PANEL ON HEALTH CARE REFORM – FALL 2008

In spring 2008, *Continuum* hosted a roundtable discussion with a handful of policy makers, academics, health care professionals, and administrators to explore the future of health care in America. Following is a transcript of that conversation. Portions of this text were edited and published in the Fall 2008 issue of *Continuum*. Our health care panel comprised:

Brent C. James BS'74 (computer science) BS'76 (medical biology) PhD'78 MSt'84, executive director of the Institute for Health Care Delivery Research and vice president, Medical Research and Continuing Medical Education at Intermountain Health Care; adjunct professor at the University of Utah School of Medicine, Department of Family and Preventive Medicine; member of many national taskforces and committees that observe health care quality and cost control

Leigh Neumayer, M.D., M.S., professor of surgery at the University of Utah School of Medicine; general surgeon

Richard J. Sperry BA'79 (economics) BA'79 (chemistry) MD'83 MS'94 PhD'95, associate vice president for health sciences at the University of Utah, professor of anesthesiology at the U of U medical school; holds the Governor Scott M. Matheson Chair in Health Care and Health Management, one of the few interdisciplinary professorships in the country

Susan Terry, M.D., FACP, medical director, University Health Care Community Clinics; a primary care doctor for 25 years

Norman J. Waitzman, Ph.D., professor of economics at the University of Utah, studies relations between health economics, labor market structure, and health outcomes

Kim Wirthlin BA'86 MPA'02, vice president, Government Relations and associate vice president, Health Sciences Public Affairs & Marketing; has tracked health care issues on a state and federal level for the past 10 years.

CONTINUUM: How would you characterize the current state of health care and health care coverage in Utah? And how does Utah stack up in comparison to the rest of the country?

SPERRY: I could begin by mentioning the data published by the Utah Department of Health. The most recent information about the uninsured in Utah is that in 2007, 10.6 percent of Utah's population was deemed to be uninsured, which equates to about 287,000 people. The uninsured group covers all age groups although it is largest by far in the 18 to 34 age group, where 17.8 percent of Utah's population reports being uninsured. And Utah does not buck the national trends of the ethnic data: About one-third of all Utah Hispanics [like those nationally] report being uninsured. The Department of Health's report suggests that 35 percent of adults living below 150 percent of the federal poverty level [roughly $10,000 per one-person household] lack health insurance. To be fair, different surveys count people differently. So there is a bit of controversy as to what the actual numbers are. But I think there's probably a consensus that the numbers are too high and that the trend is upwards.

WAITZMAN: That's an excellent point. Whether Utah does better than the nation in terms of health insurance coverage is something that would be difficult to definitively assess at this point. But the trends from both the state survey and the national survey basically see an increase in the uninsured. So, we have to start to think about what is going to drive the trend.

WIRTHLIN: One thing that really puts a personal face on this is the recent study that was done by Families USA [a nonprofit consumer health care advocacy organization]. It said that 150 Utahns die annually because they don't have access to health insurance. Nationally, two to three times as many people die from lack of access to health insurance than from homicide. And I think, Wow. That's in this state, in this country where we have this belief that you can get health care if you need it.

JAMES: But it turns out that nationally and internationally Utah's health care system as a whole stacks up pretty well. The Organization for Economic Cooperation and Development measures global mortality amenable to health care. Although the U.S. as a whole scores quite poorly, about 16th, if you break out Utah, we do quite well. A young population and LDS lifestyle are the big drivers, because two major challenges to health are smoking and alcohol.

WAITZMAN: So despite the one glass of red wine a night that's appropriate for good health, the LDS lifestyle determines the health [of the state].

JAMES: Massively, there's a huge evidence base showing that those are two major advantages.

WAITZMAN: There's a good piece of evidence on the red wine, too [laughter]. I mean, who could argue with the quality guru here in terms of the exceptionalism of Utah care. There's a lot of evidence that Utah is exceptional in certain regards, and that the nation and the world can learn from us in terms of the delivery and organization of care here. But there are ways in which we are not exceptional. The rate of uninsured in the state is rising similar to [that of] the nation. Our average employer-provided premium for health care is also statistically similar. And for a family plan, we're a little higher than the nation, largely due to the fact that we have larger families. The degree to which we have out-of-pocket payments here compares unfavorably, particularly for the family plan relative to the U.S. For the lowest wage quartile of workers in Utah, we do worse than the nation as a whole, and the disparities are unfortunate in that regard. Certainly there's room in Utah to do better.

