



PRESCRIPTIONS FOR HEALTH REFORM:

A PODCAST FROM THE BLUE CROSS BLUE SHIELD OF MASSACHUSETTS FOUNDATION

Transcript of podcast interview with George Halvorson, author of *Health Care Will Not Reform Itself* 1.15.10

Q *Health Care Will Not Reform Itself* is your fourth book, I believe, about health care. In your previous one, *Health Care Reform Now*, you laid out a pretty extensive rationale and plan for reform, so I'm wondering what your motivation was in writing this last book.

A Well, I wanted a very simple, direct, easy-to-understand book that lay readers could use to figure out what needed to be done in health care reform. My last book covered many of those same topics, but I actually took each of the five chronic diseases and explained things that could be done to improve care in America, disease by disease. I talked about things that could be done to make care better. And that's not really the book that the country needed right now. The book the country needs right now is a very simple book explaining why health care costs are going up and the kinds of things that can be done to make care better and to bring the cost of care down. This book is a shorter, very direct description of the things that we can do. That's one issue.

The second issue is I wanted to focus a little more on the magic of connectors, and talk about the kinds of things that can be done to connect caregivers with each other and caregivers with patients. Prior books touched on that topic, but there has been so much learning in that area, and we've had so many successes in that area, that I thought that it made sense to focus the book a little more on that topic. And in fact, the working title of the book, until just a few weeks before publication, was "The Magic of Connectors." We gave up that title because people who looked at it didn't have a clue as to what I was writing about, couldn't tell if it was an engineering book, or if it was a sociological book, or if it was something—a dating service. They couldn't quite figure out what the magic of connectors was.

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So there's a chapter in the middle of the book called the magic of connectors, and it talks about the fact that 75 percent of the health care costs in America come from patients with chronic conditions. Eighty percent of those costs come from patients with multiple chronic diseases, co-morbidities, and we do a really lousy job in America of connecting our caregivers who take care of those patients. Doctors who take care of one aspect of the disease don't talk to doctors who take care of another aspect. There's a total lack of coordination between the prescriptions done and the tests being run, and care suffers.

What I write about in the book is if you create connectivity between the databases of each doctor, that's really good for the patient, and if you then connect the patient with the database as well, that's even better for the patient, and so part of what's missing in American health care is connectors and connectivity. We're a siloed system. We have siloed data, siloed operations, siloed care coordination, and where we need to go to really get this right is to have caregivers working as teams, and connected. That's part of the book that I think is more spelled out than the prior books.

Q Just in terms of the word connectors, in Massachusetts when we think of health care and connectors, we think of the Health Connector insurance exchange.

A Exactly. That was one of the issues. People kept saying, "Are you writing about insurance exchanges?" and I said, "You know, there's a part of the book where I strongly endorse insurance exchanges, but that's not the book," and they said, "Well, anyone who knows health care, not only will you confuse anyone about whether or not the topic is health care, but for those people who know the topic is health care, they're going to think you're talking about Massachusetts insurance. Exactly what you just said."

However, I use connectors in the broader sense, in the sense of care support tools, and we desperately need connectors for care support tools. Every care site that has done a good job of creating connections between the caregivers has improved care. That's important. That's an important thing to understand, and it's an important thing to do. So part of the messaging in the book is we need better connectors, and I don't just mean the Massachusetts insurance model.

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Q Going back to the actual title of the book now, *Health Care Will Not Reform Itself*, why won't it reform itself, given that there are examples showing how connected care tends to work better for patients? Why won't it just evolve?

A Health care will not reform itself for two main reasons. One is that health care is making so much money in America, that it has absolutely no incentive of any kind to reform itself. It is the fastest growing part of the economy. It's a \$2.5 trillion annual cash flow. Caregivers in American health care are the best-paid caregivers in the world, in many cases by a multiple of two or three. There is no incentive, economic incentive inside of health care to do any reform. If a kid has a horrible asthma attack, they end up in the hospital and there's a \$20,000 or \$30,000 bill generated. So the caregivers get a huge revenue stream. If you prevent the asthma attack, there is no payment, and \$30,000 disappears from the revenue stream of health care. That doesn't mean caregivers encourage asthma attacks, but it means that there is no incentive in the system, in any organized way, to spend our resources on preventing asthma attacks, and the part of the system that responds to asthma attacks is extremely well rewarded. So the system is set up with perverse incentives.

