First, it’s a great honor to have been invited back here again. I think this organization is one of the great organizations in this country, and indeed around the world, in trying to change the way we approach health care. What I’d like to do this morning is give you a different way to look at the crisis in the US health care system and hopefully offer you some very specific actions that you can take to help meet the challenge.

I think the election of Barak Obama gave to many of us a new sense of promise and opportunity. Senator Obama gave us a sense of hope. But in order to realize that hope, in order to realize this promise and opportunity, will require truly transformational change in many of our institutions. And it will require the willingness on the part of all of us to re-examine and challenge our own assumptions and to see the world anew. This election was not a mandate to simply advance the partisan agendas of the past, but, rather, an opportunity to transcend them.

In an interview with CNN a couple of weeks before the election, Senator Obama said his top two priorities were fixing the economy and energy independence. And then he added, priority number three would be health care reform; I think the time is right. I agree with those priorities, but I also believe that our ability to fix the US economy, and to move towards energy independence, is intricately linked with our ability to solve the crisis in the US health care system. And let me elaborate on that.

In January of 2011, just two years from now, the leading edge of the baby boom generation will become eligible for Medicare. There are 78 million people in that generation — 30 percent of the US population — and when they become eligible for Medicare, when they fully reach the age of 65, the fiscal implications for our nation get into the trillions.

Now, for a nation that’s become acclimated to large numbers, like $700 billion, which we used to bail out Wall Street, or the $35 billion the auto industry is asking [for], a trillion dollars may not raise many eyebrows. But it is a number so enormous that it’s impossible to appreciate without some frame of reference. And let me offer you one. When you go back to your room tonight, get out your calculator and do this little exercise. I call it “zeroes matter.” A million seconds ago was last week. A billion seconds ago, Richard Nixon was leading the White House. A trillion seconds ago was 30,000 BC.

Now, we’ve got a $10 trillion national debt and it’s escalating as the population ages. When the baby boom generation fully reaches the age of 65, the projected unfunded entitlement in the
Medicare program exceeds $60 trillion. And we’re planning to finance that by selling securities to Japan and China and other countries still willing to purchase them, giving enormous leverage to some of our major international competitors who are clearly unwilling and probably unable to continue to underwrite deficit spending of that magnitude. In short, issuing debt to cover the explosion in the entitlement spendings would be a catastrophe; it is simply not an option. Today, Medicare accounts for about nine percent of all federal income taxes. That number will grow to 19 percent by 2015, and almost a third of all federal income taxes will go to that one program by 2025.

The point is, without changing our current fiscal trajectory in this nation, which is driven largely by the retiring or aging of the baby boom generation and the implications that has for the Medicare program, we’re going to face a national debt of staggering proportions and an ever-increasing portion of federal resources will be committed to this entitlement program alone. And not only does that pose a serious financial threat to the stability of our nation and our economy; the opportunity in costs involved will make it very difficult to make the investments in renewable energy R&D and the other transformational and transitional investments necessary to actually get to a post-fossil-fuel economy. And that’s why solving the health care crisis is so intricately linked with our ability to stabilize the US economy, and our ability to move to a post-fossil-fuel economy.

Unfortunately, the way the current national health care debate is being framed today is not, in my estimation, going to get us there, because it is focused primarily on financing, on coverage. Now, there’s no question that financing is an important issue; the cost of health care is rapidly exceeding the ability of many Americans to afford it. Indeed, last year, as you know, the average insurance premium for a family reached $10,800.80 a year — for the first time, exceeding the gross annual income of a full-time, minimum-wage worker.

Now, addressing that problem has become the central focus of most of the health care plans being floated today. Most proposals are seeking to ensure that all Americans have access to health insurance coverage, either by expanding their ability to access existing publically financed programs like Medicare, or by making private health insurance more affordable through additional public subsidies.

Now, I endorse those efforts; don’t get me wrong. This is important; guaranteeing all Americans affordable health insurance is an important interim step. But we have to understand, at the same time, that this step by itself will not solve the pending crisis in the US health care system, and the implications that has for our larger economy and for our ability to cut ourselves free from foreign oil. Unless we can significantly reduce the cost of health insurance itself, these additional public subsidies, which are at the heart of most of these proposals, will simply add to the fiscal pressure that health care is already putting on public budgets, will add to the national debt, and will magnify the opportunity costs, which are constraining our ability to invest as a society in other priorities.

Coming to terms with this challenge, in my view, will be one of the defining issues of our time. And in order to fully appreciate the opportunity, the responsibility, and the threat that this challenge presents to us, it is useful to look at it through the lens of the generations that preceded us, and the lens of the generations that will immediately follow us.
So let me start with a question today: How many of you in this room are between 44 and 62 years old? [Most hands raised in the audience.] Just take a moment and look around; keep your hands up. All right. Everyone who raised their hand is a member of the baby boom generation. Seventy-eight million of us. Thirty percent of the US population. We were born between 1946 and 1964; most of us were the children of people who weathered the Great Depression, who fought along in the Second World War, and who rebuilt the world in its aftermath.