JAMES: I think you're absolutely right—this really is 'the cream of the crap.' The evidence is overwhelming that we could do much better. It ain't good enough. The other little thing to throw into the financial analysis is that Utah competes with two other states for the lowest federal reimbursement for Medicare in the nation. If the same case were to be treated in Nevada, California or New York, they'd receive about 50 percent higher reimbursement. So our transition tax on the commercial industry is higher.

TERRY: And if plans like PCN are included in the insured population from a practicing physician's standpoint, it's almost worse than nothing. I mean, those kinds of plans are so restrictive and so complicated, from my standpoint

NEUMEYER: I agree.

WIRTHLIN: So just to give the background, PCN pays for care from primary care physicians, but it does not pay for specialists or hospitalization. So, a patient finds out he needs some sort of specialty care and then the primary care physician is in this terribly awkward and difficult position of trying to find help for this patient.

TERRY: Exactly. I can't send them to Leigh [Neumayer] when they need their gall bladder out without letters, or even get the ultrasound to find out that it's the gall bladder.

WIRTHLIN: I receive calls from primary care physicians outside our system who say 'Can't you help me get this patient in to see a rheumatologist?' for example. Then you get into the problem of not only the question of insurance coverage and ability to pay but also physician shortages, which makes it very difficult to get in to see a rheumatologist, period.

JAMES: Having insurance without access to a physician is meaningless. In Massachusetts**,** for example, they passed universal coverage, but the vast majority of people who have insurance can't find a physician.

CONTINUUM: Is there anything special about Utah? Do we have a better system set up as far as people who are trying to access care?

NEUMEYER: One of the things that we lack in Utah is a good, obvious safety net, which is available in other cities and counties similar in size to some of ours, especially Salt Lake City. I'm talking specifically about a county hospital whose primary job is to care for the indigent and uninsured. Without that, people go for a long time without seeking care. I had a patient who had a mammogram at a health fair and found out she had a breast mass, but she didn't pursue it further because she didn't have insurance. A year or two later, when she got insurance, she came to see me. And now she has metastatic breast cancer, which has spread to her meninges [membranes that envelop the central nervous system], bones, lungs, liver. And it's tragic, because had this been treated when she first noticed the mass a year or two ago, it would have been in a much more curable situation. If you have no insurance in Utah, there is no place to go to get any level of care except showing up in the ER.

JAMES: Except there are 130 million dollars in pre-identified charity care. Our policy at Intermountain is that if someone shows up without insurance, they are given care. The University plays that role, too, and it's not just showing up in an ER.

NEUMEYER: But it has to do in part with patients *feeling* like they don't have access. Because if you call my office and ask to get treated, my office will say fine. But if you show up in clinic to pre-register, there's a request for dollars, and there's a lot of citizens around who won't push that. Instead, they'll say, 'Well, they asked for $500, and I don't have $500 right now.' And they don't understand that if you just sit there and keep talking, there are financial counselors around.

WAITZMAN: So Brent [James], let me ask you, when someone like that shows up at Intermountain and they're ultimately eligible for charitable care, what is the process? Are there

several iterations in which they're going to be billed, and have to prove certain things in order receive care?

JAMES: Federal law has divided this care into two subgroups. For 501(c)3s like Intermountain, to count something as charitable care, it has to be identified in advance—before care is delivered. Otherwise it counts as bad debt. For-profits can write off bad debt as unidentified care debts to the community. We can't. We can only count charitable care as a contribution to the community. So as a business, it's important that we manage this kind of care up front, so we can get credit for it, as opposed to after the fact. We have a fairly sophisticated process, which we've worked on for years, to try to identify people early on, because we're going to deliver the care anyway, but it'll just be later and sicker, and not as good of an outcome. What Leigh [Neumayer] was saying is fundamentally correct, though. It's been a struggle, because people don't like to go to charitable services. So it's trying to break down that barrier.

WAITZMAN: So that patient's just going through a different door?

JAMES: What'll happen is she'll show up at the same place, and if she says she's not able to pay for care we'll say, 'Okay, let's just check that to make sure it's true.' And if it checks out, we'll just route her care through our charitable care system. But for as long as I've been at Intermountain, it has been a perennial problem to get people to say up front that they're unable to pay.

WIRTHLIN: I agree [about the perception of lack of access.] I was just going to say that the average person has no idea that the University and IHC both have charitable care systems in place. What they 'know' is that they are not insured and so have no access. The health care system, as we all know, is so complex that even when you have insurance, sometimes it's difficult to access the care that you need—let alone, when you don't have insurance, which creates this huge financial barrier. And going through that process of qualifying for the charity care . . .

NEUMEYER: . . . is embarrassing.

WIRTHLIN: Exactly. You know you're going to have to lay out your assets. And what if they say that, actually, you do have a way, over the course of many years, to pay for this care?

