was 14% twenty years ago. And the prevalence of diabetes among normal-weight adults is about 4%, and it was about 4 percent twenty years ago. The only thing that's happened is that we've had a dramatic shift in the distribution of people in those weight categories. And so it is the major driver of the growth in diabetes spending, it is a major driver in the growth in the prevalence of diabetes.

Fifth truth, and these are some tabulations we've pulled from various things from the CDC. The good news part of the talk is that much of this is preventable. Up to about 80 percent of heart disease, stroke, type 2 diabetes, hypertension, hyperlipidemia, is potentially preventable. And on the upper side, perhaps 40 percent of certain types of incident cases of cancer potentially preventable if we do three very difficult things—and they are difficult.

I don't want to understate the difficulty of getting people to change and do these things. And it deals with smoking, eating, weight, and being in shape. The other part of this is that we know that we don't, in today's delivery model, do a very good job of managing people with these multiple chronic diseases, largely because the delivery system that we have in this country, which is largely driven by Medicare policy, was built for patients in the 1950s.

The Medicare benefit design and how Medicare is structured, other than the drug benefit, has not changed materially since 1965. It is a very reactive system designed for acutely, episodically ill patients that, obviously, still exist in our health care system, but that's not the clinical profile of where the money is and the typical profile of patients driving the health care dollar.

The sixth truth. We do a lot of work—we did some polling of this when we first rolled this Partnership out, just to see what the American public's knowledge of the issue was. And then we did a separate set of polling like this with Hill staff and with key members of the Finance, Ways and Means Committee to see if they could guess this right. And we asked the two simple

questions—we asked more, but the two ones that I think are interesting is what percent of death is linked to chronic disease and what percent of spending is linked to chronic disease?

And, you know, the answers were 70 percent and 75 percent. And as you can see from the data, about 15 percent of the public gets it about right. So a lot of the challenge here is that, while this is well known in this room, it is not well known in the policy community, it's certainly not well known on Capitol Hill, and until I showed this presentation to my mom, it wasn't well known there either.

But I got to the end of the presentation and, my Mom now being an expert policymaker, as you're going to see in a minute, says, you know what? This is actually pretty simple. This doesn't have to be complicated. You manage the money and look where the embedded dollars are, the old Willie Sutton phenomenon, and you do something on the basics of primary health prevention of lifestyle and obesity and smoking.

So this doesn't have to be very complicated and, at the end of the session, my Mom is probably, or should be, a chief policy advisor to any one of the candidates on this issue, to get them focused on the right set of policies around the affordability piece. So what does that mean? The one thing that's positive about this is that the types of interventions and solutions to dealing with the affordability issue really do fall into those two issues.

What can we do to slow the growth in obesity and with it the increase in the incidence of chronic illness? What can we do on the population management side to get people to more effectively manage their chronic illnesses? Which, we don't do a very good job for a whole host of reasons now. What do we do about the design of the delivery system that was really built for patients fifty years ago, that is not really very well equipped to deal with patients today?

And as you're going to see in a minute—I'm going to lay out just a couple of issues here—the solutions to these issues are not partisan issues, per se. That doesn't mean that they're not difficult issues. But in terms of an ideological framing of this, these are not necessarily Republican issues or Democratic issues or conservative issues or liberal issues. I call them just commonsense initiatives.

And if you have this debate framed around a set of commonsense initiatives, you can pull together a bipartisan coalition, not only in Congress, but certainly of interest groups that are willing to roll up their sleeves and finally have a vehicle and an opportunity to work on something together around this very difficult issue of health care reform. So this group that Lydia mentioned, the Partnership to Fight Chronic Disease, that—I helped start it a year ago, sort of trying to figure out is there a vehicle that we could use to build a bipartisan coalition. It is now up to 115 groups.

The nice thing about it is that all the groups that used to sling arrows and shoot at me constantly about fourteen years ago, they're all members. They're all my new best friends, we love each other. The National Retail Federation, the National Association of Manufacturers, the Chamber of Commerce. All of the business groups. We got the labor unions, we got the American Hospital Association. You can go down the list. It's not just those kinds of groups—we got the

YMCA. So it is a very broad coalition of groups that have a major stake in health reform and quality and the cost of health insurance.

I think that they have seen, when you go through those six unhealthful truths, a framework that people can collaborate in a new and different way around this issue. I'm just going to leave you, you know, with the obvious places that we are focusing our discussion. Some of this is going to be a more detailed layout June 5th. We have an event in Washington, June 5th, at the Willard Hotel that the Institute for Advanced Policy Solutions here at Emory and the Partnership are sponsoring on the Hill to have the discussion directly on the Hill with policymakers and Congressional staff and a broader range of interest groups really getting the ball rolling, coming into 2009, around these issues.