My parents, I think, were typical of what Tom Brokaw called the Greatest Generation. My father was born in Cedar Rapids, Iowa, in 1915; my mother was born in Joseph, Oregon, in 1917; and they met in Pullman, Washington, in 1939 where they were both graduate students at Washington State University, and they were married in November of 1940. The Japanese attack on Pearl Harbor in December of 1941 found them in Iowa, where Dad had his first teaching job, and he was drafted in August of 1943. He was sent to basic training camp in California, and on April 3rd, 1944, he boarded the USS Robert Sherman in New York harbor for this perilous three-week trip across the Atlantic to Europe. And just before the ship sailed a Red Cross volunteer came on board and told him his first child had been born: a daughter that he wasn’t going to see for almost 18 months.

My father entered Europe through Normandy, through France; marched all the way across Europe, through the Battle of the Bulge to Berlin. And for the 17 months he served with Patton’s army in Europe, my parents wrote to each other almost every day; and I’ve often thought it was a poignant tribute to their 65-year romance that they kept every one of those letters. In 2002 my father edited them into a volume that he called “War Letters.” He gave a copy to me and a copy to each of my two sisters. And this was a remarkable document; it covers the period between August of 1943 and November of 1944. It tells the story of two ordinary citizens — new parents — and the incredible sacrifices that they made to win the Second World War. Before my father died, I used to call him up on June 6th every year, which is the anniversary of D-Day, and I thanked him for saving the world. Because that is exactly what that generation did. But not only …

Not only did they win the Second World War, they created the system of higher education. They created the Interstate Highway System; the transmission grid. They went to the moon. They cured polio. They eradicated small pox. They gave us the civil rights movement, which led to the election of an African American as president of the United States of America. They gave us the great social programs. They gave us the great social programs of the 20th century: the GI Bill and Social Security and Medicare and, of course, Medicaid. And as a result of that, our generation — everyone who raised their hand, and most of their children — have enjoyed more promise and more opportunity than any generation in the history of this nation.

I wanted to start with that perspective this morning because we should ask ourselves today what our legacy is going to be. What kind of world are we leaving our children? And right now, it’s not a very pretty picture. Without a fundamental shift in paradigm; without a fundamental change in the way we approach our health care system, the way we approach our consumption of fossil fuel; without changing our priorities and our patterns and our whole way of life. We are not going to leave our kids a world of promise and opportunity, but, rather, a world of debt and degradation.

Solving this crisis is the unfinished crisis of the baby boom generation. It is the defining issue of
our time, and it is intricately linked to the future of the US health care system. To solve this crisis there are three elements that have to be addressed. The first is that we need a shared vision; a set of agreed-upon objectives that captures the desired purpose of the US health care system. Second, we need an accurate diagnosis of the problem we’re trying to address — why the current system isn’t achieving those objectives. And third, we need a clear description of the design elements that are actually necessary to achieve the vision.

Let’s start with the question of objectives by pointing out or reminding ourselves that the purpose of the health care system is to produce health, not simply to finance and deliver health care. Health care has no intrinsic value outside its relationship to a health outcome. It’s a means to an end, not an end unto itself. No intrinsic value outside its relationship to a health outcome, except as an economic commodity, and that point has got to be reflected in our vision, in our system objectives.

Now I believe that the work you have done here, under the leadership of Dr. Berwick and others, has created a set of system objectives around which a new system can be built. And this of course is the Triple Aim: to improve the health of a defined population, to reduce per capita costs, and to improve the patient experience in terms of clinical outcomes, patient safety, and patient satisfaction (see Figure 1). You will notice that nowhere in the Triple Aim is the word “health care” even mentioned. It’s a focus on health, which is really where we need to keep our eye. Now, shifting the focus of our national health care debate from health care to health is a daunting task and it requires a fundamental change in our priorities, in our patterns of investment, and in the structure of our system — and a paradigm shift, too, for providers, for consumers, really, and for all of us.
Figure 2.

To understand the magnitude of the challenge involved, let’s take a look at this chart which shows, basically, the determinants of health — those things that have the greatest impact on your lifetime health status (see Figure 2). You’ll notice that 40 percent are related to lifestyle and behavioral issues; 15 percent are a complex set of social and economic factors that also affect the 40 percent; 30 percent are genetics; but only 10 percent has anything to do with involvement in the US health care system — which tells us that 90 percent of what keeps us healthy over our lifetimes has nothing to do with modern medical care.

So we’ve created a system that’s extraordinarily good at taking care of people after they’ve been injured, after they’ve developed a serious illness, but we’re not very good at keeping people out of the system in the first place. Now, as we’ll discuss a bit later, one of the major reasons for this is that a growing portion of cost in the system is generated by treating people with one or more chronic illnesses. Now we know that chronic illnesses, many of them are preventable, and we know that those that can’t be prevented can be effectively and efficiently managed, but it requires a certain type of delivery model.

The problem is that the US health care system, organizationally and financially, rewards isolated acute care interventions at the expense of prevention and wellness and the appropriate management of chronic care. Which is why we’re only getting a ten percent return on investment, in terms of health, for a $2.3 trillion annual expenditure on health care — and that’s something that’s simply going to have to change.

So my point is that very few people, I think, would disagree with these three objectives as the vision for our new system, as the Triple Aim to capture the system objectives. The problem is, it
is impossible to get from here to there in the current health care system, because both its financing component and its delivery component are structurally flawed, and tinkering around the edges of a flawed system is not going to get us where we need to be in this new century.

