



PRESCRIPTIONS FOR HEALTH REFORM:

A PODCAST FROM THE BLUE CROSS BLUE SHIELD OF MASSACHUSETTS FOUNDATION

Transcript of podcast interview with
Phillip Longman, author of *Best Care
Anywhere: Why VA Health Care Is Better
Than Yours* 8.22.09

Q. Many people envision the VA health system as scandal ridden and of poor quality. What did you discover in your research about the VA system that gives you a different opinion?

A. My experience starts several years ago when Fortune magazine asked me to find out whoever it was who was providing the most innovative, cost-effective health care in the United States. I think what they had in mind was find the Jack Welch of health care. So I set out to talk to people who concerned themselves with healthcare quality and different metrics of healthcare delivery, and I kept hearing an answer that I couldn't believe. Because it turns out that when you do these studies of who is providing the safest, most effective, most scientifically driven healthcare, the VA keeps coming out on top. And so I was very perplexed by that. It took me a long time to get over the cognitive dissonance. But eventually on the evidence of my own eyes and talking to veterans themselves, and spending a lot of time in veterans hospitals, I came to see how this was and also to have some ideas about how it came to be.

Q. One of the big advantages that you find with the VA system is that it establishes a lifetime relationship with its patients. I'm wondering why you think that's an advantage and why other healthcare providers aren't able to do that right now.

A. The VA is almost unique in American society in having a close to lifetime relationship with its patients. It starts when they get out of the service and extends as far as long-term nursing care. What this means is that the incentives on the institution are extremely different than with any other healthcare provider. Generally in American medicine today, no good deed goes unpunished. If you put a lot of

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money into prevention and disease management, it creates a lot of good for the patient down the line, but almost always, that patient is no longer in your plan by the time the benefits show up, so you're actually benefiting some competitor.

To be specific, if you had a smoking cessation program, you would prevent a lot of heart attacks, but most of them would be heart attacks that would have happened 10, 20, 30 years down the road. If you concern yourself with managing diabetes well, again, the long-term benefits are often decades in the future. The VA's not like this. The VA knows that if it doesn't manage diabetics well, it's on the hook down the line for the cost of their renal failure, amputations, blindness, and all the other complications. So that is an important relationship, and it drives how the VA does medicine.

There are also some things that are just unique to the culture of the VA. The VA was, as you say, a scandal-ridden and almost dysfunctional institution in the 1970s, and it got so bad that some employees took it upon themselves to do what they could to improve their working conditions. Specifically, what a lot of folks began doing in the VA back in the day was to go out and buy newly available personal computers, and use them to integrate what today we call health IT, and electronic medical records, into the actual practice of medicine. That today has progressed to the point that the VA has the world's standard in health IT. If you go to a VA hospital, you'll notice a ritual where a nurse is dispensing a pill to a patient. First she scans her own wrist bracelet, then she scans the patient's wrist bracelet, then the med itself. And if it's the wrong med or the wrong patient or the wrong dose, or whatever, she's prevented from doing the dispensation error. That's one example of how this health IT has dramatically improved safety in VA hospitals.

But there's another and more profound difference, which is because the VA has been totally wired now, since the 1980s, it has a tremendous database of patient records that researchers can go back after the fact and begin to see what works and what doesn't. For example, the VA, using its electronic medical records, identified the dangers of Vioxx long before the FDA or anybody else did, and of course that's a drug that killed more Americans than died in the Vietnam War. So through this integration of health IT into the actual practice of medicine, you begin to bring more science into the practice of medicine. Again, because of their scale, they can do this. Individual doctors using laptops doesn't get it. The typical American deals with many different specialists in the course of one disease. Typically, they don't talk to each other, they have very little ability to communicate with each other. If they have health IT systems, the systems don't talk to each other. In the case of the VA, it's all integrated, it's been up and running for almost a generation now.



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Q. Let's jump back for a moment. You were talking about the advantages of the VA and establishing a lifetime relationship. Why don't other hospitals have the same advantage? Why haven't they been able to achieve the same level of care as the VA?

A. Almost everything in this realm is counterintuitive. It turns out that the next best healthcare providers on these various metrics of quality are great big HMOs. Not all of them, but some of them. In particular, ones that by accident of history hold onto their patients for a long time. I'm thinking of, for example, Intermountain Healthcare system in Utah. Off the charts in its quality metrics. Part of the reason they've been able to do this, and I've talked to their CEO about this, is a lot of people move to Utah; there's very few people that move out. Intermountain was once part of the Mormon Church, and it has close to a lifetime relationship, not driven by profit motive, with its patients. So on a cost-benefit case, it makes sense for them to do the right things in healthcare.

