

Building a Value-Based Health Care System

Prologue Series



WHAT IS PAST
IS PROLOGUE

Michael O. Leavitt

Secretary
U.S. Department of Health and Human Services

Prologue Series

I have come to understand that public service is a generational relay. Many of the most profound problems are not ours to solve in finality, but rather to incrementally improve during our temporary stewardship.

Three foundation goals thus form the basis for my public service: to leave things better than I found them; to plant seeds for the next generation; and to conclude my work knowing I have given my all.

For nearly sixteen years, my life has evolved in four year terms. I was elected three times as Governor of Utah. Some of what I consider our accomplishments were initiated in my first term, but fully matured in my third. Likewise, some seeds planted in my third term are only now beginning to flower.

Living in four year cycles has taught me the importance of choosing priorities and impressed the need for urgency. Time passes quickly.

I am currently in my fifth year as a member of President George W. Bush's Cabinet. I served first as the Administrator of the Environmental Protection Agency and now as Secretary of Health and Human Services. The constitutional constraints on the President's service imposed limits on what initiatives I might see to completion. However, I view it as my obligation to lead with a longer horizon in mind.

Over time, I have developed a set of tools useful in keeping a long-term vision in mind while managing the day-to-day problems. One such tool is a 5,000 Day Vision, with a 500 Day Plan.

The 5,000 Day Vision is our aspiration for various long-term outcomes. The 500 Day Plan is more granular, listing what needs to be done now to bring about the larger vision. Both are recalibrated periodically.

As my stewardship comes to a close, it is time to plant seeds for the next generation. I intend to write and deliver a series of formal speeches to convey some of the 5,000 Day Vision and share what I see on our approaching horizon.

I call these speeches *The Prologue Series*. There is a statue behind the National Archives that I look at nearly every day as I drive between HHS and the White House. The statue, the work of Robert Aitken, is called "The Future." It depicts a woman looking up to the horizon from a book as if to ponder what she has just read. At the base of the statue are the words from Shakespeare's *The Tempest* "What is past is prologue."

This speech in *The Prologue Series* is titled: "Building a Value-based Health Care System."

Michael O. Leavitt

Secretary,

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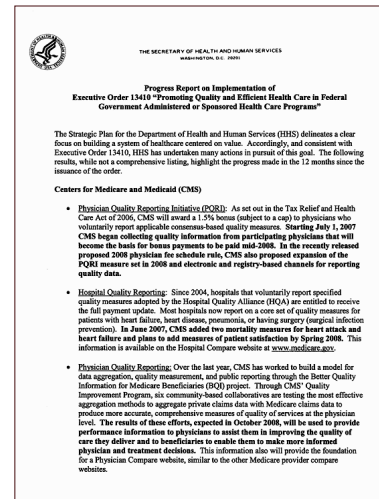
Speech given on April 23, 2008

in Washington, DC

The health care billing system we use in our country is irrational. It cannot be understood by a human being of average intelligence and limited patience. It is time that we challenge the basic assumption that health care is markedly different from the other things we buy.

I've tried to imagine applying our health care billing methods to any other part of our economy. Consider buying a new car. Building cars is a very complex enterprise with many processes and suppliers. However, buying a car is relatively straightforward. There are price and quality measures that people can compare to determine which car they think is the best value to meet their needs.

This morning [Spring 2008] I saw that *Consumer Reports* is doing a new comparison on the value represented by different hybrids, and the analysis is all over the news. We have consumer reporting for the automobile business. We don't have it for health care.



Progress Report on Executive Order 13410. The Executive Order Promoting Quality and Efficient Health Care in Federal Government Administrated or Sponsored Health Care Programs has been a positive force for change within the Federal government and across the private sector.

We need standardized methods of quality measurement and we need them soon.

The way we price health care cannot be understood by a human being of average intelligence or limited patience.

What if you decided to buy a car and the same thing happened to you that happens to people who get a knee operation? Let me describe what it might look like: the dealer would say to you, “Look, we don’t really know the price here, but we know you really need the car. So, why don’t you just come by and pick it up and you can begin to use it.” Then three weeks later, you begin to get a blizzard of bills.