Some of the worst infections that patients can possibly get in hospitals are extremely profitable to the hospitals where the patients get the infections. In California right now, two percent of the hospital admissions involve sepsis, a bloodstream infection. For older patients in California hospitals, 23 percent of the deaths come from sepsis. That's a horrible thing. Two percent of the patients, 23 percent of the deaths, number one cause of death in California hospitals, and the hospitals who have sepsis patients can bill for \$100,000.

Now, there's not a hospital in America that would cause a patient to have sepsis, but there's also no really strong economic reason for hospitals to get really good at preventing sepsis, because it takes some work. That work, if you do a lot of work, and you have your nurses doing different things and if you have your physicians doing different things, and if you have the support team doing different things, if you even cleaned rooms differently, if you do different things and the net result of doing all the different things is additional expense, and you lose the revenue from sepsis, that's not a very good economic model for American health care.

That's one issue, that there are perverse incentives that work in direct opposition to improving care. The second thing is the caregivers have absolutely no tools to use to improve care. They don't have data that they care share with each other electronically because they don't have electronic databases. They've got paper files

so if one doctor wants to share data with another doctor, it's almost impossible to do it even if they're totally committed to doing it. If they call the other doctor and want to talk to them, and the other doctor is seeing a patient when they make the phone call, the connectivity of the phone calls is really hard to pull off. If they want to share information about a patient, or get information, unless they've gotten clearance from the patient, there are some HIPAA requirements, there are some privacy requirements, that can impede the flow of necessary information about individual patients from one caregiver to another who are taking care of the same patient, and there are things that people need to worry about in that data flow.

What we've done is we've not only created no tools, we have set up obstacles. We're trying to make care better for patients, and we set up a system where we pay the care system more for bad care, we create rules that impede connections and good care, and we have absolutely no tools in place to coordinate the care, the combination of all of those things creates a health care system that's the most expensive health care system in the world by a factor of two. We are twice as expensive as the rest of the Western world, relative to the amount of money we spent on health care, and yet the other countries have better outcomes for the chronic patients, they have better infant mortality rates. They actually have better access to the physician. If you are an American patient on average and you want to see a same-day physician same day, about 29 percent of American patients get to do that. If you're in the Netherlands, if you're a Dutch patient, it's about 56 percent of the patients get to do that. The other countries have good access to primary care, better information in many cases about the patients, much more of a focus on the front end, on the prevention end, and a much less steep reward curve on the back end for bad care.

In fact, one of the things that's fascinating is that every single country in Europe spends less than \$1000 a day on hospital care. France is the top of the peak, and they right now might be at \$1050, they're just the very top of that. But they're basically a thousand and down. The other countries are \$700, \$800. Canada is well under \$1000 a day. Every country in Europe is under \$1000 a day and we can't find one single state in the U.S. that's under \$3000 a day.



Q What do you attribute that difference to?

A There are significant differences in our infrastructure. There are significant differences in our ongoing cost run, and many of those differences are very legitimate. In the U.S., you're much more likely to have a private bed. In those other countries, you're more likely to have two, three patients in a room. We have—every hospital has multiple MRI and CT scan capabilities. In Europe and Canada, those are shared. A province in Canada would have fewer CT scans than any given city in the U.S., but the cost burden of having all of those CT scans on every site is borne by the average cost per day. And if you look at the care outcomes, the care outcomes in those countries are just as good, but they're literally running at a third our rate. That makes less of an incentive to have the person in the hospital, and it creates more of the infrastructure to support primary care.

Q Where do we start to try and change our system and create more of these connections and cost savings you're speaking of? Clearly there's been a lot of ink spilled about this already.

A I think we could easily create better connectivity in America. I think if the funding for electronic medical records in America included a very clear mandate that these systems must be connectable with each other, so that we can get a data flow that goes from system to system, that would make a big difference.

