Health Reform Beyond Health Insurance

President's Address
Institute of Medicine Annual Meeting

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INSTITUTE OF MEDICINE
OF THE NATIONAL ACADEMIES

Advising the nation/Improving health

This has been a year of truly remarkable activity and achievements at the Institute of Medicine—productive, vibrant, energizing and consequential. In the past 12 months, we released more than four dozen reports and summary publications, many of which I think will stand as landmark contributions. Our program budget this year increased by more than 19 percent over the previous year. At the mid-morning break, you will be able to pick up a copy of the supplement to my annual report, which details the array of activities, financial information, and the range of products and results that emerged from our work in the past year.

At the outset of my presentation today, I will point to a few highlights from the year, but I want to spend the bulk of my remarks reflecting on current activities in Washington and on the nature of health reform.

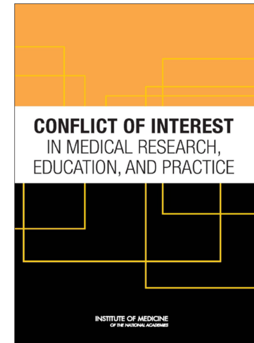
Let me begin with what will probably be for many of us and certainly for the public, the most visible innovation of this year: the new Institute of Medicine website. This is available now at our familiar web address, www.iom.edu. The result of two years' planning and development, the new IOM web site is designed to make all of our content more readily accessible and much more usable by both the public and our membership.

In addition to this new public face of the IOM, the past year witnessed the inauguration of a new project, *The Robert Wood Johnson Initiative on the Future of Nursing, at the Institute of Medicine*. This Initiative represents a new stage in our partnership with the Robert Wood Johnson Foundation that dates back to the origin of the IOM. We are very enthusiastic about this endeavor that promises to propel nursing into its proper place in the future of health and health care.

This past year also engendered a number of what could be described as "rapid response" IOM studies. Let me cite just a few examples. The study, *Initial National Priorities for Comparative Effectiveness Research*, was a remarkably brisk effort. This study emanated from a provision in the American Recovery and Reinvestment Act of February, 2009. The law asked the Institute of Medicine to identify these research priorities by the end of June, and we delivered them by the end of June. The list of 100 priority topics was based on extensive input from many sources and express criteria for selecting both individual topics and for the set of topics. I believe these criteria will still be useful when it comes time to identify the next set of priorities for research.

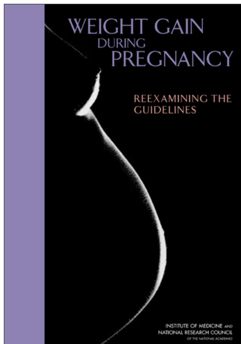
In the late summer, we were asked by the Centers for Disease Control and Prevention to take a fresh look at the standards for respiratory protection of health care providers working with patients who have or may have H1N1 influenza. An IOM

committee produced that report in a matter of weeks. Even more rapidly, following a request by the HHS Assistant Secretary for Preparedness and Response, an IOM committee turned around a report offering guidance on standards of care for use in disaster situations. These examples demonstrate that the Institute of Medicine can, under the right circumstances, produce remarkably high quality work in a very condensed period of time.



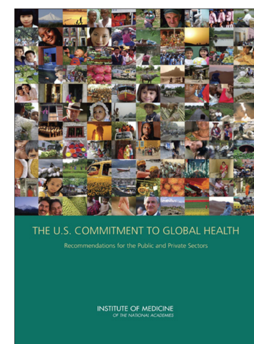
An IOM committee this past year examined the HIPAA Privacy Rule and devised ways to enhance privacy while improving research opportunities at the same time. Another important study, *Conflict of Interest in Medical Research, Education and Practice*, dealt with a controversial topic that warrants our attention and action.

A similarly controversial piece of work that is critically important was the report *Resident Duty Hours: Enhancing Sleep, Supervision and Safety*, whose recommendations deserve to be adopted as new, national standards.



We completed a number of valuable reports on nutrition standards this year, ranging from improvements in the meal requirements for national school lunch and breakfast programs, which feed more than 30 million children every day, as well as new recommendations for weight gain during pregnancy that take account of the starting weight of the pregnant mother.

Before the new administration took office last year, we released a report on the organization and role of the Department of Health and Human Services describing how it could chart a future course for a healthier America. Around the same time, another distinguished IOM committee reconsidered and reformulated *The U.S. Commitment to Global Health* in a pair of studies that point the way to a stronger international position of the United States and reliance on global health as a leading, strategic tool.