You know, one is that—the one obvious answer to this is that—and you're going to hear from Ron Goetzel in a minute. You know, people have obviously been working on this issue for a long time, of prevention, and work in productivity management. My own parochial view of that is that it's never been taken seriously by anybody in the health care cost containment community as a solution to the problem. It's been one of those things, it says yeah, it's nice to do, you guys go in the corner and solve that stuff, that's all the goody-two-shoes stuff. Let's let, you know, the real intellects in the room who can solve this problem by benefit design, let's really let the pros come in and deal with the core of the problem.

So one of, I think, the paradigm shifts here that's very important is that, by bringing this lifestyle change agenda and the focus on rising rates of disease incidence center stage into the discussion about cost containment is a major shift in the nature of the discussion, and is a major shift, I think, in the cost containment paradigm. So that's one important change that we want to continue to work on.

The second part of it, which is, again, pretty obvious, is that, you know, we have a delivery model that, unless we make changes in how we pay for health care services in this country, is not going to allow the system to build the type of collaborative, integrated approaches to working with patients to manage their care in a more proactive manner outside of the physician's office and to provide the opportunity for, I think, recentering the primary care physician and nurse community center stage in helping to coordinate and manage care.

And again, I go to the Medicare program being one of the worst offenders of this. That's a universal insurance single-payer system. If you look at their metrics of what percent of clinically recommended care do Medicare beneficiaries get around chronic disease, they are about the worst in the country. It's not about the insurance, it's about the delivery system side, it's about how you pay for health care.

And that's an area that's ripe for reform in a way that is going to be positive for primary care physicians and positive for patients. And, yes, hospitals understand there's reallocations of money in the system. The AHA is one of our biggest supporters in helping us think this through and design the system. But these innovations in delivery and the innovations in the technology base will not happen until we change the way we pay.

So there's a lot of opportunities to rethink the design around the payment model, to rethink the design around the technology base and get serious about more rapid diffusion of information technology in the health care system and allow more bundled, integrated models to develop. So these are the areas that we're doing some work in. As I said, we call them the Commonsense Approaches.

You slow the rise in the prevalence of disease, you do this in the community. And we're developing best-practice community interventions. You do this in the schools, you do this in the workplace. And there are effective programs in all three of those venues. The challenge is, is to identify the ones that work, why they work, and find ways to more rapidly diffuse those models into those three settings. And we need to modernize the system. We actually need to have a health care delivery system that recognizes that there is an integration of population and public health, along with the more traditional medical care system, and to really take seriously what you learn in a school of public health, that there are multiple determinants of health.

And as it turns out, the health care system itself is not a major determinant of the health of populations. Other factors are, such as lifestyle and behavior and the environment and social issues and cultural issues. All of those interact, I think, perhaps in far more important ways, and we need to rethink that policy set, we need to rethink the set of tools that we use to really improve the health of populations in a more general way.

At the end of the day, the reason I'm optimistic are twofold—and I'll close. One, If you look at the presidential health care proposals of Obama, Clinton, McCain, all of them, to a more or less amount of detail, have major pieces in those proposals dealing with prevention and chronic disease management and innovations in the system design. So that is a positive.

You don't hear about it because they agree about it. So that's an area that, unfortunately, it's a major part of health reform that you don't hear anything about because there's uniform agreement about how to proceed with it. They differ on the coverage side, they differ on the politics of how to proceed with the health insurance coverage, how to pay for it, what the structure that system should be, but they agree on the basic parts of health reform.

Two, is that we've been working with the finance committee. Senator Wyden has a bill up there with 12 cosponsors. It's a broad bill that deals with both coverage and affordability. The good news is that you've got 12 cosponsors—6 Republican, 6 Democrat. It is the—in the Finance Committee history, it is the bill that has the most bipartisan cosponsors of any bill that has been brought to bear to date. That perhaps provides a framework for discussion, moving into 2009, around some of these issues of affordability and chronic disease and prevention that already has a very broad bipartisan support.

And I think, finally, in closing, the groups that I've been working with have been eager, energetic, and enthusiastic about trying to get this thing, for the first time in eighty years, off on the right foot by making sure that we start with something that's critically important. It's really health reform, not just health financing reform. But starting the discussion in an area where they do have bipartisan support. And actually, perhaps, in the first year or so of a new administration,

regardless of who wins, something substantial around this issue of health reform could actually pass. So thanks for your attention, and I will turn it over to my discussants.

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