A bill would arrive from the people who made the vehicle chassis, followed by a bill from the transmission manufacturer. You would receive bills from the seat maker and the paint company and the folks who made the sound system. Later, a bill from the dealership would arrive with charges reflecting the time you spent in the showroom. A separate charge would be incurred for the salesperson’s help and a charge of \$27.90 for the coffee you drank while you waited.

Gratefully, cars aren’t sold that way. All of those costs are packaged and managed by a car company. Consumers get one price, up front. It’s a price they understand, and a price they can compare.

Some of my friends in the practice of medicine are going to find this analogy troubling. They may point out that buying a car is different from having a knee operation. The analogy isn’t perfect, but let’s not miss the point here.

Last year, Medicare paid for 255,000 knee operations. (Incidentally, we also paid for 95,000 heart bypass operations and 91,000 lung cancer treatments.) Believe me, if you pay for 255,000 of anything, you’re going to know what procedures are done, who is doing them, and what medical supplies and facilities are used, etc. We know these component costs. And not only do we know that, but the medical practitioners who perform those operations also know.

A consumer should be able to get a single price for common procedures and the price should include all costs: the hospital costs, the surgeon, the anesthesiologist, the rehab, the pharmacy, the labs, the crutches—all the component costs should be in the one price. In the auto industry, if the steering wheel maker charges an exorbitant price, the car company finds a more competitive supplier. In health care, if the medical equipment supplier charges an exorbitant price, none of the

others care. Health care is performed by army of individual contractors with nobody in charge of assuring the delivery of overall value.

Think of the many transforming benefits single-price cost information would have. A powerful, behind-the-scenes level of coordination and accountability that does not exist today would develop. If an episode price was established and the medical equipment people tried to price-gouge, it would not be up to the consumer to deal with the inflated cost. The other providers who came together on the package would say to the supplier, you're costing me money.

Another benefit can be illustrated by the case of a patient who is re-admitted to the hospital because of an avoidable hospital-acquired infection or other major error. The patient and insurer shouldn't have to incur new costs in this scenario. In an all-inclusive price environment this type of event could be more adequately and fairly addressed, just as we see with the implicit and explicit warranties on the many other goods and services we buy.

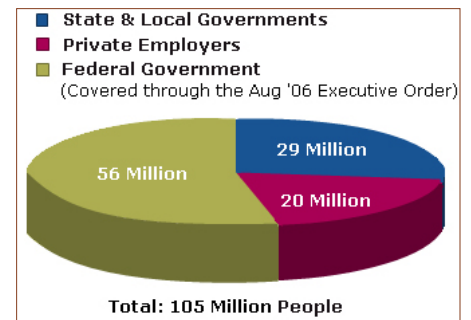
Lastly, pricing by episode-of-care promotes an environment where consumers and payers can more easily comparison shop. Apples-to-apples type comparisons make competition across the marketplace more possible and allow the market to reward performance. This is called value-based health care.

A value-based national health care movement is taking shape and gaining momentum right now. I envision a time, not far from now, when patients will be able to define and compare the cost of health care to create an informed value-based system. Information empowers consumers and industry, and motivates the entire system to provide better care.

As Secretary of Health and Human Services, I have devoted a good share of my energies and my Department's resources to nurturing this movement over the past three years. Today, I'd like to summarize the progress of the value-based movement, its present direction, and a strategy for the future.

The value-based health care movement isn't an organization with a membership card. It is a growing collection of people, organizations and governments that believe value-of-care should replace volume-of-care as the most important virtue in the way we pay for and consume health care in this country.

People Covered by Health Care Payers Who Have Committed to the Principles of Value-Based Health Care



Health care purchasers across business and local, state and the federal government have made voluntary commitments to move toward value-based purchasing. These numbers are based on signed Statements of Support of the Four Cornerstones of Value-Based Health Care.