As a final sample of this past year's work, we identified an initial set of health indicators for the "State of the USA" organization. These will be incorporated into a wider array of indicators on the state of our nation. The "State of the USA" will enable tracking progress over time, comparing localities and different states, and gauging our nation against other countries. These measures and comparisons will, I believe, prove to be a valuable resource for the public and for policy makers.

While we can justly celebrate these and many other accomplishments of the past year, I would prefer to look ahead.

As we gather today at this meeting in Washington, the Congress is in the throes of a great debate on the future of health insurance for our nation. At stake is nothing less than the health and well being of millions of our fellow citizens. This debate throws into stark relief differences in philosophy and beliefs about the role of government in contemporary society. Equally exposed is the influence of powerful vested interests. The lead article in yesterday's *New York Times* [11 October 2009] described intense lobbying over a possible excise tax on gold-plated insurance packages and the prospects for an independent authority that would help control Medicare costs. The legislative process appears to be just as bloody and messy as the proverbial sausage factory.

Advocates and opponents of pending legislation typically talk about the proposals as "health reform." Here, in this familiar setting among friends, we can be clear: even the most ambitious of the current proposals fundamentally is about insurance reform. The proposals are not truly complete even in that aspiration, as none of them attains universal coverage. But whatever the various proposals' merits in extending insurance, they will surely not achieve health system reform.

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The results of the current legislative debate will not constitute comprehensive health reform. In its full meaning, health reform will not be the product of any one piece of legislation. Rather than a single, culminating act, health reform is a progressive, sequential transformation that will play out over a period of years and be expressed in legislative, regulatory, scientific, technological, cultural, institutional, professional, educational, and, ultimately, social change.

Let me illustrate a half dozen areas where significant reforms could truly help the U.S. to realize substantial gains in health and achieve a higher performing health system. I begin with prevention since it is so fundamental and yet it is typically treated as an afterthought in health reform debates.

Prevention

Very little of the current legislative debate focuses enough attention on the prevention of disease. We all know why prevention gets short shrift: when it works it is invisible; it typically takes a long time for benefits to be realized; and it often demands daily, consistent changes in lifestyle and ingrained habits that are hard to maintain. Prevention, though, can have high payoffs.

Just last week, the Lasker Foundation awarded Mayor Michael Bloomberg of New York City the Lasker Public Service Award. Together with his then-Commissioner of Health, Tom Frieden, who is now the CDC Director, Mayor Bloomberg accomplished an incredible amount for health in a very short time. In 2003, he banned smoking in restaurants and bars. He then introduced an additional tax on cigarettes, launched a massive anti-smoking advertising campaign, and made access to nicotine patches free for any smoker who wanted to quit. Together these measures propelled New York City into a national leadership position in tobacco cessation. Today, 300,000 fewer New Yorkers are lighting up than were smoking at the time Bloomberg took office in 2002. Teen smoking declined even more precipitously: in New York City, the rate of teen smoking is half that for the nation as a whole.

When it comes to individuals paying for prevention, free may not be cheap enough.

We can learn from New York City's example that measures to prevent premature death and disability can work. We can learn from the successes of organizations like Mothers Against Drunk Driving and from companies like Safeway, which has shown that health promotion can be a boon for both employees and employers. We can learn from examples in other parts of the world. Countries like Mexico, for example, introduced requirements for immunization and other preventive practices in connection with payments of support to welfare recipients.

When it comes to individuals paying for prevention, free may not be cheap enough. We should reward individuals with insurance reductions, with access to additional services, and with outright bonuses for doing the right thing for their health. In the long term, it will pay high dividends for individuals and for all of us.

Research support

Many scientists, university leaders, and health center directors were relieved and gratified at the announcement of an additional $5 billion in stimulus funds for the National Institutes of Health (NIH) this year (and a similar amount next year), an event highlighted during a recent visit by President Obama to the NIH campus. This welcome financial boost is credited to Senator Arlen Specter of Pennsylva-

nia, who insisted on it during the legislative debate over the stimulus bill. The action came on the heels of a decade that witnessed a five-year doubling of the NIH budget, followed by a five-year, flat-line budget, effectively undoubling the previous largesse.