Let’s start with the flaws in the financing component, and, to illustrate those, I’m going to start with a little personal story … some of you have heard this before. A few years ago, I took a friend of mine down the Rogue River on a rafting trip. And this was an individual who had grown up in inner-city New York; had never been in that kind of an environment before. And it was August and the fish were running, salmon were running: there were fish in the river, dead fish on the banks. And we floated by this magnificent male Chinook, maybe a 40 pound creature — a magnificent fish — still heading upstream, but he was struggling against the current and against his fading strength, and he was all beat up.

Those of you from the Northwest — I know there are some of you right out there — have seen these big fall spawners. They are just beat up; his fins were all shredded and he had scars on his sides and this white fungus growing all over his body, and that big hook jaw was opening and closing … and just trying to drive himself up the river a little further. And my friend looks at the fish, and she looks over at me, and she says, “My God, what is wrong with that fish?” And without really thinking, I said, “Well, there’s nothing wrong with him. He’s just dying.”

Now, we don’t adopt the same benevolent view of the great circle of life as the Chinook salmon. In this country we view death as alien, as an adverse outcome; we’d like to pretend it’s optional. And, through our medical system, we’ve developed this unlimited array of diagnostic and therapeutic interventions with which we fight disease and disability, and try to stave off the inevitable consequences of aging. And that’s led to this robust industry that’s committed not just to developing these technologies, but to financing them and delivering them for the benefit of individuals.

So if you view modern medicine from the individual’s standpoint, it is miraculous; we produce miracles every day. It is amazing. But if you step back and view it from a societal standpoint, there’s a darker side. Because this arrangement wouldn’t create a problem if everyone could afford the cost of his or her own health care. So all the benefits of modern medicine would flow to the individual, and the individual would pay for the cost of those interventions with their own private resources. No public resources would be put at risk. But that’s clearly not the case today.

Today, as we just saw earlier, we’re increasingly relying on shared public resources to underwrite or subsidize the cost of health care for individuals. So, this is my first very, very important point this morning: What is really in contention in the health care debate, and what we have to focus on, is the allocation of shared public resources, not private resources. What people do with their own after-tax dollars is their own business. If you can afford the cost of your own health care, you’re not the problem. You may think it costs too much, but you’re not the system problem. And to illustrate that, let me give you an analogy.

One of the consequences of my dual roles as a physician, on the one hand, and a legislator and a governor on the other, has been an acute awareness of the fact that how I am expected to allocate resources as a doctor is very different than how I was expected to do it as a legislator or as a governor. So as a doctor, I’m committed to the individual in front of me, to do whatever I think is necessary — regardless of cost — as long as some benefit defined by myself and the patient
accrues. It’s part of the culture; it’s how we were trained.

A governor, on the other hand, can’t ignore cost. And, my responsibility as a public official is different. I couldn’t ignore cost. My responsibility was to get the greatest health benefit possible for as many people as possible, with the public dollars we could spend on health care, as opposed to education or public safety or bailing out Wall Street.

So, in other words, in the public sector, we’re dealing with resources held in common, and they need to be allocated in a way that maximizes that benefit to the larger population from which those resources flow. And if you think about it, that’s really what we try to do with the allocation of most of our public resources. But not with health care.

The financing component of the US health care system was not built around a broad and equitable commitment to access, but rather around something called “categorical eligibility.” Now, what does that mean? It means that, in this country, in order to get publically subsidized health care, as opposed to publically subsidized education or public safety services, you have to fit into a category. And these categories were created in the middle of the last century through three Acts of Congress.

The first one was in 1954 when Congress granted — told employers, basically, that they could deduct from their taxable income the cost of their contribution to their employees’ health care. That’s not counted as taxable income for the employees either, so it’s a publically subsidized tax benefit for people with employer-sponsored coverage. And that’s what created the incentives that led to the employer part of our financing system today. And the other two Acts were the enactment of Medicare and Medicaid in the mid-1960s — totally unrelated to this — and we added, then, Medicare Part B later on and the SCHIP program [State Children’s Health Insurance Program]. But these Acts were created at different times and have no sense of common purpose.

Medicare, for example, is a program for those in the category “over the age of 65.” As you know it’s an entitlement program, coming due to everyone on their 65th birthday, regardless of their economic status, but it’s financed by taxes paid by people who are still working. And, as I indicated, the cost of this program, when our generation reaches 65, is threatening the fiscal stability of our nation and squeezing out our capacity to invest in renewable energy, and anything else.

Medicaid is a program designed for some poor people but not all poor people. To be eligible for Medicaid, being poor isn’t enough. You also have to fit into one of a number of federal categories. So, if you’re a poor man, or a poor woman without kids who isn’t pregnant, you’re not eligible for Medicaid, no matter how deeply impoverished you may be.

Now, these three programs, then, form the financing and eligibility structure of the current US health care system that has these two arms, the public arm — Medicare and Medicaid, which is rapidly becoming the largest one — and the private arm — employer-based coverage, which is gradually eroding.

Now because this system was built around categories and not a broad, explicit commitment to access, there’s a growing gap between the public and private arms of the system, and in that gap are people who don’t fit into a category. They’re not 65, so they’re not eligible for the Medicare
program. They don’t meet the income or the categorical requirements for Medicaid. They don’t work for someone who offers employment-based coverage, but they can’t afford a policy in the individual market.