If we create a rule that says anyone who is allowed to write health insurance coverage in America must write that coverage and use the data that they receive from all the claims as a support system for care delivery, that would help hugely, because every health insurer in America gets information about each patient in order to pay the claim. You know what the procedure was, what the diagnoses were, who the caregivers were, time and date of service is all known in the claim system, and that data goes into an electronic system and is stored, but it's used only for actuarial purposes and financial reasons. It would be far better for the country if that data were made available so that a caregiver who's treating a patient could go to the Blue Cross database or the Aetna database and punch a button and get the information from that patient for the past two years, on other care that they've received and other places they've received the care. That type of thing could be mandated as part of the reform package, and we could get a long ways up that path very quickly.

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Kaiser Permanente, the organization that I'm the chair of, is an organization that's different than the rest of the care system, in that we not only insure care, but we provide care. So we have hospitals, clinics, pharmacies, imaging centers. Everything is self contained within our organization, so we're actually in terms of population served and care system, bigger than 42 states and 140 countries. We think about this in terms of population health and the total patient, as opposed to just thinking about it in terms of allergists or oncologists or whatever, because we're all a team. We think about having the total data.

What we've done is we've invested about \$4 billion in putting in place an electronic medical record that provides our caregivers with all of the information about all of the patients all of the time. I write about that in the book as well, that as we're looking forward to the goals of computerizing American health care, since we're a microcosm of American health care, and we're computerized, there's learnings in that that make sense to share with the world. We're talking about "What have we learned?" There are 10 things in the book that we've learned, but one of the key things, and the foundational thing, is to have all of the information about all of the patients all of the time available in real time to the caregivers so the caregivers who want to help a patient can have that information.

The second thing you do is you take that information, and you make the right thing easy to do. That's a key and important next step. You don't just put the information into a computer, you then use that information to make the right thing easy to do. There are various ways of doing that. One of them is to run the patient database through a care algorithm that identifies for this particular patient these are the three things that would be the most useful next things to do. We have some processes that do that. We also have some processes that take the data and put it into a care registry and we identify for a given patient the kinds of things that are needed for the condition they have. And then we create feedback loops to the caregivers so that that care happens.

When we did that in Colorado, we took all the patients with heart disease, created care algorithms, created feedback loops, we cut the number of deaths from heart disease by 73 percent in two years. And it's no new science. It's just getting the old science right in a very consistent way for each of those patients.

We just put this system in place, so we're doing different learnings with it, but in Hawaii, we took the patients that had congestive heart failure and coronary artery disease and diabetes, triple comorbidities, toughest, sickest patients. We put their care into care algorithms, and then we worked with the nurse, the specialists,



the primary care doctor, the pharmacist, the care team, to track care for each of these patients. In less than six months, we cut the number of hospital admissions from those sickest patients by over 75 percent, just by making sure that each of those patients was getting the right care. No new science. Every single thing we were doing was a thing that caregivers had known before that, but even in our vertically integrated system, without the computer support tool, it was hard for the doctors to coordinate all of the care for all of the patients all of the time. And so we're creating support tools to make the right thing easy to do. We're saying that America needs to look at moving in that same direction, and put tools in place that make the right thing easy to do. If you don't make the right thing easy to do, it won't happen.

Q Do we need to transform other organizations into Kaiser-like vertically integrated models, and if not, how can other insurers and providers still help to create some of these connections?

A I think we are not going to transform the entire care system into care teams like Kaiser Permanente, where we're care teams inside an organization, that's vertical integration, but I think we can create, for the rest of American health care, virtual integration. I think we can create the functional operating equivalent of vertical integration by having care registries for the patients who are sickest, have those supported by the insurance company with the data flow, and have them fed by the electronic medical records as the caregivers put those in place, but even before they're in place, fed by the claim system, and then have a feedback loop between the caregivers and the patients about their care.

One of the things that's fascinating is one percent of the patients are about 35 percent of the care. Five percent of the patients are about 50 percent of the care, and 10 percent of the patients are about 80 percent of the total care needed. So you actually don't have to do this for every patient. If you do this for 10 percent of the patients, you make massive progress. Five percent of the patients really need it because of chronic conditions and comorbidities, so if you could create this kind of electronic support for five percent of the patients in America, we could cut the number of kidney failures and heart attacks in America in half.