Virtually everybody else is dealing with patients who churn through onto other providers and healthcare plans in five years. So although there's many, many idealistic people in medicine who want to do the right thing, when they go to their MBAs, they quickly get told that, "Hey, we'll lose money on that." There's any number of examples of specialty diabetic clinics that have gone bankrupt because they can't recapture the value of what they do, and yet they tend to attract people with diabetes. This is part of what solves this riddle of why it is that competition in most other realms leads to increase in quality and lower cost, but not in this one.

Q. You lay out a solution for the health care crisis that uses the VA system as a model. Could you outline briefly how this might work in practice?

A. All over the country now we have St. Elsewhere-type hospitals—big, public hospitals that are going broke because of the cost of uncompensated care. My idea is to basically propose a deal to the communities where these hospitals are. The first part of the deal is you install the VA's software and integrate it into your practice. As it happens, because this software, known as VistA, was developed by government employees, it's public domain, essentially open source, even though it was developed at a time before anyone had a concept of open source in programming. What this means is anybody can have this for free, and many countries around the world have installed VistA, including Mexico, and now Jordan and Norway. It's not technically a difficult thing to do and of course it's been up and running for a long time and was written by doctors for doctors, it has a lot of buy-in, so it's not a huge thing to do.

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In many states, such as Massachusetts now, we have individual mandates on people to buy health insurance. What we could do is to say the default position on someone facing an individual mandate for health insurance is that they are subscribed into a plan for something like a civilian VA, where the delivery mechanism is these public hospitals needing finance. They would be guaranteed a pool of patients. We build something kind of like—I call it the VistA healthcare network. It has franchises in every city in the country eventually, so when you move, or you travel, you always have access to a system where your electronic medical records are accessible and you build it out that way.

This is not forcing people into any kind of system. If you don't want to participate in this, fine, but it is a way that we know delivers very high quality healthcare for about a third of the cost per patient of what you'd find in the private sector. And by the way, the VA has the highest rate of patient satisfaction of any healthcare provider, so chances are, once people get to actually experience this kind of healthcare, many will be clamoring to get into the system.

Q. What would you say then to those who fear government-run healthcare, and how can we ensure the system that you describe wouldn't lead to the government "practicing medicine," which seems to be a big fear among many?

A. Think of it as analogous to state universities and private universities. The fact that we have a state university system doesn't make higher education into some socialist morass. It actually injects competition into the overall system. So because there is a University of Michigan or a University of Massachusetts, private schools have to compete that much harder on quality and price. I don't see this as actually taking competition out of the healthcare system, I see it as putting it in, in the right place, getting people to compete over the right bundle of services.

Again, on the individual freedom point, if you want your own doctor and you want to stay out of any kind of managed care setting, you're free to do so. By the way, the studies say that despite what your intuition may be, this is an extremely dangerous way to get your healthcare. We're losing 98,000 people a year now to medical errors, and most people are facing dangerously uncoordinated care. But if that's what you want, under my vision, you would still be able to do that.

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Q. Who would pay for the new system, and aside from the reduction in cost for information technology, which we've already discussed, why would this be more cost effective than some other healthcare solutions?

A. There's any number of ways to pay for it. For people who are not poor, and facing an individual mandate, they would pay premiums to the system. The VA, were it able to serve more veterans (unfortunately, many veterans are not permitted to use it), it's close to being able to make money, if it can treat family members, treat veterans of all income classes. Like I said, it's a very popular form of treatment, and there's long waiting lines of people clamoring to get into this. It would be financed at least for people who are not poor largely through premiums on themselves. For the poor, we would have subsidies. But of course we're paying for the poor anyway in the form of Medicaid and dysfunctional emergency rooms, and there would be a lot of savings that would come out of that, too.

Q. You said that this could be used as the default option under the Massachusetts mandate for healthcare. In your book, you assert that the Massachusetts reforms have moved us in the right direction. How so, and where do they still fall short, in your opinion?

A. They move in the right direction because, first of all, it's something that conservatives and liberals seem to be able to come together about. Conservatives like that you're not nationalizing the healthcare system, that you're forcing people to take some personal responsibility for their health, that you're overcoming the free rider problem of young, thoughtless people who could well pay for healthcare just not bothering to, and so it's something that is doable and has some virtue.

