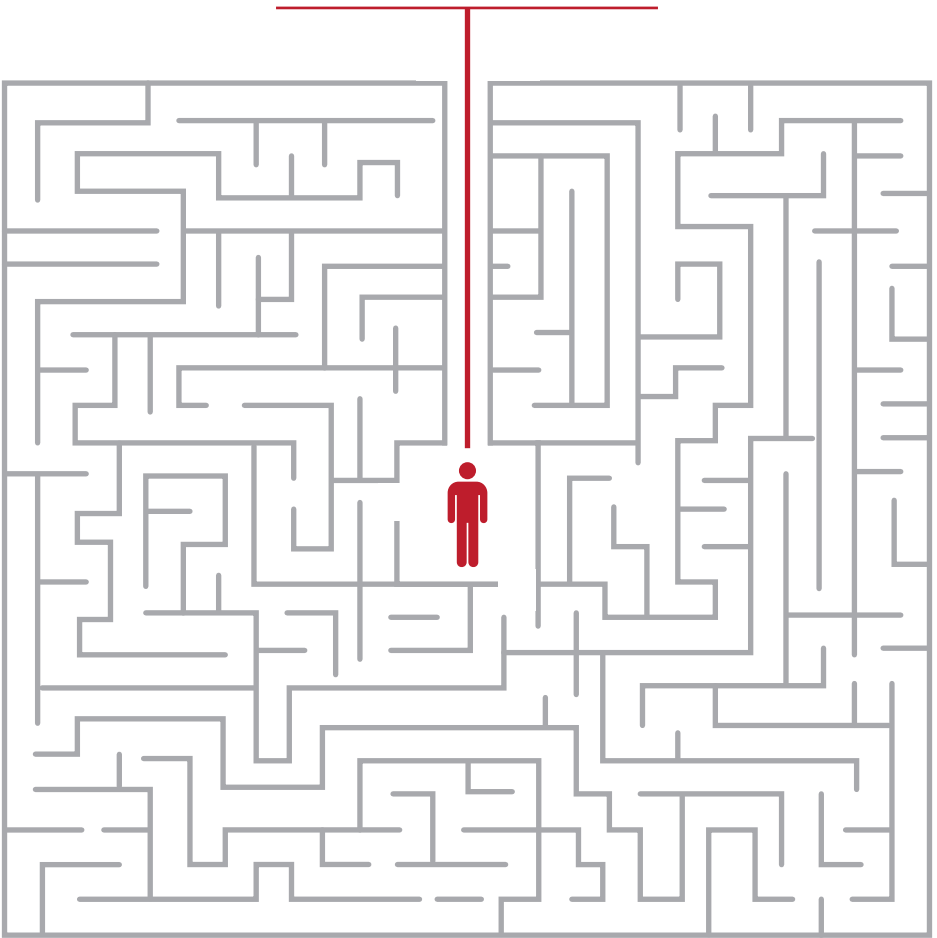# The Health Care Delivery System

A Blueprint for Reform

Introduction

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Concern about the state of the American health care system ranks consistently among the top three issues that the American public wants policymakers to address. Its prominence only increases as economic insecurity continues to grow.[1] The gaps in coverage, the high cost of insurance, and the quality of care that consumers receive are the most frequently cited problems.

More than 45 million Americans do not have health insurance, for reasons related to the cost of coverage, availability of employer-based coverage, individual priorities, and access barriers in the individual market, such as medical underwriting.[2] Lack of health insurance leads to health care that is often too little and too late, with serious health consequences as a result. And many people have insurance that is manifestly inadequate because it either lacks coverage for key services such as prescription drugs or is accompanied by steep copayments and deductibles. The number of underinsured, or those with insurance that fails to protect them from high health expenses, has risen by 60 percent since 2003.[3]

The cost of health care, which contributes to unaffordable and inadequate coverage, adversely affects not only individuals, but the economy. Consumers face onerous out-of-pocket expenses for care, adding yet another burden to illness. At the same time, health care costs have steadily claimed a larger share of the economy, now comprising 16 percent of the gross domes-

tic product, and still rising at a rate at least twice that of general inflation.[4] Some of the most crucial consequences are aggravated federal deficits, threats to the Medicare Trust Fund, medical debt-induced bankruptcy, and perceived barriers to global competitiveness of American companies.