And that’s where the 50 million Americans are today, and they’re joined by tens of millions of uninsured citizens who live, literally, one illness away from personal bankruptcy. And the inability to pay a medical bill is the second leading cause of personal bankruptcy in this wealthy nation of ours. Who’s bailing them out?

Now, because we’ve built this system around categories, rather than a broad commitment to access, the US stands alone among the industrialized nations of the world in avoiding answering the most basic question in the debate, which is simply this: In America, who has the responsibility to finance the health care needs of people who can’t do it themselves? — a growing portion of our population. And because we’ve never answered that as a matter of explicit public policy, by default we allow the economic market to answer the question for us. But markets, of course, are supposed to make a profit, not foster social responsibility, so it shouldn’t be a real surprise to anyone that no one goes out and competes people who won’t pay them. All right?

So in our market-oriented terminology, people with insurance coverage, we call them “market share.” You know, I’m 61 so I watch the Hallmark channel because it’s got reruns of *MASH* on it, and the advertisers have caught my demographic, and that’s where I learned about restless leg syndrome and all these other new problems that I have — and the drugs to treat them. So, it’s people who have insurance coverage — that’s the people we want to do business with. It’s people who can’t pay, and that’s a growing portion of our population; they are a liability so we try to avoid seeing them, and we’ve got a variety of ways to do it, but the most dramatic and insidious one, I think, is cost shifting. And you know how it works.

When people in the coverage gap get sick enough, or when they can’t find a primary care physician in the community — which will be an increasing population, for more and more people on Medicare, particularly in states with low reimbursement rates — they go to the emergency room. And there, federal laws like EMTALA [Emergency Medical Treatment and Labor Act, 1986] require that they be seen and treated, and then the uncompensated costs are simply shifted back to these third-party payers, through incremental increases in insurance premiums or bills.

Now those third-party payers then just shift the cost back on individuals. The state does it by redefining the income eligibility standards for the Medicaid program to reduce the number of people who are covered. I call that “redefining the poor for accounting purposes.” Yesterday you were poor; today you aren’t. We balance our budget; you get to go under the coverage again. And you’re going to see a lot more of that in the years to come.

The other thing … the federal government does … the state … the private sector does it in essentially the same way: they either drop coverage altogether — and, as you know, private sector employer-sponsored coverage is eroding at about five, five-plus percent a year because of cost — or they increase co-payments and deductibles that put out-of-pocket expenses on individuals, who at some point are no longer able to access the system, and they go back to the emergency room, repeating the cycle.
Now, I submit to you that this structure makes no sense. It makes no sense as a business model; it makes no sense as a social policy; it certainly makes no sense as a way to keep our population healthy. And it also costs us more, as a society, both in economic and human terms, to leave a growing portion of our population without the ability to access needed care when they need it than it would be to adopt an explicit policy of universal access on the front end.

Because today, our policy says, in effect, we won’t pay pennies to manage your blood pressure in the community, but we’ll pay tens of thousands of dollars to take care of your stroke in the hospital. Or, we won’t make sure that all of our women have access to good prenatal care, but we’re happy to pick up the cost of resuscitating a 500-gram infant in the neonatal intensive care unit, and shift that cost to the shrinking employer community that’s still willing to put up with it. And that shouldn’t be acceptable to any of us. We do have a policy of universal access in the United States; it’s called the emergency room. And it makes absolutely no sense.

So the single, entry-level question that must be asked and answered in the financing component of the US health care system is: Who has the responsibility to pay for the health care needs of that growing portion of Americans who cannot afford to do so themselves? And I believe that, any way you cut it, this is a public sector responsibility. Just as it’s a public sector responsibility to ensure that all of our children have access to primary and secondary education; just as it’s a public sector responsibility to ensure fire protection and police protection, and attend to the national defense. It is a public sector responsibility to ensure that all Americans have access to some effective level of health care.

But … but — and this is very important — it can’t be an open-ended responsibility because of the reality of fiscal limits. Public resources are finite. If they weren’t finite, we wouldn’t have a $10 trillion national debt. We wouldn’t have a $500 billion budget deficit this fiscal year. And because public resources are limited, and because we can’t spend all our tax dollars on health care at the expense of education and R&D and roads and public safety, it follows that the health care budget is also finite. And that means that the level of health care, the floor, the level of health care to which we’re going to ensure all our citizens have access is, by definition, what we’re willing to pay for with public dollars.

Now, the concept of a floor is a very important one, because one of the problems with the national debate about universal coverage is, no one wants to talk about: Coverage for what? But clearly we can’t afford to do everything that we can do for everyone who might possibly benefit from it. There are limits, and it is within this floor that we have to come to terms with our limits. It’s within this floor that we have to decide what we can and what we cannot ensure everyone will have access to. It’s here we have to come to terms with the realities of our fiscal limits. And what we’re doing today is, we’re deciding by not deciding, and simply ringing that tab up on our children’s credit card — which is not only unsustainable, I think it’s immoral as well.

So the fundamental question in the financing side of the health care debate is not how to find more money to spend on health care — $2.3 trillion ought to be enough. The real question is to make sure that that growing portion of the health care budget that’s financed with public dollars is spent in a way that benefits all of us, not just some of us; and that we actually get a health benefit for this huge expenditure of public resources.
Unfortunately, that’s not what’s happening today. Most of the proposals around health care reform today, at the state level and, increasingly, at the national level, operate within the existing flawed financing and eligibility structure. They are not designed to produce a system that will actually improve the health of Americans; they are designed to give all Americans access to the system that we already have.

