

Health Policy for the 21st Century: A Time for Renewal

The Chronic Care Imperative Demands Health Policy Reform

The new poll released today on chronic conditions in America clearly reveals that healthcare has entered a new era. Chronic care, not acute care, is America's number one health care problem. People with chronic conditions are healthcare's largest, highest-cost and fastest-growing service group, with their relative importance expected to swell well into the 21st century.

Unfortunately, the nature of their problems and our current care technology are very different than they were in 1965 when Congress established Medicare and Medicaid. Today, the methods used to finance, administer, and deliver healthcare are fundamentally inconsistent with the nature of chronic conditions.

Healthcare is Incompatible With The Nature of Chronic Conditions

In addressing this new healthcare phenomenon, it is important to ground all future health policy in a thorough understanding of the nature of chronic conditions. Chronic conditions are multi-dimensional, interdependent, disabling, ongoing, and personal. Yet, most health policy reinforces a single dimensional, fragmented, disease-based, episodic, and institutional approach to care.

Chronic conditions are multidimensional—they involve medical, functional, psycho-social, and environmental concerns. These dimensions are highly interdependent. For example, a diabetic person's depression can affect their appetite, which could result in malnutrition, which would negatively affect their diabetes, which might result in hospitalization and/or death.

We also know that chronic conditions are ongoing and that the primary concern of those afflicted is enhancing their ability to function. Chronic conditions often begin early in life. Depending upon what happens as a person's condition progresses, any chronic condition can lead to a medical crisis. For example, we know that there is a direct relationship between heart disease and prior history of smoking and stress; that a high percentage of people with diabetes have hypertension and that diabetes can lead to end stage renal disease.

Yet, health policy focuses almost exclusively on biomedical interventions provided in hospitals and physician offices. It significantly undervalues the importance of nutrition, mental health, help with performing activities of daily living, and the impact of environmental circumstances. For example, a loose rug is a hip fracture waiting to happen and dust mites send people with asthma to the emergency room.

Current payment policies contain incentives for health plans to target the healthy and avoid the most needy. Fee-for-service policies offer the greatest rewards for surgeons and other specialty physicians; and they offer the least rewards for specialists trained in the ongoing management of chronic conditions, such as general internists, family practitioners, geriatricians, and nurse practitioners. We finance reactive interventions and undervalue prevention, health maintenance, self-care, family support, and home care.



Let me share with you testimony from Dr. Alan Lazaroff, Director of Geriatric Medicine at the Centura Health system in Colorado, who specializes in chronic illness care, to illustrate my point. Dr. Lazaroff reports—

"Much of my most important work is unrecognized and uncompensated— adjustment of medication, early detection of problems, referrals to and coordination of other services, teaching and counseling. If I hospitalize a patient, I can bill Medicare every day I make a hospital visit, never mind whether this is the most appropriate treatment. If I meet with family members of a patient with Alzheimer's disease, coordinate with other professionals, counsel patients and families about both the benefits and limitations of aggressive treatment, and help my patients cope with the emotional consequences of their illness, I can bill nothing. I may be able to improve quality of life, at the same time that I reduce inappropriate and unproductive hospitalizations, ICU care and emergency room visits; but the more I focus on preventing or delaying the progression of disability, and the more money I save Medicare, the less I am paid. Something is terribly wrong with a system that rewards the unnecessary use of high-cost, high-tech services for a patient population that is equally dependent upon a vast array of supportive services and which penalizes practitioners who provide the services needed most, often at a lower cost."

Today, more and more primary care physicians are refusing to accept Medicare patients because of inadequate financing and excessive and inappropriate requirements. Most practicing geriatricians report that for every hour spent on compensated care, another hour is spent on uncompensated activity. Most health policies ignore the interdependence among public health, physician, hospital, nursing home and home health costs and among the multiple purchasers, payers, and providers that serve the same people as their chronic conditions evolve over time and across settings. We design payment policy, quality assurance methods, and record-keeping requirements as if care started and stopped at the door of institutions rooted in 1965 health policy.

Healthcare is Out of Touch With What Consumers Want

Unfortunately, we also know that our current approach is not what consumers want. They say they want to be better informed about how to minimize their risk of chronic disease and obtain the best care when needed. Yet, we provide them with little or no self care assistance or information on which programs produce better results. Consumers want affordability, yet we implement policies that save government and corporations money and increase the out-of-pocket costs of healthcare consumers. Consumers want convenience; and we give them a duplicitous array of intake forms and procedures. They want more control in making care decisions; and we give them medical directives. They want respect and dignity; and we reinforce a traditional, passive patient role.



A Vision for Health Policy in the 21st Century

If we are to meet the needs of America's 21st century consumer, health policy must embrace a person-centered, system-oriented approach to care. Payers and providers serving the same person must work together to help people with chronic conditions prevent, delay, or minimize disease and disability progression and maximize their overall health and well being.

Health Reform Must Adopt a Chronic Care Orientation

To respond to chronic conditions as healthcare's primary business, health policymakers must be guided by seven principles.

1. *Shape all future health policy by the nature of chronic conditions.*
2. *Establish a bi-partisan, industry-wide vision.* No party or interest group is exempt from chronic illness. All industry segments are interdependent in achieving cumulative cost and quality objectives.
3. *Empower consumers for self-determination.* For the first time in America's history, we have the technology to provide every consumer with up-to-date information on their risk of chronic illness and best practice methods for addressing it. Consumers want control over their own lives. We ought to give it to them and do it now.
4. *Expand and modify Medicare benefits.* This includes the addition of a pharmaceutical benefit, expansion of benefits for prevention at every stage of illness, care coordination, and various non-medical services.
5. *Eliminate regulatory barriers* for payers and providers to follow a disability prevention orientation, coordinate services across settings, and create flexibility for providers to change how they function, consistent with today's chronic care needs and wants.
6. *Build new public administration capabilities* within federal and State governments. For example, it is unconscionable that nearly a third of Medicare and a third of Medicaid dollars go to serving the same people, yet we do little to coordinate these two programs. We budget on an annual basis without recognition of how expenditures in one year could dramatically reduce costs in future years, or how expenditures in one program affect costs in another.
7. *Create new financing structures and incentives.* We must stop organizing financing policies around payment to specific providers and establish incentives to serve those in greatest need and to offer whatever *combination* of care is proven to be most cost effective in serving the chronically ill.

Conclusion

It is important for the 107th Congress to add a pharmacy benefit to Medicare, pass a patient bill of rights, and expand healthcare for the uninsured. However, none of these policy initiatives will be fully effective until we alter the basic structure for how we finance, administer, and deliver care to produce real health value in serving healthcare's largest, highest-cost and fastest-growing service group. Quality, cost containment, and consumer satisfaction are all dependent upon establishing new operating methods. We cannot wait until the 77 million baby boomers retire in 2011. The time for healthcare renewal is now.