SPERRY: I think we do have the mechanisms to provide care for those who can't pay for it. But any business eventually reaches a limit to how much charitable care or bad debt it can provide. Margins are thin for everyone, and if institutions aren't able to keep their doors open, which is already happening in other parts of the country, access will be dramatically limited. Uninsurance stresses us now, but ultimately it could break the bank. And it's going to dramatically limit access, because there are going to be institutions that can't keep their doors open.

JAMES: So in the long-term picture, there are two things that are worth putting on the table. The first is that we should get health care in perspective. Mike McGinnis [Michael McGinnis, M.D., senior vice president and director of the Health Group at The Robert Wood Johnson Foundation] suggests that about 40 percent of a person's total health—how long and how well

you live—results from behaviors pretty much under their own control. About 30 percent is genetics, where we have very little to offer medically. About 20 percent of total health is associated with public health, i.e. control of epidemics, infectious disease, immunization, sanitation. At best, health care delivery is responsible for 5 to 10 percent of a person's total health, which translates into about three-and-a-half to seven years of life expectancy on average. So we're talking about the margins here to begin with.

SPERRY: True, but if you have breast cancer, then it's very important.

JAMES: Yeah, and if we pick that up at stage one or two, that's not just treatable but curable. So that's not applied uniformly. If you're a 25-year-old who has a major trauma, and doctors manage to pull you back from the brink, then health care delivery has just given you 50 years of life.

WIRTHLIN: So, Brent [James], when you talk about 40 percent of a person's total health being determined from behaviors under their own control, one of the problems is that we're not reimbursed well for helping patients manage their health care and their preventive care. The incentives are not lined up for providers to encourage patients to take care of themselves. In fact, I'll tell you a story of a friend of mine that goes to the structure of our health care system. She is a very healthy woman in her early 50s and had asked her primary care physician to test her for osteopenia [a mild thinning of bone mass that can develop into osteoporosis], and was then put on medication to prevent further thinning. When she started her own business and was looking for an individual plan, she discovered that having this condition on her medical record made her ineligible for insurance. She's now looking at the High Risk Insurance pool (HIP), and though she has the ability to pay, she's going to have to pay hugely out of pocket. So the way that the health care system is currently structured is that someone who is actively managing their health is penalized. So it's a zero sum game where one loop passes off cost to another and passes off risk to another, and it's not based on a kind of competition that rewards value as true market competition does. It gets to the structure of health care delivery. And right now it's set up so that the incentives are misaligned.

NEUMEYER: The whole system needs to be rearranged, and it's almost going to take a crisis to get that to happen. My brother is a small-business owner in Florida and pays $1,200 a month for health care for himself and his family. And he thought they were covered for everything when he ran into problems. He was up here skiing and ended up in the hospital with a major condition that had been missed on multiple occasions in Florida. He needed a pancreas operation, but it turned out his insurance only covered Orlando and the surrounding area. So his insurance company gave him the names of six surgeons in the Orlando area. I told him to call each of them and ask how many of these operations they'd done in the last five years and what their mortality rate was. Four of them were partners and hadn't done any pancreas surgeries in the last five years, so they couldn't give a mortality rate. The other two weren't doing pancreas surgeries, either. So he could have died, and I guess that would be cheaper for the system.

JAMES: I had two people needing help like that last weekend. And I bet every physician around here acts as front people, because you're an insider, and so you spend a big chunk of

time helping people navigate the system. It's good service, but here's the definition of quality: where every American can have that sort of access without an insider helping them.

WIRTHLIN: This morning I was listening to NPR and heard that Ted Kennedy's going to a neurosurgeon at Duke who has done the most of this particular surgery. My uncle had pancreatic cancer. He went to Johns Hopkins, had the best surgeon, and he had a terrific outcome. Your brother had an insider who helped him find the best, but the truth of the matter is that you can't go to the best physician unless you have the ability to pay for that out-of-network care.

WAITZMAN: Well, I think we're talking about disparity in the system. With the managed care revolution we saw the creation of very strict networks and the relaxation over time for a variety of reasons.

JAMES: The second thing to be said is that we're very clearly heading in to a major national health care crisis around money. The United States is currently about 46 trillion dollars in debt in the sense of commitment to U.S. citizens through entitlement programs beyond current or projected levels of taxation. It's about the net value of the United States of America. And two-thirds of the shortfall is Medicare, which is about 30 trillion dollars in the red for people currently alive. To get this in perspective, the social security debt is just 5.7 trillion. The Federal government is not paying the full price for the care that Medicare beneficiaries receive. It's a net negative, because they're underpaying the true cost of the care. About a third of the care we deliver is Medicare, so we do the same thing the University does—we lay off that difference, that hidden tax from Federal and State governments, on the commercial market. What that means is that commercial inflation is going at about twice of what it would be. As a result of rising health care costs, we see employers abandoning health insurance. It's a bottom-up phenomenon where the little guys bailed first and now the big companies are shifting more and more of the financial burden onto their employees. Twelve years ago, over 85 percent of all Americans had health insurance through their place of work. Currently, fewer than 60 percent are now insured through their employer, and that rate continues to drop.