Unfortunately, lurching from feast to famine, from starvation to gluttony, is no healthier for the scientific enterprise than it would be for any of our physical bodies. The solution, superficially, seems obvious: establish a three-year (or, even better, a five-year) research budget and fund the NIH accordingly. The problem is that this eminently reasonable idea runs counter to all the processes and prerogatives of the Congress, which is, after all, on a two-year election cycle and enacts a new budget annually. This proposal falls into a category I call the "no-brainer non-starter"—ideas that are obviously good, but politically non-viable. Another example is an additional $1 per gallon gasoline tax. This is obviously a good idea, but politically not very saleable. So what can we do?

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Perhaps it would be more politically palatable to suggest that the Congress should adopt an initial three-year budget for the NIH and then decide on an annual update every year to apply to the fourth year hence. In other words, let science progress with the predictability of at least the next three years, and let Congress debate and adopt a fourth-year budget each year.

Costs

When we engaged in a series of town hall meetings the year before last to air public concerns about health care, I was struck by how many people put forward as their number-one concern the high cost of medical care. Uniformly when individuals at these public meetings spoke about cost, they meant the out-of-pocket personal costs that they experienced and not the costs that were paid by their employers or by others.

I am similarly struck in the current debate in the Congress about affordability of insurance reform that the predominant concern is the cost borne by the government through Medicare and Medicaid and its impact on the federal deficit.

The financial burdens of health care on families and on government are both critical problems. No just society would allow essential medical care to bankrupt individuals and impoverish families. The projected, unfunded federal deficit cannot be tamed unless government expenditures on health care are brought under control. But neither political leaders nor the public at large are focusing enough

attention on the underlying problem of the total costs of health care to society.

You might well ask, “Why, exactly, are total health care costs a problem?” Suppose, for the sake of discussion, I were to tell you that the combined expenditures for cosmetics, pet supplies, and personal electronic devices in the United States were growing at a rate faster than health care costs. I hasten to add that I have no idea whether that is true, but for the sake of discussion, just suppose that it were. Would you be worried about this growth in expenditures, or would it be a cause for optimism about future economic prosperity? Since these personal expense items are matters of individual preference and choice, since they occur in highly competitive markets, and since everyone pays for his or her own cosmetics, pet, pet food, and pet electronic gear, I doubt that anyone other than potential investors would need to pay much heed.

In health care, however, there are at least two fundamental differences: first, with electronics, the consumer, the decision maker and the payer are one and the same, the buyer. But in the case of health care, the consumer is typically the patient and family, separate from the main decision maker, who is typically a physician, and yet again separate from the main payer, who is typically a third party, either employer or government. This introduces what the economists call “moral hazard” from asymmetries in the burdens, benefits, risks, and decision making.

Most measures that directly confront the cost burdens of health care are politically fraught. For example, many economists agree that one step in the right direction would be to tax employer-provided health benefits as regular income.

A second difference is that because of misaligned incentives, misplaced competition (who can do more rather than who can do better) and lack of information, health expenditures in the United States frequently do not produce commensurate health benefits. Witness evidence on variation in practice within the U.S., where higher Medicare expenditures are not associated with better outcomes, and international comparisons on measures such as life expectancy, infant mortality, quality of care, and avoidable mortality, where the U.S. is surpassed by many countries that spend much less on health. Such results suggest inefficiencies in production that go well beyond problems of outright waste, fraud, and abuse.

One approach to resolving the cost conundrum in health care lies in how we pay doctors, and I will come to physician incentives in a moment, along with other steps, such as the role of comparative effectiveness research, that bear on costs as well as obtaining value in health care.

Most measures that directly confront the cost burdens of health care are politically fraught. For example, many economists agree that one step in the right direc-

tion would be to tax employer-provided health benefits as regular income. This would simultaneously serve three purposes: first, it would generate hundreds of billions of dollars in tax revenues to ease the public burden of health costs; second, it would reduce the inequity between those who gain insurance through employment and those who purchase insurance on their own; and, third, it would encourage employees to seek lower cost health plans and obtain the difference in employer contributions as regular income.

One principled argument against such change is that it would encourage employers to drop health benefits *per se*. If they did so, the argument goes, employees would eventually gain less total compensation since health benefits have tended to rise faster than salaries, and they would lose a measure of assurance about their coverage that they now gain from their employers' choice of health plan options. However, everyone gains if the health benefit portion of compensation rises more slowly because health costs are rising more slowly. And the risk of individuals choosing a less suitable health plan could be ameliorated by requirements for core coverage among all qualified plans.