Compounding the access and cost problems are acute concerns about the quality of health care. One comprehensive study following almost 7,000 patients over a two-year period found that they received only 54 percent of the care scientifically recommended for their conditions.[5] The Institute of Medicine estimates that roughly 100,000 deaths per year result from errors and injuries to patients in hospital care.[6] Disparities in the effectiveness and quality of care delivered across racial and ethnic groups continue to grow. The United States also lags behind other nations and most other industries in the use of information technologies, organizational design, and other systems that can reduce errors and improve quality.[7]

Perhaps the most disturbing statistics relate to our population health. Despite spending the most in the world on health care—a projected $7,868 per capita in 2008[8]—we consistently rank behind other nations in infant mortality and life expectancy. Stated simply, our population health and health care systems are failing.

These problems are forcing solutions, particularly with regard to access. States have led the charge, with a number proposing, and some enacting, plans to provide health insurance to some or all residents. Legislation from both parties has been introduced in Congress to do the same. And the major presidential candidates have proposed more far-seeking reform plans than have been seen on the campaign trail in over a decade.

To date, it has proven easier to enact policies regarding health coverage and financing rather than how much is paid and for what value of care. This is logical, in part because tackling health care coverage and financing first is necessary for most large-scale improvements to the system. The fragmentation that results from having millions of uninsured and underinsured Americans impedes cost containment and quality care, as well as access to care. This situation is exacerbated because multiple public and private payers set their own rules, standards, and benefits—and often find it easier to shift costs to other payers rather than contain them. For these reasons and others, getting everyone into the system and financing their coverage are considered prerequisites for making system changes such as rationalizing payment systems and improving the delivery of care.

The emphasis on addressing coverage and financing first also reflects the political practicality of these issues. The options and their implications are fairly well defined. Expanding public and private coverage, funded through "shared responsibility" or assessments on multiple payers, has gained bipartisan support. The leadership to embrace and implement these policies has emerged among various public and private policymakers.

Yet, no matter how necessary it is to improve access, resolving this problem alone will not produce a first-rate system of care in the United States. The case in point is Massachusetts: Its new coverage policy has made rapid progress toward covering all state residents. But it must now address issues of unforeseen costs and quality concerns. This lesson is not lost on policymakers.[9] Most now seem to recognize that they cannot innovate in one area and ignore the rest. Unless we link affordability and coverage to large improvements in the quality, structure, and payment patterns of health care in America, our medical bills will remain far too high and the value of our health care far too low. And unless we simultaneously tackle the threats to health outside of the health system, our population health will remain below its potential. Nevertheless, the ideas on how to translate these realizations into a concrete set of policies remain sketchy.

This book aims to fill that gap. It offers recommendations and pathways to systematically promote quality, efficiency, patient-centeredness, and other salient characteristics of a high-performing health system. The blueprint it lays out includes a vision of how different parts of the system should be structured and how they should function. Even more specifically, it proposes policies that the next administration and Congress could enact over the next five years to improve our health system.

To ensure that the policies put forth in this book contribute to the debate without being redundant, the chapters do not address the question of who gets insurance and how that insurance is organized. The chapters assume that the proposed policies would be implemented in a system where everyone has access to affordable, quality health coverage. This assumption may seem bold: After all, the United States remains one of the only industrialized countries without a national health insurance system. Yet it is a common goal among the authors, and the literature is abundant with information on the benefits and risks of various proposals. This book also presumes that with or without national reform, the United States will have a quasi-public, quasi-private health care system. This is

a safe assumption; it is unlikely that either a pure market or single-payer plan will emerge in the near future.