WAITZMAN: This is a critical part of the health care dilemma—whether employer-provided insurance can be sustained in the new era. What's partly responsible for the decline is a very rapid increase in health insurance premiums. In the last seven years, we've had over 100 percent increase in insurance premiums and only a 27 percent increase in earnings. Much of this cost increase has been shifted onto employees, but a lot of it has been held by the employers as well. But the other idea that Brent [James] brought up is this issue of cost shifting, passing on the costs for underpayment from Medicare and Medicaid to private insurers, which I think is a very important one. Cost is a very bizarre concept when we start to talk about the nature of prices and how they're formed. Medicare, for example, takes a very careful method of developing how much they should pay for things. And from their perspective, they are paying the cost. Of course, from the provider's perspective, many feel they're being underpaid, because they can't retain the level of care based on Medicare reimbursement. But, I would just remind us that U.S. prices and fees are high relative to the rest of the world. So what we call a cost here is partly derived from the structure of the market itself. It's not inherent that we do more for the patient per se, although we do in some areas, or that we have high-tech procedures. It's the fact that the rest of the world is paying less than we do for the same thing. So, 'What's driving cost?'

is an interesting question. It gets to the core of how we're going to deal with the health care problem beyond just covering more people.

JAMES: I spent a chunk of time in Europe, Canada, Australia, and Singapore, looking at health care systems. When we carefully asked people what they sought in a health care system, the number one answer was a good physician-patient or nurse-patient relationship, also called 'satisfaction.' The second most popular answer was total health, how well and how long you live. And then there was a third element, a phenomenon called 'rescue care.' A guy named Johnson defined it in 1986. It's the almost overwhelming feeling we have as human beings to help someone who's suffering or facing death. Now for this to kick in, it requires a name and a face, it requires that emotional and personal relationship. It turns out it doesn't have to be humans—we respond similarly to animals. The most recent example in Utah is the mine disaster. Hopefully, those six men died in the collapse. But we spent tens of millions of dollars and lost a couple more people trying to rescue them. And that's not an [atypical] response. That's 'rescue care.' When we compare the United States to other countries, we do very poorly on satisfaction. We actually do fairly poorly on total health. But when it comes to the 'rescue' world, the United States is by far the best. If you are seriously ill, you want to be in the United States. If you're not ill and you're just trying to maintain health, you'd be better in Sweden or Germany. France looks pretty good, too.

TERRY: Is that why we spend so much more money overall?

JAMES: About half of all health care expenditures in the United States are incurred in the terminal episode of life that ends in death. You end up not prolonging life, but prolonging dying. It's a huge investment, and most people don't want it. But we don't know where the boundary is and we can't pull back. This ties directly to the balance between primary care and specialty care. We have a payment system that is optimized for rescue care.

WAITZMAN: I think that's an excellent way to sort of trichotomize the aims in health care. We really place a very high premium in rescue care, probably dating back to the founding of the nation, and that's very much internalized. But it's not sufficient to say that's what's been driving this very rapid increase in health care costs since the 1960s. We also have to think about the complexity of our insurance delivery and the technologies that we've developed to keep people alive. The organization of health care that creates rewards for technology development, enforces the kind of values we have. So with respect to the articulation of a name, it is nice to say that rescue care is an important component, but it's more complex.

WIRTHLIN: Well the other complexity, and you mentioned it too, Brent, is, where do we draw the line?

NEUMEYER: Right.

WIRTHLIN: Where we draw the line is a very complex question. And it happens at the beginning of life as well.

WAITZMAN: And hospitals are reimbursed to provide that type of care. The NICU [Newborn Intensive Care Unit] is a huge profit center.

JAMES: That's right. Our payment system is optimized to provide rescue care. When you compare the United States to Sweden, their infant mortality rate is about half. As soon as you risk-adjust for gestational age, the difference disappears. What that says is that the Swedes are classifying premature infants differently—as stillbirths—while we're classifying them as salvageable infants, and we're going to pull out all the stops to try to save them.
NEUMEYER: Right. I heard that if you deliver a premature baby in Sweden, they wait 12 hours. If the baby is still alive, then they'll institute care. I don't know if that's true, but you know, in many ways…you know it's a selection bias.

