



TOOL IS FOR CHANGE

The most delicate work put
any time we breathe
DISEASE OF THE HEART

This disc

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FIX THIS MESS

The United States, with its state-of-the-art medical institutions, groundbreaking research and cutting-edge technology, is the home of medical haves and have-nots. Today, 47 million Americans are without health insurance, up from 45 million in 2005. Worse, recent gains in coverage to children have been eliminated, leaving 8.6 million youngsters under the age of 18 uninsured.

As the national outcry for health care reform grows louder, every presidential candidate has scrambled to assemble a health care platform. They don't have a choice: U.S. voters—fed up with rising health insurance premiums and studies showing U.S. health care lagging behind that of other nations—are pushing reform as a top domestic priority.

“Every person who aspires to be president knows the nation wants vigorous debate and reform on this issue,” says Laura Morlock, PhD '73, a professor of Health Policy and Management (HPM).

To detail the complexity of the nation's health care woes would fill volumes. Simply put: “It's a mess,” says Jonathan Weiner, an expert in health care organization and financing, and an HPM professor.

How bad is it? A May 2007 Commonwealth Fund study, which has compared the U.S. to five other industrialized countries since 2004, ranks the U.S. system last on its scorecard. The United States spends more than other nations, yet scores lowest on measurable parameters—quality of care, access

to care, efficiencies of the global health care system, equity of care and health outcomes.

HOW WE GOT WHERE WE ARE TODAY ...1900s

Most hospital care was free or very inexpensive. Hospitals, set up as philanthropic organizations, housed the poor and insane who were sick. Hospitals provided little clinical benefit for most illnesses.

“There is no one approach that is going to fix the problem,” says Ellen MacKenzie, the Fred and Julie Soper Professor and Chair of Health Policy and Management. “We have sociologists, economists, gerontologists, lawyers, business experts... And it is going to take this collective expertise to move forward.”

Bit by bit, piece by piece, Bloomberg School health care policy experts are examining varied aspects of the country's ailing health care delivery system—and offering up their Rx's to the nation's policymakers.

Ideas range from the straightforward to the downright revolutionary. Expand the existing Medicare program to cover everyone. Push the nation toward electronic personal health records. Create a super regulatory body, like the U.S. Federal Reserve Board, to oversee health care pricing.

The following pages offer both a brief inventory of America's health care problems and a sampling of solutions.

But first, a story that illustrates the schizophrenic nature of the American health care system.

Weiner, DrPH '81, remembers walking near Johns Hopkins Hospital with a German colleague. The visiting doctor was perplexed, and somewhat shocked, when a large tractor-trailer rolled up with a very expensive MRI scanning machine—certainly not the hospital's first.

The doctor turned to his American colleague: “He asked me how we could afford another MRI when people two blocks away don't even have health care,” Weiner remembers. “I told him, I don't know.”



Quality

The Problem: When it comes to coordinating care between specialists or empowering patients to manage their health, the United States falls short, according to the Commonwealth study. “Our system is

focused on acute care,” says Ellen MacKenzie, PhD ’79, MSc ’75. “With the prevalence of chronic conditions, and our aging population, we need to develop a system that emphasizes continuity and coordination of services. This will require an integrated strategy that empowers patients and families to become active participants in their care.”

HOW WE GOT WHERE WE ARE TODAY ...1930s

As the Depression worsened, people had difficulty paying hospital bills. As a result, medical insurance programs, modeled after the Texas plan, proliferated. Hospital charges were based on the cost of care, plus a small 10 percent markup for reserves.

HOW WE GOT WHERE WE ARE TODAY ...1920s

The ability of hospitals to improve the health status of patients increased dramatically. The upshot: Americans sought out hospitals when they became ill.

...1929

Baylor Hospital in Dallas, Texas, began the first program to sell health insurance, to school teachers in Dallas County. This became the prototype Blue Cross Plan.

The Fix: Chad Boulton, MD, MPH, MBA, and his team have developed just that type of interdisciplinary model, called Guided Care, for the elderly.

“Guided Care is like having a nurse in the family,” says Boulton, director of the Lipitz Center for Integrated Health Care and the Eugene and Mildred Lipitz Professor in Health Care Policy.

The Hopkins team is halfway through a multi-site randomized trial to evaluate the approach with 48 physicians and 933 older patients and 319 family members in the Baltimore-Washington area. With Guided Care, chronically ill patients work closely with a specially prepared registered nurse who

coordinates the efforts of all the patients’ health care providers; coaches the patients in self-management; smooths the transition between sites of care; and educates and supports the patients and their family members.