We offer here a summary of each chapter and the policies they propose, as well as an overview of the goals that this blueprint aims to achieve, including the overarching concepts and implications for different types of people that enter the health care system.

GOALS FOR HEALTH SYSTEM REFORM

The design of a health reform plan should begin with a clear idea of what it hopes to accomplish. A reformed system should achieve better performance on the six dimensions outlined by the Institute of Medicine in *Crossing the Quality Chasm: A New Health System for the 21st Century:*

- **Safety:** Avoiding injury and harm from care that is meant to aid patients.
- **Effectiveness:** Assuring that "evidence-based" care is actually delivered by avoiding overuse of medically unproven care and underuse of medically sound care.
- **Patient-centeredness:** Involving patients thoroughly in their care decision-making process, thereby respecting their culture, social circumstances, and needs.
- **Timeliness:** Avoiding unwanted delays in treatment.
- **Efficiency:** Seeking to reduce waste—low-value-added processes and products—in all its forms, including supplies, equipment, capital, and space.
- **Equity:** Closing racial, ethnic, gender, and socioeconomic gaps in care and outcomes.

A health care system that makes advances along these six dimensions would be far more able to meet patient needs. Care would be safer, more reliable, more integrated, and timely. Patients could rely on receiving the full range of preventive, acute, and chronic services that are proven effective. They could also know that they would not be subjected to the risks and costs of excessive, ineffective, and unscientific care that does not help them. Health care providers would benefit through increased satisfaction at being able to deliver care that produces greater health and longevity for their patients, and reduces pain and suffering. Payers, in turn, would get higher value: more quality and better outcomes for their dollar.

These aspirations, taken together, are best understood by considering their application to individuals in different circumstances: those who are well, at risk, acutely ill, chronically ill, or at the end of life. The "well" are relatively healthy, seeking care only when they feel it is needed, and are less likely to recognize or act on their need for health promotion and preventive services. The "at risk" experience unmet care needs, dissatisfaction with the system, or expectations that go unmet. These are individuals who attempt to access preventive and health-promoting services but who may not receive these services efficiently. The "acutely ill" have time-limited or curable health problems, and typically receive outpatient care for an accident or infection. The "chronically ill" have persistent medical problems, such as diabetes or hypertension, that can be managed but last for months and in many cases cannot be definitively cured. The last population, those "at the end of life," comprise individuals whose proper care is palliative rather than curative.

Integrating the six dimensions of an improved health care system across the population will ensure that patients receive the best quality of care possible (see table on page 6). For example, to ensure that the "chronically ill" receive safe care, an improved health care system must make all pertinent information easily available to both patients and their clinicians. For the "acutely ill" to receive effective care, an improved health care system must ensure that a patient promptly receives all proven treatments likely to improve their health and is protected from excessive and ineffective care. And to ensure that the "well" receive timely care, they must be able to contact—through telephone or the Internet—their primary care clinician or other trustworthy sources of knowledge to ask questions, make requests, and receive replies. A safe, effective, patient-centered, timely, efficient, and equitable system would improve the health of all populations.

One of the greatest challenges for an improved health care system is to achieve racial and economic equity. Research demonstrates that socioeconomic status and race or ethnicity often determine the type of care one will receive. Care itself is often of poorer quality for low-income Americans and people of color than that received by populations who are white, have more income, or have more education. Low-income Americans, for example, are more apt to receive less timely and effective care due to an inability to pay, and African Americans, though less likely to have cardiovascular disease, are more likely to die from it.