WIRTHLIN: They did an hour-long program on CNN about health care in America. And the first story was about a young couple who had premature twins, and one of them had serious complications. It was flown to another hospital in California where they did all kinds of care, and ended up having to go to Indiana, where they continued on this little infant. Well, the insurance was really basic, and it doesn't take long to hit your limit when you're spending $50,000 a day. Now what do these parents do? They took out loans on their credit cards, and did everything they could to continue to try to save the life of this child. They get the little girl to a point where she's able to go home, and at 18 months she's back in the hospital. And this father tearfully talks about how he had to finally tell the doctors to stop, as his child had arrested for five minutes. Their baby died, they lost their home, they're bankrupt, and they are starting all over, no resources whatsoever. They would have been better off if they had been on Medicaid. But it goes to show that once it gets going, at what point do you say, 'No'?

JAMES: Two statistics. One good example of how we draw the line is hospice care. Hospice care means that you stop trying to find a cure for someone who is facing terminal illness. And it turns out that in Utah, 34 percent of the people who die, die in hospice. We're the best in the nation. The state who scores lowest in the nation is New Jersey, with 2 percent. And it's a profound difference.

Another statistic is that Dr. Jack Wennberg [the founding editor of *The Dartmouth Atlas of Health Care*, which examines the patterns of medical resource intensity and utilization in the United States] identifies Utah and Minnesota as the two most efficient states [for Medicare] in the nation. They say that if the rest of the nation delivered Medicare the way that we do in Utah and Minnesota, the cost of Medicare would fall by 32 percent. This is fairly profound. I personally believe that a big part of the health care crisis is associated with how you think about those options [for delivering care]. I don't know why it evolved here. It may be via social structure, and how we think about death; if we see it as a part of life. It may be because we're a relatively smart, small group that has always had this kind of humanitarian attitude of helping out and working together. We are profoundly different, and other external groups identify Utah as one of the best places in the nation for this, despite all our problems.

NEUMEYER: The Bill Gates Foundation decided that as far as global health, the biggest impact they could have is to determine what kind of health care interventions they can do in a developing country that will provide more productive citizens, not necessarily sustain life. About 10 to 20 percent of those are relatively simple surgical interventions that can return people, who have 20, 30, 40 years of productive life left, back to their societies. And the overall impact of that on the country as a whole is huge. This really requires a huge paradigm shift in the U.S. population— —not necessarily of the health care people but of the population in

general—because we are all about rescue care and as soon as there's something that needs to be rescued, we go there.

CONTINUUM: So in regard to whether our health care system is broken or not, it seems that it reflects what we value in society.

JAMES: That's exactly correct.

WIRTHLIN: It does reflect the values of society in some ways except when it comes to the nature of competition within the health care system. It seems to me that if you're going to restructure health care, you've got to reform the nature of competition within health care.

JAMES: Well, first of all, let's be up front about this: It's not a system. It's never been designed as a carefully organized system. But it's evolving. And the biggest change is happening at the level of clinics and hospitals. It's the idea of coordinated team-based care and reflects the changing demographics in our physician makeup, where now more than half of our medical school enrollees are female. It has to do with lifestyle choices, too, and proves that when you're a member of an effective team, you don't have to destroy the rest of your life to practice good medicine. This is a fundamental, profound shift , which ties straight into electronic data big time. Those go kind of go hand-in-glove, back and forth. The implication? Just to be a little provocative, but I think this is fundamentally true, solo practice in medicine is intellectually dead.

TERRY: But isn't it something like 40 percent of practices are one and two people?

JAMES: Even higher. It's fairly clear, though, that we're past the tipping point. There is major trauma inside the profession, lots of screaming still to come. But on the other hand, look at the way the University organizes its care delivery, right? Look at how we organize at Intermountain.

WIRTHLIN: On the other side, to what extent do you see insurance reimbursing differently to support that kind of coordinated care?

JAMES: It's clear that primary care does more for total health than does rescue care. So far the insurance hasn't made the transition, but it has to, and it's starting to. You see this sort of fundamental shift toward a more rational system. It's almost essential because of what it means to practice medicine today. It seems to me it's a matter of the insurance aligning, which you see starting up. Big debates about that are coming up.

TERRY: I think that the team is absolutely essential to continuing, because there is no way that I as an individual can go into an exam room with a patient and in 15 minutes accomplish every single thing that's supposed to happen. Even with insurance, and regardless of how wealthy you are, you still only get 50 percent or less of the health care—preventive services and things like that—that you should get when you see the doctor. On the other hand, I don't get paid, and my office doesn't get paid, to have anyone on my team spend 15 minutes doing a fall risk assessment or spending 20 minutes setting goals for stopping smoking or losing weight, which

are the kinds of things that will help that patient improve that 40 percent of what determines a person's total health.