The problem is, with Massachusetts anyway, that it hasn't gone far enough. They haven't thought through, okay, now that we've just added a whole bunch of new people with access to the healthcare system, how are we going to improve the healthcare system itself so it's efficient, we can afford this, we get the health outcomes that we want. That's sort of an unfortunate aspect of the healthcare debate generally so far, is it's been primarily about finance and access as opposed to what we are actually buying for our healthcare dollar and how it's provided. It turns out, based on the work of Elliot Fisher and others at the Dartmouth Medical School and many other studies, that somewhere about a third of all the money that we're spending on healthcare now are is for treatments that are at best unnecessary and at worst harmful.

We have to figure out a way to reform the system so we don't have that kind of outcome, and one of the ways to do it is to build a VA-like institution that can take advantage of economies of scale, that can do this population-level research using electronic medical records, that can develop protocols of care for what's appropriate—who needs back surgery, who doesn't—and put some more science into the actual practice of medicine. Like you say, a lot of this is counterintuitive. It took me a long time to get my head around it. But that's what the data tells us works in healthcare.

Q. What do you think would be hardest for doctors and other care providers to adjust to under this new system? I think clearly there would be some changes in how they would be practicing.

A. There'd be winners and losers. Specialists who engage in or make their living performing unnecessary back surgeries and heart operations obviously have something to fear from this idea. But the VA itself, their corp of doctors has produced two Nobel Prize winners, the VA is one of the hottest internships in medicine now because young people know the future is IT, and the VA is the pioneer of that. A lot of VA doctors very much appreciate not having to worry about malpractice, which the VA handles for them, or any of the business aspects of medicine. They typically have dual assignments with the VA and university research hospitals because they're attracted to this public-spirited, scientifically driven model of medicine. So some of the best people in medicine are attracted to the VA, and I think there's a lot of people in medicine who would just love to wash their hands of all the commercial aspects of it, and do what they were trained to do.

Q. Aside from improving the overall quality of care, what are some of the broader economic and social advantages to a system like the VA system, applied broadly?

A. Take a concrete example, of, say, the state of New York, which has taken the decision to close 20 percent of the hospitals in the state because they can't afford to run them anymore. Many hospitals, even ones making money, are now facing this sort of base-closure-type process, where they're being zeroed out. What this means in places like the South Bronx is that the only hospital in the neighborhood is closing. Also closing is the only vibrant source of revenue to that local economy, so the people that have the restaurants and the dry cleaning and all that depend often on the hospital.

This is a situation you can find all over the country. So this is a way to stimulate and preserve those economies that are under duress while at the same time improving

the quality of healthcare that the local folks get, and lowering its costs. So that's very stimulative. Just to be able to reduce by a third, at least in theory, the 17 percent of GDP that is now going to healthcare, without getting any better life tables than Costa Rica, using that money for other purposes could bring a lot of prosperity, whether it's in infrastructure, education, name whatever your passion. But for now, most of this money, well not most of it, at least a third of it, is going to waste.

Q. Last question, then: What would you advise the Obama administration as it begins to look at this problem? Where would you suggest they start?

A. Ultimately, although it's important that we provide health insurance to the 47 million plus who don't have it, that can't be the end of the story. We have to improve the efficiency, and that means hands-on changes, whether it's paying for performance or mandating that doctors and other providers use electronic medical records

I think one of the things that's most scary about the moment is that I think the public has caught on, and certainly healthcare policy elites recognize that health IT is extremely important, everybody's in favor of it, except when you get right down to it, there's all these different private vendors out there trying to sell their health IT, and these are proprietary systems where data goes into a black hole and you have to pay the provider to get it back out. It's really important, I think, that going forward, health IT be open source like the VA's system is, which means that anybody can modify it or improve it to suit their own purposes, which means that we're not paying all kinds of money just for profit, but it's staying with the people who actually deliver the healthcare.

Right now, this program, VistA, that the VA employees basically wrote for themselves, has migrated outside of the VA, and is now supported by computer programmers around the world who just for idealistic reasons want to keep this thing alive. The Bush administration did its best to kill VistA, and I think did a lot to harm the VA, too. But the VA is still standing and is still good, and my first advice would be, look at this health IT system, make sure that we don't go down this wrong technology path so that we wind up with all kinds of different systems that can't talk to each other, that were written by people who know a lot about computing but nothing about medicine, and like that. That's a decision that really needs to be made soon, because we are committing to health IT, but unfortunately committing to a proprietary model that's against the grain of everything else that's going on in computing, which is gravitating to open source across the board.

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