Matching Populations with Principles for the Health System

	Well	At risk	Acutely ill	Chronically ill	End of life
Safe	Patients are alerted immediately when one of their medications is recalled due to safety issues.	Patients have access to information on interactions between their prescribed medications and over-the-counter drugs.	Newly prescribed medications do not have adverse interactions with other drugs in patients' regimens.	All key patient information is available to patients and their clinicians.	Patients are not subjected to more intensive care or aggressive management than they desire.
Effective	Patients receive reminders when they need key screening tests.	Patients and clinicians have a shared understanding of preventive health goals.	Patients receive all vtreatments likely to improve their outcome.	Patients receive all treatments likely to reduce complications of their conditions.	Patients' pain is well controlled.
Patient-centered	Patients are offered a variety of options for working with providers.	Patients' concerns are heard and addressed.	Patients' urgency is heard and addressed.	Patients are actively engaged in the management of their conditions.	Patients are in settings of their preference.
Timely	Patients can access their medical practice to ask questions and make requests by phone or email.	Providers address patients' questions within the time frame the patients want.	Patients with acute complaints can be seen for evaluation promptly.	Patients' frequent, routine follow-up care is provided without significant waits.	Patients' care site can be changed promptly according to needs and preferences.
Efficient	Prevention is provided in multiple settings beyond the medical system through lower-priced providers.	Patients receive education and follow-up, and avoid tests and medications unlikely to benefit them.	Care is delivered in the most cost-effective setting.	Patients are prescribed the most cost-effective medications.	Patients' preferences to avoid hospitalization or intensive care at end of life are known and respected by providers.
Equitable	Culturally sensitive outreach programs are developed and implemented.	A diverse provider organization provides a welcoming setting for care.	All patients are equally likely to receive treatments expected to be beneficial.	All patients are equally likely to receive treatments expected to be beneficial.	Patient preferences regarding end-of-life care are respected.

While not always explicit, the recommendations detailed throughout the book address the racial and economic inequality in our current system. For example, investing in federal scholarships and loan repayment programs for newly trained providers will not only increase the number of providers in underserved areas, but it will also likely increase the diversity of the health care workforce—a proven strategy to reduce racial health care disparities. And because chronic disease is most prevalent in low-income populations and communities of color, providing federal funding for evidence-based programs for chronic disease self-management will also address these disparities. These policies and others will ensure that we do not continue to leave many of our most vulnerable behind.

ENACTING HEALTH SYSTEM REFORM

One common theme that runs through all the chapters in this book is that strong, national leadership is needed to enhance our health system's quality, efficiency, and effectiveness. The next president must be dedicated to reform. He should use his power and influence to create a sense of urgency and forge consensus on how to move forward. The next administration must be focused on developing pragmatic solutions and using executive authority to achieve them.

Policymakers should rethink who makes the key decisions and how they are made. There is currently no single federal policy when it comes to health care. Each public program, such as Medicare and the Veterans Health Administration, has its own eligibility rules, benefits, cost sharing, provider payment rates, quality systems, and consumer protections. Those programs' policies tend to be set by law, which means that Congress is essentially the management team. All the while, there is a significant state role in Medicaid, the State Children's Health Insurance Programs, insurance regulation, and provider licensure. This complexity has limited the ability of public programs to adopt best practices for quality and access and align their purchasing with value. It also adds to the high administrative costs of the system.

The next president and Congress should consider improving the management structure for health coverage programs funded by the federal government. This could be achieved by creating an independent agency to set the standards for the key operating parameters of the public programs. For example, the agency could be charged with defining what constitutes "high-value health care." This definition would then be used to guide programs' coverage, quality review, and/or payment policies. A new agency could have broad scope and authority, similar to the Health Care Connector in Massachusetts. The connector sets statewide standards on coverage delivered to state residents. Some policy analysts envision a new agency creating the "rules of the road," that is, a set of regulatory policies that steer private and public insurers toward a safe, effective, patient-centered, timely, efficient, and equitable system. Regardless of its precise scope and authority, a new governance structure is undoubtedly essential to transform the current chaos into a high-functioning system.