SPERRY: I think, from that perspective, that the practice of primary care is very different from specialty care. Both might complain about their reimbursement, but your overhead structure is such that you can't take the time to do those kinds of things and keep your doors open. The surgeon, I think they may have more time. They may not take it, but there is probably more buffer space there than there is in a very thinly margined primary care practice.

TERRY: But isn't it true that even for general surgery most of the high overhead part of their practice is footed by somebody else? I mean, it's in the hospital; it's in the operating room—the anesthesiologist, the equipment, the nurses, the staff…

SPERRY: I guess it depends on how much of their care is in their clinic versus in the institution…

NEUMEYER: I think you're absolutely right. The patients usually ask me 'what will this cost?' and I usually tell them, well my part is the smallest part. I might be able to charge for that visit. But then from the operating day for 90 days forward, everything I do for that patient is within my global surgical fee, which has gradually decreased over time. But it is true that for even the simplest procedure done in the hospital you add in things that are two to three times what I'm charging.

WIRTHLIN: Yet the insurance companies don't reimburse for the cycle of care that Susan [Terry] would like to provide patients. For example, if you have if you go to a gastroenterologist and that GI doc spends 20 minutes or half an hour talking to you to try and figure out what's going on, she's not getting reimbursed in the same way that she will as soon as she starts a procedure. So the incentive, which is to get this procedure going, is set up wrong.

JAMES: Care coordination embedded in a primary care office works far more effectively than disease management or care coordination embedded in an insurance plan. Which is exactly what'd you expect if you're familiar with those systems. And I see that evolving quite nicely. This is a bottom-up approach that organizes everything around value-added, front-line work processes. I'm actually a lot more sanguine about the possibility of building something rational than I've been in a long time. This is a bottom up approach that organizes everything around value-added, front-line work processes. One of my fears is that when you get government involved, they're usually not responsive to that level of detail. And the devil really is in the details. I think you need government policy working with care delivery systems in order for this kind of reform to be successful.

WAITZMAN: While there's great innovation that's occurring within IHC, the University, and other integrated health care systems that will create greater value per dollar, there's also growing awareness that our system is broken with respect to the overall coordination of rules that guide delivery and insurance. There are vast disparities. The access to the system is awry. And insurance is structured so that we reimburse in a backward way.

JAMES: We're paid to harm our patients, and that's a verifiable truth. If I allow major complications to occur, then I'm reimbursed more.

SPERRY: A better way of saying that is that we still get paid when we harm our patients.

JAMES: Another point is that we're getting exactly what we pay for. We tend to pay for procedures and rescue care, so we get lots of procedures and lots of rescue care. This is a key factor.

Another thing you need to know is that other countries have exactly the same problems. So don't look for solutions in Europe. Don't look for solutions in Canada. I get a ton of those guys coming through visiting to see how care's delivered in Utah, believe it or not, because they face exactly the same problems. There's a standard working list of the top five problems within health care, and nobody's solved them. Travel the world and it's the same list of five things: The first problem is variation in care on a geographic basis. It's so high that it's impossible that all Americans are getting good care, even with full access. The second biggest problem is high rates of care directly judged to be inappropriate. This is where the medical risk treatment outweighed any potential benefit to the patient and we did it anyway . . . usually in a rescue setting. The third problem is unacceptable rates of care-associated injury and death. This is where the care delivered actively killed somebody, whose death was judged to be preventable upon review. The fourth problem is that the system does it right only 55 percent of the time. There are things that we know for a fact should be done every time but the system does right only 55 percent of the time. Now, that's better than zero, but it's not nearly 95 percent or 98 percent, where it ought to be. And the last one is that there's at least 50 percent waste in the system. This is non-value-adding from a patient's perspective, and that's where the opportunity exists.

CONTINUUM*: In what ways do you see opportunity for health care reform? Do we blow up the system and start anew? Or work within the current system?*

TERRY: It'll blow itself up.

NEUMEYER: Do you think that's happening right now?

SPERRY: I don't think it's there yet. The system functions well for some people—probably for those people who control most of the resources and have the political power. So I don't know if the crisis is deep enough that the people who are in positions of power will either by force or by choice be willing to make the changes.

NEUMEYER: It's not there yet, but I agree with Brent [James], I think [that point] is coming sooner than we think. We need a lot of help outside the health care system, or the non-system itself, so that people understand how much their behaviors contribute to the overall crisis..

JAMES: So here's the underlying problem, and it's a philosophical debate: Do you regard health care as a free market, which is what insurance is designed to deal with? Or do you regard it as a shared social benefit?