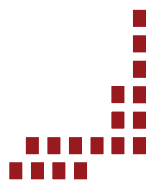
At the end of the day this is about empowering consumers giving them the tools and information they need to maximize their health-care dollars, and to make well-informed decisions regarding health-care providers and services

—Ed Mullins
President, Sergeants Benevolent Association of New York City



The Four Cornerstones:

- 1. Standard Quality Measures**
- 2. Cost Comparisons**
- 3. Interoperable Health Technology**
- 4. Incentives**



The Four Cornerstones Framework is a big-picture work plan.

We are seeing the emergence of a framework that helps people visualize the major requirements of value-based health care. The framework is the Four Cornerstones. The first cornerstone is standard quality measures. The second is cost comparisons. The third is interoperable electronic health records, and the fourth is incentives. The Four Cornerstone Framework is a big-picture work plan. It's safe to say that tens of thousands of Americans are creating practical expressions of the Four Cornerstones.

The First Cornerstone

The first cornerstone is standard quality measures. When you shop for a car, there are many standards you can consider. Fuel economy is a critical one for people today.

There is abundant work being done around the United States to develop standard measures of health care quality. In the last three years, there's been an explosive growth in the number of groups that are working to crack the code on quality.

The result is a large increase in the number of measures of quality. The problem is, we have not had much standardization. Our progress is highly fragmented. As a friend of mine likes to say, the great thing about health care standards is there's just so many to choose from. That's not progress.

Great effort has been made the last three years to change that. The medical family: patient-centered organizations, insurers, government, employers and unions, have worked to develop what I collectively refer to as the "Quality Enterprise," an alliance that includes groups like the National Quality Forum, the AMA Physicians Consortium, the AQA (formally the Ambulatory Quality Alliance), the Hospital Quality Alliance and many others.

Collectively, the "Quality Enterprise" is focused on defining, aligning and implementing quality measures. My belief is that the collaborative stakeholder process is the best way to develop national standards. The commitment across HHS is to adopt endorsed measures and to adapt our activities as the process evolves.

Progress on a modest number of uniform measures is occurring but it is still taking too much time. Frankly, the process remains complicated and slow. Hopefully, it will gain speed as all of us gain experience. However, our health care system needs standardized methods of quality measurement, and we need them soon.

As health care's largest payer, I believe that HHS has a duty to push the envelope. Accordingly, HHS is creating an inventory of all of the quality measures that we are currently using in the Department. And there are an amazing number of quality measures—hundreds of them.

Before the conclusion of my service, I plan to publish these measures to the health care marketplace so they can see our current and planned quality measurement thinking. My intent is to accelerate the velocity of the measurement and collaborative processes, and to enable measurement development and endorsement organizations to keep pace with our efforts.

The Second Cornerstone

The second cornerstone is cost comparison. It's what you do once you've settled on the make and model of the car you want. You check newspaper ads, the web and visit showrooms, looking for the best price.

During the past three years we have seen a steady but slow development of comparative-cost data in the health care field. For example, Medicare is reporting on its costs for common physician and hospital procedures.

I have also seen a number of insurance companies aggressively organize and shape pricing data for their own beneficiaries. Once again, the glaring deficiency has been the lack of speed in developing standards for data collection. We need to do better.

I commend the leadership of the Robert Wood Johnson Foundation. It is providing funding to create episode-based cost-of-care measures for 20 common conditions. This is a very good start, but it is only a start. Cost comparison efforts need more speed if we are to stimulate the market place with useful cost information. I emphasize again the importance of this, not just for the purposes of measurement, but also for the transformative impact cost comparison information can immediately have on the whole system of health care.

Back to our role in pushing the envelope and the second cornerstone of cost comparison. I want to make clear that HHS will use efficiency measures when they're available, but we cannot continue to let perfect be the enemy of good when the status quo is a far more potent enemy.

Health insurance plans are committed to a safer, more effective and interconnected health care system.

—Karen Ignagni,
President and CEO, America's Health
Insurance Plans

Consumers in the marketplace are sophisticated when they have access to information, enabling them to make informed decisions about the services and products they purchase. Decisions in health care should be no different.

—Governor Sonny Perdue, Georgia



EPA.gov Web site compares the fuel economy and environmental impact of vehicles.