BRIDGING VISION WITH PRAGMATIC POLICIES

This idea of improved health policy leadership and coherence is only as good as the delivery system improvements it advances. As noted above, in the health policy debate there is a dearth of specific policy recommendations to improve the delivery system. This is not for a lack of original ideas. A number of experts and practitioners have identified important systems improvements that could yield measurable progress toward safe, effective, patient-centered, efficient, and equitable health care. And these improvements would go a long way in promoting a healthier America. Yet these ideas are often disconnected from the current system, with no policy pathway, backed by leadership and organization, to get from here to there.

This project created partnerships between some of the best thinkers on health delivery reform and some of the best policy practitioners in order to produce a usable blueprint for health system delivery reform. The scholars and experts whose thoughts are reflected in this book have extensive experience both in health policy development and implementation. They have led major health systems, research centers, and academic associations, and are widely considered to be among the leading authorities in the field. Their partners are policymakers who have cumulative decades of congressional and executive branch experience. Together, they have been involved in every major piece of health policy for the past 15 years, and several of them are the best of a new generation of health policy leaders. Their work has been organized into six chapters covering the health system's key structures and functions. These chapters, along with a subset of the policies they recommend, are described below.

Infrastructure

Chapter one of the book, by David Blumenthal and Karen Davenport, addresses infrastructure and explains that a health system performing to its potential requires the raw materials for high performance. Health care depends on a highly trained, balanced, and motivated workforce; current and accurate information; and technologies that enable the former to use the latter in the right place, the right way, and at the right time. People, knowledge, and the means for their application are, in the end, the foundation upon which an efficient, high-quality health system rests. This chap-

ter explores the state of that foundation in the United States, identifies critical deficiencies, and proposes policies to address them. Policy recommendations include:

- Investing in federal scholarship and loan repayment programs—including the National Health Service Corps and the nursing scholarship and loan repayment programs—to ease the burden of educational expenses and encourage newly trained providers to practice in underserved areas or in primary care.
- Creating a federal, long-term investment in comparative effectiveness research that will guide clinical practice and payment systems, increasing effective and efficient health care delivery.
- Providing federal funds to support the acquisition of federally certified electronic health records, their maintenance, and the technical assistance needed to implement and use them effectively. This could include providing matching grants to safety net providers.

Organization

Chapter two begins with the assertion that the most effective way to address our cost and quality challenges is to confront the root cause—the chaos in everyday health care. Thomas Lee and Robert Berenson argue that we should focus our efforts on accelerating the organization of health care providers into team-like configurations so that they can adopt systems that are likely to reduce errors of overuse, underuse, and misuse, and improve the overall coordination of care. Health care spending will inevitably rise as people live longer and new tests and therapies become available. But, these cost increases can be mitigated if clinicians have help identifying the best and most cost-effective management strategies, if they are given the incentives to adopt these strategies, and if they work in teams that help patients stay as healthy as possible. Policies to support and develop teams of providers with the tools to deliver efficient care include:

- Developing a federal commission with authority to offer one-stop shopping where would-be integrated organizations can obtain a facilitated review of proposals to develop new organizational models and payment approaches.

- Aligning payment approaches to hospitals with incentives for physicians, and encouraging the development of hospital-physician organizations functioning as self-contained and integrated delivery systems—beginning with payment reform in Medicare.
- Supporting regional organizations to support public reporting on individual and organizational quality, with Medicare actively participating by contributing provider-specific data, consistent with privacy protections, to permit more robust measurement of provider performance.

Quality

Chapter three, by Donald Berwick and Chiquita Brooks-LaSure, addresses the subject of quality improvement—a key goal for increasing health system organization. Berwick and Brooks-LaSure explain the apparent contradiction between the fact that the United States has the highest quality health care in the world, yet also has a quality "chasm." Despite excellence in rescue care, the availability of technological care, and bioscientific productivity, the United States' health care system significantly underperforms in numerous other crucial dimensions, both with regard to the technical potential of care and by international comparisons. This gap is reflected both in absolute terms—such as rates of injuries to patients in care, overuse of unnecessary and sometime harmful care, and racial and socioeconomic inequity—and in relative terms when outcomes and satisfaction are compared between the United States and other developed nations. Policies to improve quality at the individual and population level include:

- Holding hospital boards accountable for quality, equivalent to requirements for proper financial stewardship, and subject to penalties for failure to discharge it properly; and requiring them to implement mechanisms for its enforcement, possibly as a condition of participation in Medicare.
- Creating a Medicare-based initiative to reduce preventable hospital admissions and readmissions, and working with hospitals to help mitigate the financial burden of that transition.
- Expanding hospice care through both support to community-based programs—especially in small communities—and proper redesign of Medicare and Medicaid payment systems to limit expensive treatments that do little to improve the quality of life.