MacKenzie and her team have applied similar strategies to help people who have lost a limb to injury or chronic disease like diabetes. Their program, called “Promoting Amputee Life Skills,” uses an eight-week course to teach patients the skills they need to manage pain and their daily lives. In a randomized, controlled trial involving 500



HOW WE GOT WHERE WE ARE TODAY ...1960s

After greatly expanding their services, hospitals saw costs begin to increase at 2 to 3 times the rate of inflation. Most hospitals had a list of prices for roughly 5,000 items. There were no discounts. Nearly everyone paid the same rate. The Medicare program was established in 1965.

amputees, they found the program to be successful in building self-confidence and improving functioning. The program is now being translated to an online format, so more people can benefit—especially those in remote areas or with limited mobility.

Access

The Problem: Among the world's 30 most industrialized countries, only the United States, Mexico and Turkey do not have nearly universal health coverage. According to recent data, 47 million Americans are without health insurance. The fallout: The uninsured avoid care because it is too costly. Or they seek care but are saddled with the highest costs because they are not represented by federal programs or private insurers. The problem is growing, says Gerard Anderson, an HPM professor, and Hugh Waters, an HPM associate professor. The number of uninsured in the United States has been increasing an average of one million people per year since the 1970s.

The Fix: In July, Anderson, PhD, and Waters, PhD '99, MS, unveiled a proposal for universal coverage at the Brookings Institution in Washington, D.C. Unlike others who have proposed comprehensive reforms, such as giving

HOW WE GOT WHERE WE ARE TODAY ...1970s

Most public and private insurers began negotiating discounted hospital charges.

vouchers to people to buy their own coverage, the team wants to expand the federal Medicare program for the elderly to the uninsured. They call their plan Medicare Part E(veryone).

Private health plans or companies could offer the plan and those without employment-sponsored health insurance could enroll directly. The premiums would be the same for everyone—and the federal government would subsidize poorer citizens who cannot afford coverage. By covering younger, healthier individuals, the plan would actually lower the government's cost per person. "This is one way to quickly achieve universal, continuous, and affordable care for everyone," says Anderson. The projected total cost to the U.S. government: \$94.4 billion.

MORE HEALTH CARE FIXES

Empower the Patient. Consider the pills that are thrown away, or the test results that are ignored. By prescribing treatments and screenings that patients don't want, providers waste medical resources. John F. P. Bridges, PhD, an HPM assistant professor, says we need to curb paternalism and increase efficiency. The founding editor of a new medical journal called *The Patient—Patient Centered Outcomes Research*, Bridges recommends adopting a patient-centered approach in which empowered patients collaborate with providers to make informed decisions about their health care.

Invest in Preventive Care Strategies. Tobacco-related illnesses claim 438,000 lives each year, including tens of thousands who did not smoke but became ill from secondhand smoke. Beefing up preventive policies to tackle smoking and other lifestyle issues could save billions of dollars and countless lives, notes Stephen Teret, JD, MPH '79, an HPM professor.

Improve Primary Care. Countries with weak primary care systems (including Belgium, France, Germany, and the United States) show higher costs but poorer performance on major health indicators such as life expectancy and child survival, according to recent work at the School led by Barbara Starfield, MD, MPH '63, an HPM professor.

As countries like the U.S. undertake health care reform, "mostly directed at conserving costs," Starfield notes, policymakers should consider "that a strong primary-care orientation within health service systems continues to exert a positive effect," particularly for children.

Restructure the Health Care Workforce. Rather than increase medical education funding to train more doctors, as advocated by the American Association of Medical Colleges, the money would better be spent on providing health care for millions of uninsured Americans. That's according to a recent study by Jonathan Weiner, published in the August 4, 2007, issue of the *British Medical Journal*. —MBR



Efficiency

The Problem: While the United States continues to outspend other nations, these dollars are not as efficiently spent as possible, says HPM's Jonathan Weiner. The U.S., for example, spends about 15 percent of GDP (gross domestic product) on health care, nearly double that of the United Kingdom. Yet the U.K. consistently outranks the U.S. on measures of efficiency—administrative costs, use of information technology, deployment of interdisciplinary teams. Bringing greater efficiency to the U.S. system does not mean scrapping private insurers, managed care or federal programs, Weiner says, but it may require radical change.

The Fix: One idea Weiner has advocated is the creation of a quasi-governmental body, such as the U.S. Federal Reserve Board, which oversees monetary policy, to coordinate and evaluate the efficiency of health care. For example, the board might grade major medical technologies, procedure and services to essentially weed out costly, inefficient treatments. Then, using a cost-benefit analysis, the board would place a value on each option. The most "efficient," or cost-effective treatments, would be covered by insurance plans. Other riskier or more expensive treatments would be permitted—but patients might have to buy supplemental coverage or cover these costs themselves.