So the question is, why don't we as a society set that as a goal? Why don't we as a society say we're going to make care better for these people and set that objective, and having set that objective, then we need to work backward and say, okay, what tools do we need to put in place to make that objective happen? That's what we should base all care strategy and policy around, is putting the tools in place

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necessary to make those kinds of improvements in care. Five conditions drive the vast majority of the care needs. We don't need to do it for a hundred different medical conditions, we can do it for half a dozen and do it really well, make a huge difference in the care of Americans, cut the cost of care, and improve the quality of care.

If we decide to do that, then the question is how do we create the focus necessary to make that happen, and we need to do that programmatically, because we can't do it each site inventing its own set of objectives and its own set of focuses. That's a really silly way to fix care. Even in a factory, you wouldn't have each unit, each subunit, each part of the factory creating its own independent agenda, and then hoping somehow that it linked up with somebody else's agenda. What you need is a focus on the things we want to achieve, and then put tools in place to actually achieve those things, and then track the results, keep track of how many kids have asthma attacks, and keep track of what happens to the kids when they have the asthma attacks, and then create a feedback loop so the kids who are having asthma attacks because they don't have inhalers, because they don't have the education, because they don't have the follow up, create feedback loops that work backward to help those kids.

That's why a couple of things are really important. Right now for America, asthma's the fastest growing condition for kids. It's the most expensive condition for kids, it's the number one cause of death in kids of age categories, and we only get asthma care right in America 46 percent of the time. That's the most recent study, says 46 percent of the time, kids get right care. Over half the time, they're getting the wrong care. Right now there is no feedback loop that tells anyone when a kid has a horrible asthma attack and is in the emergency room and almost dies, or dies, there's no feedback loop that tells anybody upstream in their care that this happened and that kid needs help, and there's nothing that tracks whether or not the kid got the help.

That's one of the reasons I'm a strong supporter of universal coverage, because we need all of the kids covered, all of the time, so we have the continuous data flow that only comes from coverage. Because if a kid goes to a site and then they're not covered, and then they go to a different site, and there's no continuous data, and they have insurance, and they don't have insurance, all of their data is discontinuous, and you can't track anything over time, you can't coordinate anything, and you can't identify who's accountable for anything. And so you have a really chaotic, ineffective, dysfunctional data flow and care delivery. But if you said we want every kid covered, one, and two, everyone who provides that



coverage is accountable for supporting better asthma care, and you can make that a requirement, or you can't do business in America in health insurance, and then identify the fact that there has to be a data flow that both tracks the care and goes back to the primary caregiver, you could do that from the claims database as well as from an electronic medical record. Not quite as quickly and not real time, but well enough to cut over half of those hospital admissions from asthma for kids.

That's only going to happen if we think about it systematically and cover all kids. It will not happen haphazardly, it won't happen serendipitously, it won't happen because a bunch of caregivers suddenly wake up in the morning and decide to coordinate care. Remember they can't coordinate care if there's no care-coordination tool. Who's the hospital going to call? The hospital has a kid who comes in almost dead, they work through the night, save their life. In the morning, they've got a kid who's breathing normally who's going to need a day or two of recovery, who do they tell about that? Who do they notify? Who do they say the care for this child failed, and we need to do a better job on educating the child on what early symptoms look like.

There are some very basic things that can be done for asthma patients. You can teach asthma patients what early symptoms look like, you can give interceptor medications, you can have inhalers, you can have different types of approaches, and as a result of coordinating care really well, you can cut the number of those admissions in half or more. But if you don't have someone who sends a trigger back to someone else, it's not going to work. The current non-system doesn't have either part of that communication happening. It doesn't have the hospital notifying anyone, and it doesn't have anyone to notify.

So we need a universal coverage for our patients with chronic conditions and for our kids with asthma, and then we need a mechanism to create the care coordination, and we need to have the connectors, and that's why again, I was calling the book "The Magic of Connectors," because that's the missing link. The missing link is not science about asthma. The missing link is not emergency rooms. The missing link is connecting the data about those kids in a way that makes it easier for the caregivers to do the right thing, and it cuts the number of asthma attacks. So making the right thing easy to do is a critically important part of the agenda, and we have not made that, at any level, part of the agenda of American health care reform..