Payment reform

The fourth chapter, by Paul Ginsburg with input from Elizabeth Fowler, proposes ideas for using federal payment policy to drive systemic reform. Provider payment structures play an important role in how well the health care delivery system meets the goals of delivering care efficiently and at high levels of quality. Even though practitioners and health organization managers are professionals that seek to serve patients in an efficient and high-quality manner, they nevertheless respond to the incentives that come from how they are paid, sometimes perceiving that they have no choice. Policies to align federal payment policy with larger system goals include:

- Revamping the payment system in Medicare so that relative payments for different services better reflect relative costs of delivering those services, thus eliminating inadvertent incentives that negatively influence practice patterns.
- Promoting care coordination through ideas such as having beneficiaries designate a primary care physician practice to serve as their medical home, with the practice receiving a capitation payment designed to cover services not reimbursed under fee-for-service arrangements.
- Bundling payments for acute episodes of care involving a major procedure or inpatient stay; for example, combining payments for post-acute care (both facility care and home health services) into the payment for inpatient care.

Patient activation

The fifth chapter, by Judith Hibbard and Katherine Hayes, examines the demand side of the equation: how best to engage individuals in their own health and care. Chronic disease is a major health threat in the United States. One of the most important factors that determines its onset, as well as health and functioning post-onset, is how well individuals are able to self-manage their health on a day-to-day basis. Maintaining a healthy weight, engaging in regular exercise, and obtaining preventive care require persistent effort. People are more likely to make good decisions and take appropriate actions to promote their own health if they are engaged,

informed, have the necessary resources, and feel confident that they can take care of themselves. There is general agreement on the importance of empowering consumers to be more informed and judicious users of care. The authors go beyond "consumer-directed health care" to explore new models and policies, including:

- Building in accountability and support for patient self-management through provider reimbursement policies.
- Expanding the evidence base to identify what kinds of supports actually engage and activate consumers.
- Removing barriers that keep consumers from taking a greater role in managing their health, including removing financial barriers to making cost-effective choices.

Achieving population health

The last, but surely one of the most important chapters, by Steven Schroeder and Dora Hughes, sets forth an agenda on population health. Even if the access, quality, and cost problems in the medical system are resolved, the health status gains delivered to the American public through a traditional view of the delivery system could pale relative to those potentially gained through population-wide programs. The authors focus on behavioral threats such as tobacco use and obesity, as well as broader public health challenges, and they propose solutions that include:

- Setting national goals of improved health performance, both absolutely and in comparison with other developed nations, and fixing organizational responsibility and authority for achieving those goals.
- Enacting comprehensive tobacco control policies, including a federal smoke-free policy, increased tobacco taxes, warning labels, countermarketing strategies, and smoking cessation efforts.
- Reducing obesity through policies such as updating nutritional standards for school lunches, expanding social marketing, eliminating "food deserts," and promoting physical activity through workplaces and schools (e.g., increased funding and quality of physical education).

POLICY PATHWAYS

These six chapters offer policies that address many of the structural and functional components of the health delivery system. Some of the policies could be implemented through executive actions, such as support for the Centers for Medicare and Medicaid Services' participation in multi-payer coalitions and cooperatives to specify, enforce, and support health care quality improvements. Specific national improvement goals backed by the administration would simplify the current chaotic situation in which hundreds of priorities are created by a wide array of stakeholders. This approach applies to population, as well as personal, health services. The next administration could also take steps to improve the accuracy of Medicare payment schedules, such as recognizing that productivity may increase over time and that services with rapid growth may need midstream payment adjustments. Medicare payments are often the benchmark for private payers, and Medicare leadership can affect the entire health system.