WAITZMAN: Right. Those are the two poles of the spectrum, and there's a lot in between. The question really is how the individual market is structured to allow the incentives that arise from

the flow of market forces, and how much government is going to regulate it to preserve that shared benefit to the community. Both Republicans and Democrats indicate that they're ready for health care reform. Part of the division is over the poles that Brent indicated and whether we try to preserve aspects of the employer-based system, Part of the division is over the poles that Brent indicated and whether we try to preserve aspects of the employer-based system, which both the left and the right want to destroy for different reasons. The left wants to move toward a fully government-run single-payer system. And the right wants an individual insurance market, which gives individuals much more choice. But there's also a group that believes we should preserve aspects of this employer-based system as we transition to a new system. For example, I like the fact that the University of Utah is a big organization and can negotiate with insurance providers such as Brent [at Intermountain] as to what my benefits package is going to look like, what will be reimbursed and so on and so forth.. If I were an individual trying to insure myself, I'd have to do incredible investigation, and there's going to be a lot of market forces involved, and I'd be going up against a very large power. And so, how the individual market is structured and how much government is regulating it is very important. It gets complex fast, unfortunately, but I agree, this tension between market and government provision is certainly there.

SPERRY: Should we focus on states changing their system state by state by state, or is it something that should be left for the federal government?

JAMES: I think it's a very complex problem with no clear solution—not just in the United States but in all Western democracies. Most other countries feel their health care system is in crisis: France certainly is, and Sweden is, too. Brits, too. Canadians, too. When it's not clear what a solution would be, one idea is to run a series of experiments at a state level and find out what works. We are much more likely to craft a workable solution in Utah than we are at a national level. If we can't do it here, I have no idea how they're going to pull it off there. This is the crucible of the states.

SPERRY: So the states are laboratories?

TERRY: And I think that creates an upward pressure, so that something has to happen in the states that don't take the initiative.

WAITZMAN: So what's the impediment for our state to become the crucible? We're an ideal state to do it, so why don't we do it?

JAMES: We are doing it in some sense. I see innovation on two or three different levels. We have a legislative task force that's trying to address this issue and get the debate on the surface. What I regard as really important is how I see health care shifting in this state. But I think that change will happen down at the level of real people and real hospitals and real insurance plans facing real problems and coming together to find solutions. I think that's how it works. The reason that we will succeed as a state is that we are small enough and we have that humanitarian attitude in this community,. The nation needs just a few concrete good examples that can be built on.

WAITZMAN: What about saying that the rate of uninsured people is growing?

JAMES: It just drives the rate of change faste. If you look at the national debate, it's very clear that people are talking past each other if you get the government control versus the free market crowd. So John Goodman—he's one of the more radical, you know, free market crowd—and I've watched people kick sand in his face, which is probably appropriate. So the idea that you're having an acute myocardial infarction and you're in the ambulance on the way to the hospital and you're looking up hospitals on the Net, it doesn't seem like a very good idea. And what he says is, of course, 'I don't mean that.'

JAMES: Interestingly, a Dartmouth group looked at the span of a terminal episode in patients' lives and analyzed the relationship between how much was spent on each patient and the quality of care they received. It turned out, unfortunately, that the interaction was negative: The more you spend, the worse the quality of care. It's a very consistent statistical result and very convincing: higher cost means lower quality. He found the same thing to be true among academic medical centers. Then he took the 100 best hospitals in the United States from the *U.S. News & World Report* and showed that it persisted there, too. So this is not a community versus academic phenomenon. This is a systems failure.

WIRTHLIN: Regarding behaviors, we've got to figure out a way to align incentives. A really good friend of mine is a diabetic. She takes such superb care of herself that if you did blood sugar on her you wouldn't know that she's diabetic. She's in great health but is still in HIP, paying $500 a month because she was denied by every other health insurance company.

JAMES: So it's called underwriting, what you're talking about?

WIRTHLIN: Yeah, right. Through underwriting, health insurance is incentivized to save money by denying care to high risk people. Her husband is a small-business owner. So, what do they do? They pay $1,050 a month for her family of three to be covered by health insurance, even though she's in excellent health. Couldn't you restructure the system so that you could start reimbursing for the outcome of a medical condition, which is more like competition than what we have right now?

JAMES: Danny Ortiz, the chairman physician of the Mayo Clinic, goes by what you call 'value-based care.' So for chronic disease especially, take congestive heart failure, you would go to some well-run systems and figure out what congestive heart failure should cost, put a nice margin in there, and then structure reimbursement based on that information.