Q I have to ask: I'm sitting here in Massachusetts, and Massachusetts has been one of the leaders in terms of mandating coverage. I'm wondering how you would evaluate Massachusetts' implementation of that as an example of what you're talking about?

A I think Massachusetts has next steps in its pathway. I think the next steps in the pathway need to focus on systematic care improvement and creating some of those linkages. I think the fact that Massachusetts has done an individual mandate and created the exchanges and worked toward universal coverage is absolutely wonderful, and I think it creates an opportunity now to go forward and do some of the next step things. I think Massachusetts should have a state plan for dealing with some of those conditions. Massachusetts is talking about chronic care as an area where there needs to be focus, and if someone has developed a very specific plan for really improving care for the patients with chronic care, that would be wonderful. I haven't heard that that's happened yet. I think it might be a work in progress. I think it's something that people understand as a directionally correct thing to do, but in terms of actually doing it, I think it hasn't happened.

Q Let's touch on the other big component of the Massachusetts reforms, which is the insurance exchange, the Connector that we spoke of before. How do you see these kinds of exchanges fitting into creating a more connected system in your sense of the word, and do you have any thoughts on Massachusetts's rollout of their Connector?

A My sense is that the connectors, if they're done really well could have a very, very positive impact on the way health care is purchased in America, that a connector model that works like an Orbitz for health, that gives caregivers information about who does the best hip surgery and who has the highest survival rate for Stage 3 breast cancer, who has the best survival rate for coronary artery bypass surgery, some of those kinds of things, and identifying the performance as well as the cost of various health systems is a really important evolution in health care decision making and purchasing. I think there's an exchange model that we need to evolve toward, and we can't get there in one year, but we can get there in a couple of years, in a few years. I think there's an exchange model that ought to be a part of the goal of American health care, is to have consumers able to make informed choices about care systems and caregivers. I think that's work that needs to be done, and I think that's a pathway we need to go down.

I think Massachusetts went part of the way. I think Massachusetts is moving in that direction, and that's a very good thing. I think it's created a first step but not a final step in that approach, but I salute Massachusetts hugely for going down the path it's gone down, and for making as much progress as it has made.

Q One can't read the health care news these days without seeing debate over the public option. Now, the argument is that it could have an impact on costs within the system. But would the public option have any impact, positive or negative, on the way care is delivered and the way it connected?

A Well, the people who advocate the public option often say that they're hoping that somehow the public option would be a factor for good, that it would help make care better in some way. They imagine that there would be a government-run health plan and that the government-run health plan would somehow be an innovator in care improvement. The government-run health plan that we have now is Medicare. And on the deals that they're putting together right now, they're making sure that the number of things Medicare can do to be innovative is quite limited. Even the pilots that are being written into the bill are being written into the bill with an understanding that there would be some experimental things done relative to Medicare care improvement. But those things would be constrained by regulation and they would be forced to go back to Congress for individual approval, and what they've done is even in the few areas where they're talking about doing innovative stuff, they've put handcuffs and constraints around the innovation, which makes me a little skeptical that a government-based organization would be the template for creativity.

I think it would be very, very hard for a government-based organization to do some of the kinds of things that we have done relative to improving care. One of the things that's true about improving care is that there is a continuous improvement mode, so we were doing things in the hospitals that we owned three years ago relative to sepsis that we thought were good at the time, and they were good at the time, relative to other things happening, and then a year later, we got a little better at it, and now, we're a little better at it, and what we'll do next year will be even better. If we were subject to regulation in that process, regulation tends to lock into place and stay there, so our ability to do continuous improvement would be constrained by most government models. Now maybe you can invent a government version that isn't constrained by either bureaucracy or rules, but [it is] a little hard to imagine exactly what that might look like.



Q Shifting a bit now from coverage of care: You also wrote about how we need to create a “culture of health” overall. Would you talk about what sorts of goals we need to set here and who needs to drive them?