HHS will soon publish information by cost and by volume on the top Medicare procedures as part of an efficiency road map that we're developing. We are hopeful that by showing specifically where efficiency measures are needed, we will speed the collaborative process.

Because I want to learn more about the power of value-based competition, Medicare is developing a demonstration that establishes bundled payments for hospital-based episodes-of-care. Participating hospitals would be able to competitively bid for these episodes. We would then share the savings with the beneficiaries who choose hospitals that priced their care below the episode rate. This not only holds the potential to improve quality and reduce costs by encouraging physicians and hospitals to work together; it also encourages and allows consumers to make informed decisions.

The Third Cornerstone

Let's move to the third cornerstone, health IT. Three years ago, there were 200 vendors selling electronic medical equipment or systems and no standards existed for interoperability. One system could not exchange information with another. Since that time, we've made remarkable progress. A process is in place to establish standards for systems that will allow interoperability while addressing privacy and security of information. We are now steadily marching toward interoperability.



Future Hospital Performance Report
These quality ratings are designed to help choose the hospital that may best meet the needs of people with certain conditions. View [ratings](#) to see their performance or [click on a category](#) to see the rating scales.

Medical Condition: Heart Attack

Rating Key
 ★★★★★ Above the US Average | ★★★★★ Below US Average | Improve from Previous Year
 ↑ Normal | ↓ Worse

Hospital	CAHS	2008-2009	2009-2010	Total Rating	Heart Attack Care Costs			Hospital Patient Satisfaction		
					Heart Attack Performance	Heart Attack Care Costs	Heart Attack Care Costs	Overall Rating	Overall Rating	Overall Rating
Hospital A ABC STREET NEW YORK NY 10001-10001	475	480	\$1,793 - \$3,344	★★★★★	★★★★★	★★★★★	★★★★★	★★★★★	★★★★★	★★★★★
Hospital B ABC STREET NEW YORK NY 10001-10001	678	681	\$6,073 - \$9,049	★★★★★	★★★★★	★★★★★	★★★★★	★★★★★	★★★★★	★★★★★
State Average	507%	507%	55%	62%	73%	82%	93%	93%	93%	93%
U.S. Average	84%	80%	70%	67%	77%	81%	91%	91%	91%	91%

www.hospitalcompare.hhs.gov displays quality rating for hospitals. Our vision is to create a more expansive Hospital Performance Report for all common procedures and every doctor.

We've created a process with the Certification Commission for Healthcare Information Technology or CCHIT, so products can be certified as demonstrating they meet standards of interoperability. Today, more than 75 percent of the products sold in the marketplace carry the certification of CCHIT. In addition, a national health information network will start testing the flow of information between different providers by the end of this year [2008]. By next year, we will be transmitting and sharing real data.

The number of hospitals and larger physician practices that employ electronic medical records have steadily increased. However, we continue to have a serious challenge among small-to-medium practices. Fewer than 10 percent of smaller medical groups have health IT systems.

We have studied this issue carefully and have come to the conclusion that the issues are two-fold. They are economic burden and the burden of change. We have begun to experiment

with different methods of changing the macro-economics of reimbursement so that even small practice doctors share in the financial benefits.

We are also beginning a pilot program to provide Medicare beneficiaries with personal health records. With the entry of major technology players, the momentum is beginning to build. We are on the verge of an era when consumer management of personal records is going to increase the adoption of interoperable systems by providers. Once the consumer is directly involved, there will be dramatically heightened interest in the cost and quality of health care.

One thing I am sure of is that consumers will not become seriously engaged in managing their health records until those records can be automatically populated with information from across the organizations that provide their care. Personal health records won't catch on if people have to manually enter large amounts of information into their own records. If they can download and easily maintain records, consumers will have a very important tool.

Finally, HHS is signaling that in the near future, payers like Medicare won't reimburse doctors at the highest level unless they're willing to interact with us at the highest level of efficiency, including interoperable systems.

A good example of this is e-prescribing. The software exists today in nearly all pharmacies and many doctors' offices. It saves money. It saves lives. It is convenient. Congress has finally realized that it's now time to fully implement e-prescribing by including incentives and disincentives in the Medicare legislation passed in July 2008. This statute enables financial incentives for providers during the initial years of implementation and disincentives for non-complying providers soon after. I intend to implement this system prior to the end of the President's term in January of 2009.