In addition, Weiner says, the U.S. must improve its use of technology through the burgeoning field of health informatics. Consider that all the nearly 7 million residents of Hong Kong have electronic medical records. "We really are the laggards," Weiner says, noting that the U.S. has no consistent program to convert patient records to electronic versions.

He advocates the creation of electronic health records (EHRs) or, even better, Internet-based personal health records (PHRs) that patients can take with them from doctor to doctor. "Within a generation, we'll see the positive side of health information technology," he predicts. "Health care will get more humane ... because the technical side of what doctors do will be handled by the electronic box."

HOW WE GOT WHERE WE ARE TODAY ...1980s

Managed care plans began to negotiate with hospitals. They wanted discounted charges in return for placing hospitals in their network. The Medicare program had moved away from paying costs in 1983 with the implementation of the Prospective Payment System.



Equity

The Problem: The U.S. ranks the lowest on measures of equity, or fairness, in the Commonwealth study, in part because of the lack of universal health coverage. The hardest hit are the poor. "Low-income Americans were much more likely...to report not visiting a physician when sick, not filling a prescription, or not seeing a dentist when needed because of costs," the report concludes.

Thomas A. LaVeist, the William C. and Nancy F. Richardson Professor in Health Policy and director of the Hopkins Center for Health Disparities Solutions, sees this every day: "In this country, some people get very good care. Some people get very poor care. It depends on your race, ethnicity, social and economic status, as well as where you live," he notes.

The disparities problem is complex. Among the Medicare population of adults over 65, for example, African-American diabetics are eight times more likely to require amputation of a limb because of poor management of the chronic condition. "Yet they have the same insurance coverage," says LaVeist, PhD.

The causes are multifaceted, he says. African Americans may live in areas without adequate primary care; they may be receiving sub-optimal care or health education; or they may not be engaging in behaviors to properly manage their disease.

Another area of growing concern is the number of uninsured Americans, particularly Hispanics, who also face language barriers to



HOW WE GOT WHERE WE ARE TODAY ...1990s

Nearly all private insurers and managed care plans stopped using full charges as the basis of payment. Each segment of the market found its own way to pay hospitals—the Medicare program began limiting the amount it would spend; managed care programs used market power to negotiate discounted charges; and commercial insurers asked for similar discounts.

obtaining proper care. One-third of Hispanics have no health insurance coverage—the largest percentage of any ethnic group.

The Fix: LaVeist says the United States has to move toward evidence-based medicine—with more tightly regimented treatment protocols to level the playing field. “The one place we don’t find racial or ethnic disparities in health care is in the active-duty military,” he says. “In the military you don’t have black culture or white culture, you have ‘green’ culture,” he says.

“When the lifestyles, health care access, and practice are similar, the outcomes are similar,” he says. To LaVeist, U.S. experience shows that health care does not flourish when left to a free market. “There are public goods and services that are not optimally distributed by the free market—for example, police services, emergency services and national defense,” he says. “Health care may also be one of them.”

Medical Error

The Problem: A well-functioning health care system should ensure that people lead healthy lives, the Commonwealth report says. To that end, the report looks at deaths that could have been prevented. The United States, compared to other nations, ranks last on measures of healthy life expectancy at age 60, infant mortality and mortality amenable to health care.

Albert Wu, an HPM professor, believes one way Americans can lead healthier lives is

to cut down on medication errors by being more aware of the medicines they are using. He estimates that at least 1.5 million Americans are injured every year by medication errors.

The Fix: “We are a medication-taking society,” says Wu, MD, MPH. He estimates that four out of five Americans take at least one medication every week. That means 4 billion prescriptions are filled every year. “It’s not surprising there are so many things that go wrong,” he says.

Patients need to have and maintain complete records of medications they are taking as well as information about allergies or other health problems. For their part, physicians can rely more heavily on electronic information resources and electronic decision-making aids to help prescribe medicines more safely. “Rather than scratching a prescription onto a piece of paper, physicians could type the medication, dosage and instructions they want to prescribe into a computer,” Wu says. “The program—with information about the patient and his or her medication history—could pop up a warning about any potential drug interactions.”

HOW WE GOT WHERE WE ARE TODAY ...2000s

Hospital charges began increasing much faster than hospital costs. Today hospital charges today are roughly 2 to 4 times more than the actual cost of the service. Most insurers—including Medicaid, Medicare and private insurers—don’t pay hospital charges. They pay a negotiated percentage of hospital cost. The result: It’s only the uninsured or self-pay patients who end up paying the full charge, up to 4 times as much as people with health insurance pay.

TIMELINE SOURCE: Gerard F. Anderson, Congressional Testimony, 2004, and Health Affairs, 2007.