Which brings us to the second flaw in the delivery system: the problem here is not how we pay for health care; the problem is what we’re buying and how that care is organized and delivered, and what return on investment we’re actually getting for that huge investment. Now Don Berwick told me not to mention him today; this is not the car he drives, but he does have an analogy, which I want to use, and you’ve probably heard it — it is one of the best analogies that captures the problem we’re facing here.

So, as Don likes to point out, every car has a maximum speed. And what we’re going to do here is, we’re going to compare the performance of a car to the performance of the US health care system. So, you can take your Porsche or your GMC pick-up or your Honda Accord or your Prius or whatever … your ’56 Chevy … out to the Bonneville salt flats and put the pedal to the floor, and pretty soon it’s going to go as fast as it can possibly go; it’s going to reach its maximum speed.

And when I heard Don share this story, he said: “Now, what can you do, then, if you don’t like that?” Well, you can yell at your car; you can file an incident report with somebody; you can offer it an incentive. But the point is, it’s just not going to go any faster. There’s a reason a Porsche goes faster than a Volkswagen, because the maximum speed is a function of the car — it’s built into the car, it’s part of the car itself.

And, by the same token, the poor performance and inefficiency of the US health care system is a function of the system — it’s built into it, it’s designed into it. And that’s not going to change just by changing who pays for it. And that is a huge shift in focus that has to take place if we want to solve the crisis in the US health care system.

Now, to understand that, we simply need to look, as we mentioned earlier, where most of the money in the health care system goes. And today, as most of you know, probably 80 percent of the money in the system goes to treat people with one or more chronic illnesses — from diabetes to congestive heart failure to mental health and chemical dependency issues.

And, secondly, the way those dollars are distributed throughout the population is very uneven. About one percent of the population consumes around 35 percent of the health care dollars in any given year; 10 percent of the population consumes about 70 percent of the health care dollars. So, to recall the infamous 20th century bank robber, Willie Sutton, who was asked why he robbed banks, infamously said, “Because that’s where the money is.”

So, it would behoove us, if we want to solve the health care crisis, to begin by looking at where the money is and how we might reduce that cost. Well, we know some things about chronic illnesses. First of all, we know that many of them are preventable; we know that lifestyle contributes as much as 90 percent to the development of diabetes, 80 percent to the development of heart disease. We know that these diseases are progressive, that they start out with a very low level of intensity and then complications accrue, and if you don’t get on those complications
right away with the right interventions they get worse, requiring more complicated, more expensive interventions; often hospitalization, sometimes poor outcomes.

And we also know how to manage chronic care; we’ve known it for a long time. There are models all over the place, but it requires a certain specific kind of delivery model. You have to have physicians who actually talk to each other and communicate with each other and work in partnership with non-physicians — with the family and with community services and providers as well — managing that person longitudinally over time.

You need well-educated patients who can recognize the early signs of a complication, so, if you have congestive heart failure and you weigh two pounds more this morning than you did yesterday morning, you need to know that’s a problem, and you have to have a system where you can access somebody who can help you manage that on the front end, rather than waiting until you’re really sick and end up in the hospital.

So we need a system that’s integrated, with shared responsibility, that’s very collaborative and does the right thing at the right time, very, very quickly. The problem is it that the US health care system evolved one way, and the demands on the system evolved in a different way. Just like the financing system, the demands have changed, the environment has changed, but the structure of the system hasn’t.

First of all, we still operate in the model of an acute care / infectious disease approach; in other words, episodic medical interventions of high intensity, treating a stroke or a heart attack or a broken bone. Now that makes sense for a lot of things. It makes sense for the acute life-threatening conditions you might see in an emergency room, and it also makes sense for a lot of acute non-life-threatening conditions like a urinary tract infections or strep throat — many of which are showing up in “minute clinics” in CVS and Walmart. The problem is it’s become a de facto one-size-fits-all delivery model in the face of very different delivery challenges, not the least of which is chronic care management.

Secondly, most doctors still practice by themselves or in small groups. Less than four percent of physicians, I think, in the country practice in groups of more than 50. Doctors don’t communicate well with each other. They practice as independent, autonomous economic entities with very little formalized collaboration and communication between one another. And that creates a real problem because the average person with one chronic illness may have five to seven physicians taking care of them, and if they don’t communicate with each other, the potential for drug interactions and gaps in care and other complications is enormous. And even if you have an electronic medical record in your office, it may not be interoperable with those of other physicians or non-physicians who are taking care of the same patient.

And, finally, we don’t have very good information. Most of the data on patients today is still locked up in paper on medical records in hospitals and doctors’ offices throughout the country. So the inability to have patient information computerized and aggregated, where we can track it and monitor it, prevents the health care system from having the kind of continuous process improvement loop that is characteristic of most other sectors in the United States today. You know, the most common admitting diagnosis for people on Medicare is congestive heart failure, and about 40 percent of those people are readmitted within 90 days with the same diagnosis. That’s not a financing problem; that is a delivery system organizational problem.
And, finally, we have these financial incentives. This is from a book by George Halvorson, who’s the CEO of Kaiser [Permanente] — *Health Care Reform Now!* , which is a really enjoyable read. He points out that we’ve got 9,000 billing codes for which hospitals and doctors get paid, but there’s no code for a “cure.” *He–low??* There’s no code for “prevention.” There’s no billing code for “health improvement.” They’re not billable events. So it’s not surprising that the whole system is organized around these revenue streams that reward isolated acute care interventions at the expense of wellness and prevention and the appropriate management of chronic disease. And just throwing more money into the system, to the insurance side, is not going to change any of that, which is really the heart of the problem.