The Fourth Cornerstone

The fourth cornerstone is incentives. This is where we begin to answer the question, "How is all this going to save money?" Well, the answer is that it's not only going to improve efficiency, but it will also eliminate duplication and unnecessary services.

Value is a function of both quality and cost. As the availability of quality and cost information improves, so will our capacity to develop incentives that reward better results. When we reward high quality, low cost outcomes through incentives, we send signals to

The momentum is beginning to build. We are on the verge of an era when consumer management of personal records is going to increase.

A study found that 80 percent of medical errors began with miscommunication, missing or incorrect information about patients, or lack of access to patient records.

—Annals of Medicine, 2004

It saves money and lives. It's time to fully implement e-prescribing.

We continue to have a serious challenge with small to medium-sized practices, where fewer than 10 percent of the practices use health IT systems.

The national health care market is really a network of local markets. If we're actually going to see a national system of health care that has a philosophy of value-based care, we're going to have to implement it one market at a time.

the marketplace that 'value' is important. These 'value signals' are just another way to describe incentives and disincentives.

Value-signal strength can be progressive. That is, the stronger the signal, the more predictable the behavior. For example, as information on quality and cost becomes more reliable, health care plans are better able to design benefits, which in turn will guide patients to consider value. Patients are better informed and motivated. In the future, we will see insurance plans and employers saying to their employees, "If you will go to a high-quality, moderate-cost physician, we'll pay for most of it. But if you insist on going to your brother-in-law who is unwilling to participate in quality measurement and is still high-priced, you're going to have to chip-in on that."

Sometimes we will see incentives and disincentives used in combination. We've seen this before. Do you remember when the ATMs were first put into banks? They would put people in the lobby and show customers how to use their cards. They gave out toaster ovens and would do just about anything they could to get people to use the ATMs. People needed incentives to use the new technology. But there was a point at which the banks changed their approach, and said, "If you're going to come to the counter, we're going to charge you more." The E-prescribing legislation I described earlier exemplifies this balance of incentives and disincentives.

National Standards and Local Solutions

As we implement value-based health care, it is important to remember there really is no such thing as a national health care market. The national health care system is really a network of local markets. If we're actually going to see a national model of health care with a philosophy of value-based care, we're going to have to implement it one market at a time.

I mentioned earlier that we are working with collaborative stakeholder organizations that have emerged across the country. They want to figure out how to measure and improve quality. In the last three years, I've visited over 100 different medical markets to talk about value-based care with stakeholder communities.

I have learned three things from these visits that will help focus our implementation efforts:

- Local trust is important
- Value-based health care requires national standards
- Medicare reform is key

Building a Value-based Health Care System

Doctors and hospitals are understandably suspicious of a distant entity issuing performance evaluations on their practice.

I have formed an important principle that I believe defines the operational strategy of the value movement. It's expressed in just four words: national standards, local solutions.

To harmonize the need for national standards with the need for local solutions, we created a unified recognizable national brand that we will give to local collaborative organizations that are willing to use common quality standards.

The brand is Chartered Value Exchange or CVE. We're seeking authority from Congress to release Medicare claims data to support the work of Charter Value Exchanges. Thus far, we have awarded 14 of these charters, and I'm hopeful to see 50 of them by 2010. This year [2008] we're going to help the CVEs organize a formalized, self-governed network. I see this as the beginning of a network that will ultimately take over issuing new charters.

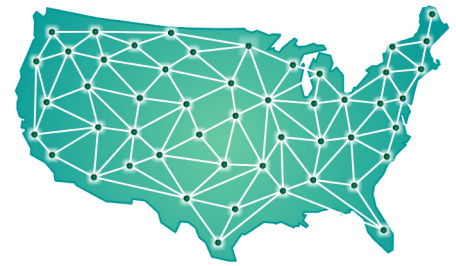
Medicare is the key to reform. The more I work with health care reform and the more I focus on this problem, the more I am persuaded that health care reform and Medicare reform have a symbiotic relationship. In fact, I'm persuaded that in this country, health care reform cannot be accomplished without Medicare reform.