A That is one where the government role is hugely important, just the opposite of what I said on the last topic. I think it’s critically important that the government be the leader in creating a culture of health for the country. I think we need to have fewer diabetics, we need to have fewer people with heart disease. We’ve just done some research at Kaiser Permanente looking at 25 years of data, and identified the people with high cholesterol levels in their 40’s are twice as likely to have Alzheimer’s in their 60’s. There’s all kinds of short- and long-term consequences of not managing some aspects of individual health. We need a population health agenda for the country. We could cut the number of diabetics in this country in half. You get people walking half an hour a day, four days a week, you cut the number of people who become diabetic by 40 percent. If you lose 10 pounds, you cut it by 50 percent. Two basic steps, but we don’t have any agenda in this country to make either one of those things happen.

There’s a number of other things we could do relative to population health. If we set as a culture the goal of becoming a healthy population, if we really wanted to have a national culture of health, we could do some really important things that otherwise won’t happen.

The Finns did that. If you look in my book, in the last chapter, there’s actually a chart from Finland showing that they learned that they had the highest coronary artery disease rate and the highest obesity rate in Europe, and they said, “We should fix this,” and so they worked toward a national culture of health. They’ve gone from 20 percent worse than the rest of Europe to about 20 percent better. They’ve done that by focusing collectively, as a society, on the available foods, on getting exercise, on having activity levels. They’ve done a magnificent job of focusing on their health and making health a value as opposed to making health kind of an annoying thing that people preach about. And it worked. It has worked in Finland. Finland’s a very, very small country, but it’s a big enough country to make the point that you actually can take it from a culture of non-health to a culture of health.

If President Obama and the Congress and Secretary Sebelius led us in that direction, I think there are a lot of people in America who would be interested in going down that path, and I think there are some important things we could do as a country. We would need to sit down—again, it’s like having the connectivity

or focusing on asthma. We would need to say, “What do we need to do to make activity levels happen?” And then we would need to say, “What can employers do, what can schools do, what can communities do?” If we just identify a few basic things that need to happen like creating easier access to activity, then we could bring everyone together thinking collectively and creatively about what those pieces look like. That could happen. That could happen.

I’ve been in China, and if you walk through the cities of China, every once in a while you find these exercise bicycles, both in Shanghai and Beijing, the couple places I’ve been, you find these exercise bikes that are set up so that people can just walk over, get on the bike, and pedal like crazy for a while. They have all kinds of opportunities to get a little physical activity. I haven’t found any place in the U.S. that has comparable equipment or a comparable approach. We could. We could easily turn different areas into much more exercise-friendly areas. We could create walking clubs. Even in Minnesota a couple of years ago when I was there we had some exercisers who created a walking club and would walk the Mall of America every morning, just as it opened, because it can be pretty cold in a Minnesota winter. The Mall of American is a big enough building, you can get a couple mile walk just walking the middle of the corridor, so there were walking clubs that would go over and do that. It was a wonderful idea, and I think they’re still doing it, but the number of people doing it is relatively small. When diabetes is the fastest-growing condition in America, and it’s caused almost entirely by inactivity and being overweight—we have the highest diabetes rate in the world—and we could turn that around, even if we got just world averages, we could save the Medicare trust fund just by taking the pressure of diabetes off.

One of the things that people don’t know is that diabetics consume 32 percent of the total cost of Medicare. It’s the fastest growing disease, it has a huge impact on the cost of Medicare, and if we had half as many people being diabetic, think what that would do to the Medicare trust fund, more than any other single thing you can think of.

Q In summary then, pulling back to look at the reform of the overall system, what do you think is the most important thing for President Obama and Congress to keep in mind as they move forward?

A I think we need to be thinking along two tracks. I think we need to have a track of covering everyone. I think we’re the only country in the industrialized world that has not done that, and it’s time for us to do it. So we need to get that right. We need to cover everyone. That’s the A. And B, we need to improve care. We need



to systematically improve care. I think the president and Secretary Sebelius can lead us in that direction as well. It's more than just cover everyone, it's improve care as well. We need to remember that we cannot improve care effectively until everyone's covered. You cannot fix asthma care as long as kids are covered, not covered, covered, not covered. You really need continuous coverage and with continuous coverage, you need to do the right things to make care better. We need to do that in a systematic way. I think both those things need to happen.