So my point is that there’s no way that *this* system can achieve the Triple Aim, no matter how much money you throw at it and no matter who pays for it. We need nothing short of transformational change, which was one of the themes of the last presidential election. But you cannot achieve transformational change by operating within the constraints of this badly flawed eligibility and financing structure that we have today.

So what I want to do in the next couple of minutes is, I want to lay out five key elements, design elements, that, I think, in one form or another, have *got* to be part of a new system — if we’re serious about achieving the Triple Aim in the United States of America.

First, we need a much more rational and sustainable financing system, and I would abolish categorical eligibility and replace it with a publically financed floor in which access to publically subsidized health care is based on economic need, not an arbitrary set of categories that were created in the middle of the last century. Now, because of the reality of fiscal limits, there has to be a defined benefit in that floor. And I would define that benefit through a transparent public process where health services were prioritized, from the most important to the least important in terms of the health produced; very similar to what we did with the Oregon Health Plan.

Now this floor can serve as the basic level of care for everyone, which, administratively, is *much* more efficient, very much like the Medicare program. Or, it could serve as just a floor for individuals below a certain income level, with sliding scale subsidies that go down as income goes up. But it’s a more rational system than using the emergency room to provide universal care for all our citizens.

Secondly, this new publically financed tier — now we’re talking about, again, the public dollars in the system, not about what people do with their private after-tax dollars. This tier has got to include what I call “value-based cost-sharing,” where co-payments are not simply used to shift costs, economic burden, to individuals, but rather to help drive individual behavior and responsibility within the context of the overall system objectives. So you may have *no* co-payments or very low co-payments for services that are very effective at producing health or high on the priority list, and higher co-payments for things that are less effective and things that may have a lower priority.

So, for example, there may be no co-payments whatsoever for well child care, immunizations, prenatal care; screening for breast cancer, prostate cancer, hypertension, diabetes; or the drugs you need to manage chronic conditions — because any barrier to access to those services and medications creates huge downstream costs, both economically and in human terms.
But if you have a service where there’s less medical evidence to support the efficacy — let’s say, surgery for low back pain, or prostatectomy for BPH [benign prostatic hyperplasia, or enlarged prostate] — maybe there’s a 50 percent co-pay. And if you and your partner want to determine the sex of your unborn child through an ultrasound and the ultrasound isn’t indicated for a healthy term pregnancy, you can get that too, but you have to pay the whole thing out of your own pocket.

So, value-based cost sharing recognizes two things we pretend don’t exist in the United States: the first one is that people with more money in America can always buy more stuff, including health care. And secondly, we are always going to have at least two tiers based on income, as every other nation on the planet does. But, there should not be a qualitative difference between those two tiers in terms of health outcomes.

The third element is that we’ve got to design our care in a way that gets beyond the one-size-fits-all acute care model that underlies our current system. And I would recommend organizing care around what Dr. David Lawrence, the former CEO of Kaiser [Permanente], calls “families of conditions” — that is, conditions with a common set of delivery activities and requirements where a lot of the care could be standardized, and the focus is on the areas of uncertainty. And I would organize initially around those five families of conditions that account for the vast majority of costs in the system and the vast majority of patient encounters:

1. Pregnancy, child birth, and early childhood care
2. Chronic life-threatening conditions — diabetes, CHF — where most of the cost is today
3. Acute life-threatening conditions — the kinds of things you’d see in a Level 1 trauma center
4. Acute episodic non-life-threatening conditions
5. End-of-life care

Fourth, I think the revenue, and, again, we’re talking about public revenue, needs to flow to regional and locally organized entities that assume risk and responsibility for the health of a shared — a defined — population. And that could, as the folks at IHI pointed out, be a hospital, an affiliated physician group, a large primary care group, a visionary health plan, or I think, probably, an entirely new health entity. Now this concept, which is really at the heart, I think, of one of the elements of the Triple Aim, is maybe the most radical but, I think, the single most important component to create a system that can actually achieve the Triple Aim.

First of all, it recognizes that there will be local and regional differences in how you deliver care. The care organization may be the same; the product may be the same, but you’re going to provide care very differently in New Mexico, particularly if you have a large Native American population in your catchment group. It will be different in downtown New York than it is in suburban Seattle. So it recognizes those local and regional differences.

Secondly, and most importantly, it provides a single point of contact, an advocate or case manager for everybody in that defined population, which allows us to, then, operate as the integrator. It allows us to identify the 10 percent of the population driving 70 percent of the cost and manage them, and educate them. It allows us to coordinate the medical and non-medical community and family services that are necessary to appropriately manage chronic conditions. It
allows us to target at-risk kids and get them set up on a healthy life trajectory. And it allows us to create a relationship that gives us the capacity to provide the counseling and compassion and education and support — non-medical values that are so important at the end of life.

Now finally, payment — and again we’re talking about public revenue streams here — I think would take three forms. You would have a very generous subscription payment, the purpose of which is to manage that relationship with each individual: patient education, maintaining an electronic record, office visits, etc. Secondly, there would be a risk-adjusted, bundled payment for complicated conditions, particularly those requiring hospitalization.