Congress could relatively easily enact other proposed policies with support from the president. The chapters identify a number of existing bills and policies that require small changes or simple passage. For example, reauthorization of the Workforce Investment Act—expected in the next Congress—could provide an opportunity for leveraging funding to specifically target the training, recruitment, and retention of health care workers in general, or a specific group—such as long-term care workers—in particular. Legislation on funding comparative effectiveness research, which is key to improving quality and efficiency, is both bipartisan and widely supported. And policies to advance health information technology, which undergirds health delivery improvement across the board, have progressed in this Congress and could cross the finish line in the next.

Still other recommendations are achievable, but are more novel or difficult. This is true in the area of organization; increasing the extent to which individual providers are associated with integrated health delivery organizations will require payment, legal, and cultural changes. Improving the effectiveness and safety of care will require organizations to use information and technology to set and meet quality goals, and be held accountable for them. Making patients active participants in their own health monitoring, self-management, and care will necessitate reimbursement models

that foster it, cost-sharing policies that enable it, and information systems that encourage it. And a shift of resources and policy focus from specialty care to primary care and from personalized medicine to population health will take leadership.

These policies are challenging, but they are eminently feasible and would set the delivery system on the pathway toward a high-performing health system. The ideas in this book are bold, but grounded in current realities of the system. They often cost money or take on powerful special interests, but do so only when the short-run pain has the potential to yield long-run benefits. They also cut across the spectrum of public programs and policies—offering options that are narrow and broad, and can be adopted by the executive branch, Congress, or both. We do think that these actions are best enacted by the federal government: a central theme across the chapters is the need for national leadership. A more cohesive governance structure for federal policy would aid in achieving the shared goals of a safe, effective, patient-centered, timely, efficient, and equitable health system for all.

EXPECTATIONS FOR THE BLUEPRINT

This book is designed to contribute to a larger debate on health system change. It aims to ensure that issues of health care quality and population health are not left out of a debate focused on health care costs and coverage, and that delivery system reform is central to any plan. The signs that such a debate could take place in the near future are strong. Both presidential candidates proposed to reform the health care system, demonstrating the political ripeness of the issue. When that opportunity presents itself, it will be essential to be ready with grounded policies that are more than patches, and can serve as pathways toward a high-performing health system.

Setting down this pathway is not just possible, but essential, to our health and to the economy. The policy blueprint set forth in this manuscript includes proven strategies that can be included in any presidential or congressional health reform plan. Because the solutions are steeped in evidence regarding their effectiveness, they are non-partisan in nature—any administration, regardless of political persuasion, could pull policies

and ideas from this blueprint. Policymakers will find here not just broad concepts, but detailed options for improving various aspects of the delivery system. The blueprint's main goal is to improve and create a delivery system that provides the best health care possible to the American people.

ENDNOTES

1   See NBC News/*Wall Street Journal* survey conducted September 19-21, 2008, available at http://s.wsj. net/public/resources/documents/WSJ_NBCPoll_092408.pdf; and Kaiser Family Foundation, "Kaiser Health Tracking Poll: Election 2008," Issue 9, August 2008, available at http://www.kff.org/kaiserpolls/ upload/7808.pdf.

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6   Institute of Medicine, *To Err is Human: Building a Safer Health Care System* (Washington, DC: National Academies Press, 2000).

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8   Centers for Medicaid and Medicare Services, "National Health Expenditure Projects 2007-2012," available at http://www.cms.hhs.gov/NationalHealthExpendData/Downloads/proj2007.pdf.

9   Kaiser Commission on Medicaid and the Uninsured, "Massachusetts Health Care Reform: Two Years Later" (May 2008).

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