JAMES: Another idea from John Goodman that I think has a lot of potential is to subdivide health care into a series of categories and then structure different incentives for each category. So you break up preventative care, versus acute self-limited illness, versus chronic diseases, versus acute life-threatening conditions, like an AMI or trauma or stroke. And insurance companies start to say, 'Okay, if you put this together at that granular level, what should the incentives start to look like for each piece?' And you can start to construct a system that's a heck of a lot more rational. Now what I need on the other side, believe it or not, is a system of care delivery. So I need a University Hospital with a primary care network that can be responsive to that kind of a tool. And that's not going to happen at the federal level.

TERRY: The concern I have about that is that I don't want to see payment for preventative care going to one group and payment for ongoing chronic disease going to another group. To me that takes away from what I do as a physician and my relationship with the patient . . . my team being there to take care of all those needs.

JAMES: All of those different services could be provided within the same primary care practice. It's about structuring different payment incentives within those categories.

TERRY: What about care coordination? Our coders just informed us that Medicare will not pay us for our time spent on care coordination if it's within the University system. Now if that isn't ridiculous! It might take us a half an hour to talk to a few specialists and figure out a couple of appointments and various services at the U, but we can't bill for it. But if I send them to Brent's system, they'll pay me for it.

JAMES: Yeah. It's crazy that way. I have some hard evidence now that care coordination embedded in a primary care office works far more effectively than disease management or care coordination embedded in an insurance plan. Which is exactly what'd you expect if you're familiar with those systems. And I see that evolving quite nicely.
SPERRY: So what's the appropriate measure for health?

JAMES: Well, I can think of two off the top of my head, and those are the easy ones. Satisfaction is a critical measure. It reflects what patients consistently identify as their number one wish: the relationship with a caring health professional. The number two most important measure I think is cost. How's that for crazy? Once you get those two out of the way, health is how long and how well you live, I guess.

CONTINUUM: Are you optimistic or pessimistic about the system and its future?

NEUMEYER: The whole system needs to be rearranged, and it may take a crisis to get that to happen, because people are not willing to give up what they have right now, both on the provider side and the access side. The current system is limping along, and if it continues to exist in its current state, I'm pessimistic that it will end up providing me with health care in 20 years. But I'm optimistic about the opportunities there are for change, especially in Utah. We have a unique population and a cohesive group of physicians, even though we're not terribly organized. We could serve as a template for what could happen across the country. Although we don't deal with some of the unique situations of giant cities that have huge numbers of uninsured and underinsured people, what we learn here could be applied elsewhere.

TERRY: I'd say I'm optimistic because, as Brent [James] was saying, I see a lot of change happening at the front line. Our system is working hard on a grassroots level to create coordinated teams and to bring the relationship closer between specialty services and primary care. I also see improved coordination between Intermountain and the University, which covers the bulk of the health care in the state, and I'm encouraged by that. And I hate to say I don't care, but I think I won't be as influenced by whether it's single-pay or state or whether it's just improved reimbursement from the payers we have as long as it recognizes the primary care advantage, the care coordination, and the need to reimburse for things that can't simply be a one-on-one primary care physician issue.

WAITZMAN: Well there's a clear trajectory that's moving us more toward seriously considering reform on both the state and national level. We're swept up in increasing chronic illnesses, rising costs, chronic illnesses, more treatments for those illnesses, an aging population, scarce financing, changes in the labor market, and international competition squeezing us. All of these factors will push us more and more toward intervention and discussion about reform and policy. Utah is an exception in many ways, but with respect to the trajectory, we're basically right in line. And we're a bit behind the ball with respect to the task force that is in place. Maine, Vermont, and Massachusetts have made attempts to move toward universal coverage and have instituted innovative structures that span the market to government health care reform. There are 12 other states that are involved in seriously pushing in that direction. If we're going to take advantage of our exceptionalism, we have to integrate reform in a more serious way.

JAMES: I agree that the current system is unacceptable. At the same time, I'm optimistic that change is happening. It's multi-factorial and is going to require a fundamental shift in the way we think of ourselves as physicians and nurses and as an organized system of caregivers. We know enough about how the system performs or doesn't perform and the exact causes of the failure, which gives us an opportunity to talk about how we structure our public policy. And now there are some emerging solutions. Utah is widely regarded as one of the best examples in the world. If we can't do it, nobody can. So let's go do it. .

SPERRY: I agree that the current system is not acceptable. At the same time, there are a lot of good things to be said about health care and how it's delivered in the United States, and certainly in Utah. But there are enough problems with our system, or non-system, that we don't have much choice but to change it, and I'm actually optimistic. The topic of health care reform isn't something that is just discussed by health policy experts and health care economists. Some action is being taken in so many arenas that I have to believe there is momentum building for change; hopefully it will be sustained. I think that it will . . . because it has to be.