And then, finally, an annual performance payment for improving the health of the population around certain metrics — reducing hospitalizations, reducing complications — which, to me, makes much more sense than the case-by-case, procedure-by-procedure pay-for-performance processes that are being developed today. [applause] You like that ... huh?? Finally, and this is very important, traditional fee-for-service medicine will continue to flourish in this robust secondary insurance market for services and procedures that are not covered within this basic floor.

Now, what I’ve described to you this morning obviously doesn’t remotely resemble the health care system we have today. And moving from where we are to that system is an enormous political challenge because of the number of economic stakeholders involved. Now, we’ve just come off an election cycle, and after every election, the major culprits are listed, in no particular order, as: big pharma, the insurance companies, hospitals, and doctors … and then on down from there, in levels of darkness.

But the fact is we’re all part of the problem. The uninsured are stakeholders in this debate; so is everybody — the 60 percent of us that have good workplace-based coverage. You’ve got seniors on Medicare; people with disabilities and other specialties; employers large and small, those offering coverage, those not offering coverage; doctors, hospitals, other providers; insurers, health plans, drug companies, medical device companies … the list goes on and on!

And here’s what happens: whenever someone lays out a vision or key design elements of a new system, every one of those stakeholders does a little bit of mental calculus. They go, “Hmmm, given the current organizational structure and financial incentives, if we go from where we are today to this new system, I’m going to lose some money.” And so, they all become advocates, for or against a reform proposal, based on how they think it’s going to adversely affect them in the short term, from an economic standpoint. And so, because of this — collectively and individually — we have prevented a serious discussion of a problem that poses a clear and present threat to this nation.

And we did it in this last election cycle. How many candidates did you hear even talk about the cliff we’re coming to two years from now with the Medicare program? How many people talked about the organizational challenges inside the health care system? It was all about insurance coverage — and we can thank ourselves for doing that.

The position we’re in politically, I think, is captured in this little raft, this little picture. We’re all in a raft and it’s coming under this bridge, here … I’m going to call that raft the US medical system. And in that raft are all the stakeholders. I’m there as a medical doctor; we’ve got a
hospital CEO, we’ve got a senior citizen, we’ve got an insurance exec, we’ve got a few business people … the list goes on and on. And we’re floating down in this raft, and suddenly we come around this corner here … and suddenly, the river disappears! And we can hear this ominous rumbling and see the mist kind of rising from where the river used to be.

What do we do? We turn around, and we grab our paddles even tighter until our knuckles are white, and we start digging furiously in the water, trying to keep our end of the raft upstream, deriving some perverse sense of security that the people on the other end are going to go over before we do. We can do better. We can do better. And, by the way, this precipice here is about two years away, my friends. We don’t have a lot of time to figure out a strategy.

![The Future State – Most Can Be Winners](image)

Figure 3.

Now, I have three more slides here, which I have blatantly lifted from Dr. Berwick. But I think this slide really captures the political challenge that we face (see Figure 3). And he plots economic burden on this side and time here. If this is the current health care system, the one we all know and love, and let’s say this is the future state that’s built around those five principles, or something of that nature. And if we could move from here to here and the economic burden on all the stakeholders went down during the transition process, it would be very easy. The politics would be easy. No one would lose. We would have done it a long time ago.
But the problem is that it looks more like that (see Figure 4). The reality is that to go from the current system — with its structure, with its culture, with its financial incentives — to a more rational system in the short term, a whole lot of individuals and institutions are going to take a very, very serious economic hit. And all of those individuals and institutions have the capacity to jam things up in the political process. So it seems to me that to put together the politics of reform, we have to shift the focus of the debate from where we want to end up to how we’re going to get there. Shift the focus of the debate to the transition.

Now what I’ve tried to offer you today, in a very quick overview, are the key elements of the vision of a new system — of what that future state might look like. Our challenge, then, is to drive the focus of the debate back into that transition by making the very real politics and economics of the transition legitimate. Legitimize and acknowledge them and change the focus of the political debate, from how an individual economic stakeholder is disadvantaged in the short term to how we can mitigate the economic impact on all the stakeholders, as we move from where we are to where we need to go.

Now, what’s going on with General Motors? They want a bailout. The only way I would support that is if that bailout was used to help them make the transition to produce cars that are fuel efficient and that compete on the global market, and thus increase employment and stabilize that industry.

There is no difference in the health care system. We will need some kind of investment — not to simply give more people access to the current system, but to manage that transition while the industry redesigns itself to the demands of the 21st century. We have the capacity to do that … But without agreeing on a vision there is no political pathway by which to get there. As the
Roman Senator Seneca once said, “No wind is the right wind if you don’t know what port you’re sailing for.”

Unfortunately, I still think that the national political debate has misdiagnosed this problem as one of coverage. Our challenge, I think, and the challenge I’m asking or throwing to you today, is: We need to refocus that debate by operating through organizations like the Institute for Healthcare Improvement [www.ihi.org]; by operating through the Estes Park Institute [www.estespark.org]; by operating through grassroots movements like the Archimedes Movement [www.wecandobetter.org]. Our challenge is to use our individual and collective influence to rally around a clear vision for the future of the US health care system, and then call on our new administration and our new president to lead us through the transition.