If Medicare isn't the payer, it is likely that the payer is following Medicare's quite unfortunate price-fixing system. Likewise, Medicare is dependent on the whole system changing if it is going to achieve sustainability.

In the final days that remain in this Administration, you can expect continued urgency from me on this point. You may have taken notice of the significant number of administrative actions we are taking to advance the cause of value-based health care.

Administrative actions, while significant, need strong complementary action from Congress if expeditious change is to occur. Each year, there are multiple opportunities for meaningful congressional action in this area.

One very meaningful opportunity recently slipped away from Congress to the detriment of taxpayers and Medicare beneficiaries. For years, the Government Accountability Office and the Inspector General of the Department of Health and Human Service have



By 2010, we envision a network of over 50 Chartered Value Exchanges (CVEs).

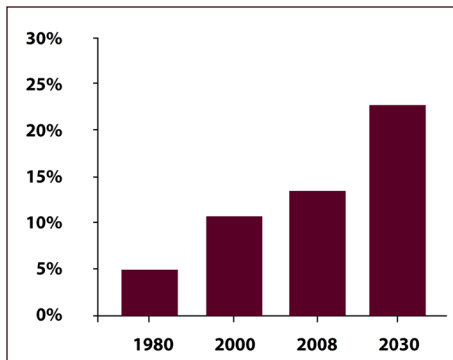
Individuals can and will make higher-quality health care decisions when given the education, motivation an opportunity to do so. Ultimately, personal responsibility and accountability coupled with strong health advocacy and readily accessible cost and quality information can make all the difference in reducing health care costs and improving quality of care.

—H. Edward Hanway,
Chairman and CEO, CIGNA Corporation

Given that the quality and cost of health care a patient receives can vary among different doctors and different hospitals, consumers need information that helps them pick the right physicians when they have a particular medical condition or need surgery.

— John Lumpkin, MD, MPH
Senior Vice President, Robert Wood Johnson Foundation

Medicare Spending as Percentage of the Federal Budget



Source: Office of Management and Budget

been saying Medicare is paying too much for Durable Medical Equipment (DME). DME prices are based on a fee-schedule established by law in the 1980s and subsequently updated for inflation rather than on competitively determined market prices. It is quite plainly a price-fixing program, and the equipment suppliers like it because they get overpaid and don't have to compete.

For example, an oxygen concentrator (a device that delivers oxygen to a patient through a tube) costs about \$600 on the open market. Medicare beneficiaries typically rent the machines. The rental period, set by statute, is up to 36 months. The monthly rental payment, also set by statute, is \$198.40. So renting an oxygen concentrator for 36 months costs \$7,142.

As with most items and services in Medicare Part B, beneficiaries pay 20 percent of the costs, and Medicare pays the remaining 80 percent. The government, therefore, pays \$5,714 – almost 10 times the free-market price of purchasing a concentrator outright. The patient alone pays \$1,428 – more than twice the free-market price of purchase. Even allowing for the costs of setting up equipment, training and fitting the beneficiary, and other things, the rental fee is way out of line.

In light of this obvious and expensive fault in our federal delivery system, Congress instituted a plan for ramping up DME competitive bidding when it passed the Medicare Modernization Act in 2003. My Department has now conducted the bidding in 10 locales.

Unsurprisingly, the bids came in substantially below what Medicare currently pays – on average 26 percent below. These new prices took effect on July 1, significantly benefiting taxpayers and patients.

But those who benefit from excessive fees in the current system kicked into lobbying overdrive, pressuring Congress to delay the implementation, since they stand to lose substantial business in a competitive environment. Make no mistake: “Delay” means “kill.” Killing this competitive-bidding program will cost taxpayers about \$1 billion annually and will unjustly overcharge senior citizens. Sadly, these lobbying efforts were successful in their design, illustrating how proprietary health care interests have become exceedingly expert at exerting their influence on Capitol Hill to protect the status quo. The outcome of this issue also hints that if Congress cannot uphold even this modest effort at entitlement

reform, there is little reason to believe its members will muster the political courage for the unspeakably harder choices that await them. Let us hope members of Congress can rise above the pressure of special interests to enable Medicare to change its ways from a system that encourages volume to one that rewards value.