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There may be ways to make revisions in the tax status of employer-provided health benefits more politically acceptable. The understandable resistance to increased taxes could be mitigated, for example, by compensatory adjustments in tax rates for low- and middle-income families. The changes could be introduced only in part, for example, by leaving a portion of employer-provided or individually-acquired health insurance as tax-free income, and the changes could be phased in over time. The current political furor over proposals to tax even a fraction of very-high-cost health plans, an extremely attenuated version of this policy idea, illustrates how much political courage and skill such reforms require.

With or without changes in the tax code, but ideally in tandem with them, other policy steps to help stem rising costs include: facilitate national competition among insurers by easing state-based restrictions; encourage pooling of small and medium-sized employers so as to create larger, eligible groups that would be more reliable in actuarial projections and more rewarding to competing insurers; and give individuals more income-related financial incentives to make prudent choices in health care. Income-related, rising deductible plans would serve this purpose, though the risk in higher deductible plans is that individuals will refrain from seeking necessary and valuable care. This is why I want prevention to be cheaper than free and why such cost-effective interventions as essential drugs for hypertension, diabetes, and other chronic conditions should be priced very attractively to the individual, ideally as part of comprehensive illness management programs.

Whatever progress we aspire to achieve in health will be frustrated if we cannot restrain the growth in total health costs. This is the key to solving the public and personal burdens of health costs—to contain the federal deficit and to make care affordable for everyone. Now that health care devours one in every six dollars in the U.S. economy, it is unavoidably consequential to the economy as a whole. We can no longer afford as a nation to overlook the perverse incentives that accelerate the rise in total health costs and our failure to gain health benefits commensurate with what we spend.

Insurance coverage and comparative effectiveness research

When we purchase health insurance and consider what we acquired, we tend to think about what the insurance entitles us to obtain in the way of medical services, hospital care, drugs, and other benefits. I submit that there is another way to think about health insurance that is equally apt, namely, health insurance as a social compact, an implicit agreement amongst all of the policyholders.

I would ask, 'What is the alternative to learning what works and what does not?'

Rather than think about what insurance entitles me to obtain, I should think, "What does this insurance entitle me to require my neighbors to pay for me and what am I, in turn, obligated to pay for them?" If we thought about insurance in those terms, I think comparative effectiveness research would have a good deal of appeal.

In the American Recovery and Reinvestment Act, comparative effectiveness research amounted to one-quarter of one percent of the total funding, yet it sparked a disproportionate share of criticism. Some consumers and some doctors were concerned that comparative effectiveness research could diminish the doctor's and the patient's ability to make individually tailored decisions. Some manufacturers were concerned about an effect that would stultify innovation. Now, we see calls that if comparative effectiveness research is done at all, we should be prohibited from applying the results to actual decisions.

I would ask, "What is the alternative to learning what works and what does not?" Why settle for choices based on data-free clinical intuition and habit, even if they were undistorted by financial incentives, which surely is not always the case? Done well, comparative effectiveness research has a powerful potential to contribute to smarter choices that will benefit patients and all of us who directly and indirectly pay the bills.

Reframe Medicare

The Medicare Act of 1965 contains the following provision:

> *Nothing in this title shall be construed to authorize any federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided...or to exercise any supervision or control over the administration or operation of any such institution, agency, or person.*

This provision expresses what the Medicare Act is not, rather than what its objective is. Today, we need Medicare to be more than an efficient check writer. It would serve us well to reframe the aim of Medicare *to achieve the highest attainable level of health for every dollar spent by individual enrollees and by the public.*

If we reconceived Medicare in this way, it would change how we approached the deployment of public resources through Medicare.

Physician payment and medical education

Periodically, and almost surely in the wake of the current reform debates, the Congress will consider whether and how much to cut physician payment under Medicare. Hospitals may be temporarily insulated from the current round, but if history is any guide, probably not for long. These debates and the contortions they induce in professional organizations, largely miss the point. When it comes to affecting the cost of care, how much physicians are paid pales in comparison to *how* physicians are paid because decisions by doctors leverage so many other costs in health care. Without doubt, paying doctors a fee for each service leads to more services; this is basic economics. The perverse effects of physicians' personal financial interests was abundantly illustrated in Atul Gawande's story about doctors in McAllen, Texas who refer patients to facilities that they own.

When it comes to affecting the cost of care, how much physicians are paid pales in comparison to *how* physicians are paid because decisions by doctors leverage so many other costs in health care.

Let me suggest a few directions in physician payment reform:

First we should pay more for primary care. We need to attract physicians to the caring specialties, and none is more fundamental than primary care. Ideally, we would increase professional earnings for delivering primary care while reducing, even to zero, the out-of-pocket cost to the patient for receiving primary care.