This is something that we can do, so I want to ask anyone in this audience, or anyone who’s listening online: if you believe, as I do, that we need to refocus the US health care debate — from how we pay for health care to what we’re buying, how that care is organized and delivered, and what return on investment we’re getting for health — then I ask you to join me at this website [www.wecandobetter.org].

If you are willing to embrace the vision of a new health care system that I laid out for you today; if you are now willing to help move the debate from where we want to go to how we’re actually going to get there; if you are willing to commit your time and energy and ingenuity to making sure this transition works for all of us, and not just some of us, then come to this website so I can contact you, and together we can move in this direction.

This is something we can do, because we have done it before. And I want to remind you, as I wrap up here, that we have in fact been here before. In the middle of the Second World War, we re-tooled the entire US industry towards the war effort. There was a period in which you could not buy a consumer car in the mid-1940s.

And I would remind you of the bold challenge that John F. Kennedy offered the nation in 1962, when he said, “I believe that this nation should commit itself to achieving the goal, before this decade is out, of landing a man on the moon and returning him safely to earth.”

Now a lot of people don’t realize that he had received a report, it might have been from the National Science Council, shortly before he gave that speech, that said: “This is impossible, Mr. President. We don’t have the technology; we don’t have the tools; we don’t have the capacity — we can’t go to the moon.” And he issued that challenge anyway. It was a leap of imagination.

And in fact, shortly before his death, and I believe it was in a speech opening NASA, here’s what he said: “We shall send to the moon, 240,000 miles away, from the control station in Houston, a giant rocket more than 300 feet tall, made from new metal allies, none of which have yet been invented, capable of withstanding heat and stress several times more than have yet been experienced, fitted together with the precision better than the finest watch, carrying all the equipment needed for propulsion, guidance controls, communication and survival, on an untried mission to an unknown celestial body.” Talk about a leap of imagination!

I submit to you that the challenge, the leap of imagination necessary to describe what the optimal health care system should look like is much, much less than the imagination it took to go to the
moon. What John F. Kennedy gave us, back in the early 60s, was not a road map. He gave us a
destination. He gave us a powerful vision. He gave us as a society a sense of common purpose;
one that allowed us to refocus our energy, our creativity, our commitment as a nation to achieve
a common goal, and that was going to the moon — and ultimately we did it.

That is exactly where we are today. We need a common vision, we need a sense of common
purpose around the US health care system, and no one in our nation is better prepared and better
positioned to articulate this vision for America than the president-elect. And no one is better
qualified than Barak Obama to lead us through the transition that we face today.

The challenges that we are going to have to overcome to get there, to reach our goal, are not as
obvious or as urgent as the menace of the Third Reich, which motivated our parents and
grandparents. But they’re just as deadly sure; maybe because they’re less obvious. They’re less
obvious than a Pearl Harbor; they’re less tangible than the specter of a Nazi Panzer Division
snuffing out the flame of freedom as it rolls across the face of the earth. But I promise you this:
these challenges, around the US medical system, if we are as successful in meeting them, will
have every bit as much an impact on the lives of our children and grandchildren as did the
winning of the Second World War on our generation.

Albert Einstein once said that you should not solve today’s problems by using the level of
thinking you were at when you created them. I agree, but I think the late Western novelist,
Edward Abby, put it much more succinctly, although maybe not as eloquently, when he said,
“Society is like a stew; if you don’t stir it up from time to time, you get a lot of scum on the top.”

Our job, my friends, is to stir it up. Our job is to recognize that the responsibility to fix the US
medical system, with its ominous implications for the stability of our economy, for our ability to
move to a post-fossil-fuel world, doesn’t belong to someone else. It’s not going to happen for us
in Washington, DC; it’s not going to happen for us in our state capitols. It’s going to happen
through the commitment and engagement of people like you in communities throughout this
nation of ours.

It’s something we can do; it is something we must do. And if we’re not willing to do it for
ourselves, then we should do it for our children and grandchildren — a gift for the future.
Those people who are going to inherit our world and who, on our current trajectory, are going to
inherit a staggering burden of debt and a dysfunctional system that was created on our watch,
and through our inability to act in concert as a community, is being perpetuated.

Let me close this morning with the words of Oregon poet, Ken Stafford, who, much more
elocuently than I captured, I think, the challenge, the opportunity, but also the responsibility
before us, of what he calls Lloyd’s Story. This is a true story. Lloyd Reynolds, the international
citizen of Portland, spent his last days silent, unable to write or speak, lying in a hospital bed. On
his last day at home, as his wife scurried to pack his suitcase for the hospital, Lloyd found his
way outside to the garden. And there she found him, on his knees, awkwardly planting flower
bulbs with a spoon.

“Lloyd,” she said, “You’ll never see those flowers bloom.” He smiled at her, “They’re not for
me,” he said, “They’re for you. Salmon coming home; they’re for you. Calls of the wild geese;
they’re for you. The last old trees; they’re for you and your children to the seventh generation.
and beyond. They’re all blooming into being for you.”

That, my friends, is our challenge. To plant the seeds of tomorrow — to create that vision, that beacon of hope towards which we can lead our states and our nation over the next five or 10 years — by acting, by leading, by personally committing ourselves to this quest; not as captives of the past, not as victims of the status quo, but as the proud architects of a new and brighter future.

Thank you very much.