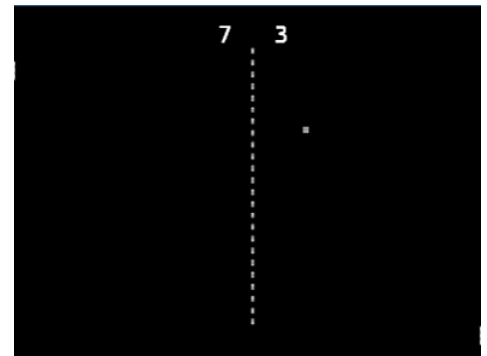
In our review of the Four Cornerstones, our work plan and our progress, there is one other thing we should acknowledge. We are not very good at this yet. We have a lot to learn. I was talking with my son the other day about the first video game I saw. Do you remember Pong?

It was simple, yet it captivated us. I spent a lot of time dropping quarters into the top of a table and playing Pong at the Pizza Factory in Cedar City, Utah. Over time we became more sophisticated, with games like Pac-Man and Donkey Kong. I'm not sure you can really say Donkey Kong and sophisticated in the same sentence, but you remember the game.

It had new functions, it had strategy and color, and you could play it at home. Things have changed vastly since then. Today [2008] the big favorite at my house is Wii. You can virtually swing a golf club, throw a ball or have a boxing match. Your opponent can be across the room or across the world, thanks to the internet. This is just the way technology shapes our future and it is the way the world changes. We are just leaving the Pong era in developing value-based health care.

We'll get better at this. We'll move from Pong to Pac-Man to Wii games like Tiger Woods Golf. But it will take time. Better information about quality and cost will not appear all at once, nor will the benefits. It will happen gradually over the next decade and just like the emergence of other technology, we will see benefits at every step as progress is made. As it is with every social and economic transformation, we will see new tools emerge that will help change and transform what we now know to be the status quo.

I deliberately chose to leave for another day a lot of commentary about how critical the economic pressures have been and will become. Intuitively, everyone understands the picture. In conclusion, I want to be on record as saying I am among those who believe that the unbridled escalation of health care cost is the most serious economic threat our nation faces in the decades ahead.

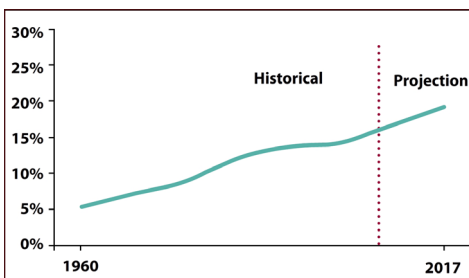


Pong, released in 1972

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National Health Expenditures as Percentage of GDP



Source: Office of the Actuary National Health Expenditure Data

Left on autopilot, I have no doubt that the percentage of our nation's economy devoted to health care will steadily escalate. Ultimately the weight of those expenditures will bring our economic system to its knees. There is no place on the world leader-board for a nation that spends 25 to 30 percent of its gross domestic product on health care. And unless we change, that is exactly where we're headed.

In brief, I want to leave you with a clear message. In a global economy, our nation's health care expenses are a major liability, threatening our very ability to remain economically competitive. We can solve this problem; but it is going to take concerted, collaborative effort in four key areas:

- We must evolve our inefficient, paper-based medical records to an electronic interoperable system.
- We must measure and publish useful, objective information regarding the quality of care provided to consumers using transparent measures.
- We must measure and publish useful information on health care costs, including information on episode-based costs that enable comparisons and reward innovation.
- Finally, we must use incentives to refocus all health care stakeholders on value as the principal virtue of our system.

Every generation of Americans has overcome challenges to secure our nation's role as the world's economic leader. I believe solving the health care puzzle is this generation's challenge. It will require change.

In a global market there are three ways to approach change. You can fight it and fail; you can accept it and survive, or you can lead it and prosper.

We are the United States of America; let us lead.

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