Next, we should move as briskly as we can to bundled payment schemes, illness management that promotes team-based and home-based care, and capitation methods of reimbursement. In other words, cover illnesses and patient lives, not services.

I would go further: Give every medical student in the country an opportunity for a fully subsidized education in exchange for a period of public service in the armed forces, in the public health service, in an underserved area (radically expanding the National Health Service Corps), or in a less developed country.

Finally, replace the dysfunctional malpractice system that neither deters errors nor consistently recognizes and pays injured patients. Alternatives, such as an administrative claims ("workmen's compensation") type of program, were suggested in IOM's 2002 study, *Fostering Rapid Advances in Health Care*. They were a good idea then, and they are a good idea now.

Imagining the future

These changes would get us started on the path to health reform: (1) take prevention seriously; (2) make consistent and predictable investments in research; (3) focus on reducing overall costs, rather than on shifting the cost burden; (4) use comparative effectiveness research; (5) reframe Medicare with the goal of attaining value in terms of health per dollar; and (6) align physician payment with patients' health needs, coupled with reforms in medical tuition coverage in return for national service and malpractice reform. But all this would be just a start.

We can imagine more.

Imagine a time in the not too distant future when health information technology will have been well launched. Integrated information technology in health care simultaneously serves the needs for patient care, quality improvement, real-time continuing medical education, post-marketing surveillance of drugs and devices, clinical decision support, and technology assessment—and makes all this available in the usual course of clinical practice. An integrated health IT system, together with advances in telemedicine, can also bring higher quality of care to populations in remote areas and facilitate expert monitoring of patients in intensive care.

Imagine hospitals uniformly adopting operations research methods to reduce mindless variation in patient flow and squeeze out inefficiencies.

Imagine if insurance executives were locked in a room until they emerged with a single, universal insurance form, thus bringing some of the efficiencies of a

"virtual" single-payer system, while enabling the service innovations and performance fostered by competition.

Imagine hospitals uniformly adopting operations research methods to reduce mindless variation in patient flow and squeeze out inefficiencies. The same hospitals make hospital-acquired infections a thing of the past, establish fail-safe systems to eliminate errors, and make it not simply possible for caregivers always to do the right thing, but impossible ever to do the wrong thing.

Imagine that we face up to important health concerns that are politically too hot to handle . . .

Imagine clinical decisions consistently guided by science, empirical evidence, and informed patient preferences. Then imagine laying to rest unwarranted disparities in care and reducing health illiteracy and its consequences.

Imagine if we elevated our sights beyond the next two- or four-year election cycle, we could focus on preparing an adequate health workforce for the long term—doctors, nurses, pharmacists, and other professionals and paraprofessionals, each prepared to play a part in delivering needed services at high quality, working efficiently in team-based practice.

Imagine improving the environment for innovation and new product development by incentivizing investment and lowering barriers to entry, while enhancing monitoring and regulatory responsiveness for safety, measures of benefit, comparative effectiveness, and value added.

Imagine that we prepare ethically at the same time as we advance technically for the advent of personalized medicine. And imagine individualized health care that remains centered on each patient and integrates all aspects of care and health promotion to serve each patient's health needs.

Imagine that we face up to important health concerns that are politically too hot to handle, such as coping with chronic disease at advanced stages and at the end of life, and that we deal with them sensitively, ethically, individually, and comprehensively.

Can you imagine a time when we fully incorporate mental and dental health into our thinking about health? What is it about problems above the neck that seems to exclude them so often from policy about health care?

Since we started with prevention, let's not neglect the nation's public health infrastructure; promotion of nutritious and healthful diets, healthy and safe environ-

ments, healthy families, and healthy communities; and preparedness to detect and respond to natural and human-initiated threats to health.

And finally, imagine bridging the "Triple Divides" between public health and medicine, between veterinary medicine and human health, and between global health and domestic health, recognizing that "global" inevitably includes our own health and well being, too.

This is a very big agenda. It is a long-term agenda. It is a vital agenda. I believe that the Institute of Medicine is as well positioned as any enterprise to help make it a reality. Indeed, I believe it is our responsibility, individually and collectively. We each, in our professional capacities as institutional leaders and as citizens, have an opportunity to give the public the health care it deserves, to reduce the burden of disease, and to advance America's and the world's health—that is, to create health reform worthy of the name.

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