



Delivering Change Through Health System Organization



“Change” is on the minds of many Americans during this election cycle, and it is relevant to any discussion of the U.S. health care system as well. Our health care system must change: while we spend more than twice as much on health care as any other nation—over \$7,000 per capita in 2006—we do not, on the whole,

get good value for our health care dollar. The U.S. falls short on many performance measures when compared with other countries, and there is tremendous unexplained variation in health care quality and costs across states and regions.

Americans are feeling the effects of this expensive, sometimes inadequate care firsthand. A survey of the public published this month conducted by Harris Interactive on behalf of the Commonwealth Fund’s Commission on a High Performance Health System found that eight of 10 respondents agree that the health system needs either fundamental change or complete rebuilding. Nine of 10 adults say it is very important for the 2008 presidential candidates to seek reforms that address health care quality, access, and costs.

Americans’ health care experiences offer further evidence of the need for change. Health care delivery in the United States is fraught with fragmentation at the national, state, community, and practice levels. There is no single national entity or set of policies guiding the overall organization of the health care system. Doctors and hospitals practicing in the same community and caring for the same patients are not “connected” to each other, and there is a critical shortage of primary care providers. And our current disjointed financing model—a mix of private insurers and public programs, each with its own set of rules and payment

methods—further fragments the health care delivery system, contributing to waste and high administrative costs. Greater organization is instrumental to ensure timely access to care, care coordination, and smooth flow of information among doctors and patients.

So what do I mean by an organized health care system? I mean a system that—at every point on the care continuum—makes it easy for patients and families to obtain the comprehensive, coordinated care they need. Second, but just as important, I mean a system that does everything it can to support physicians and other providers so they can deliver that excellent care.

As outlined in the Commission report published with the public views survey, *Organizing the U.S. Health Care Delivery System for High Performance*, an ideal health care delivery system that is truly patient-centered would have six key attributes:

1. Patients’ clinically relevant information is available to all providers at the point-of-care and to patients through electronic health record systems;
2. Patient care is coordinated among multiple providers and care transitions across settings are actively managed;
3. Providers (including nurses and the rest of the care team) both within and across settings have accountability to each other, review each other’s work, and work together to reliably deliver high quality, high value, care;
4. Patients have easy access to appropriate care and information, including off-hours. There are multiple points of entry to the system, and the providers are culturally competent and responsive to the needs of the patient;

5. There is clear accountability for the total care of the patient; and
6. The system is continuously innovating and learning in order to improve the quality, value, and patient experience of health care delivery.

Any policies put in place to achieve these attributes should work for different kinds of organizations, from small practices and unrelated hospitals to fully integrated delivery systems. The authors of the report identify a combination of scalable policies that would be critical to achieving greater organization across a continuum of organizations. For example, payment reform—including the development of bundled payment systems that reward coordinated, high-value care rather than individual services—could range from blended fee-for-service and per-patient fees for primary care practices that act as medical homes to global fees for an acute hospitalization and follow-up care over 30 days. Such payment systems, along with paying providers for achieving certain levels of quality, would help coordinate the delivery of care.

Beyond payment reform, we need a center to evaluate the comparative effectiveness of drugs, devices, procedures, and we need to design health benefits around those recommendations. We also need to introduce an insurance connector to offer affordable choices to small employers and individuals, including the option of purchasing coverage through a public plan using these new payment and benefit design principles. Most of all, we need national leadership among all stakeholders, including government, providers,

employers, and consumers—real leadership that recognizes the value of public-private collaboration.

In the end, changes of the kind I've described will work only if physicians and other health care professionals see in them the opportunity to provide all of their patients with the best care possible. The reforms must support providers in improving the quality of care and realign financial incentives to reward high-quality, efficient care. This would include rewards for delivering better care and better outcomes, rather than simply providing more services, which is what the current, predominantly fee-for-service system rewards.

W. Edwards Deming, one of the fathers of quality improvement, once said, "It is not necessary to change. Survival is not mandatory." Yet, most of us have a fairly strong survival instinct, and most physicians and other health care providers are driven by a continual search for more effective ways to keep people healthy and care for the sick.

What is needed in the national debate is consensus that the status quo is no longer acceptable. Working together we can change course—and move the U.S. health system on a path to high performance.

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