The Road to Reform

Can we get there from here?

By Dr. Elliott Fisher

Fisher is the director of the Center for Population Health and Policy at the Dartmouth Institute for Health Policy and Clinical Practice, as well as the primary investigator for the Dartmouth Atlas of Health Care. *A professor of medicine and of community and family medicine at DMS, he joined the Dartmouth faculty in 1987. He holds an M.D. from Harvard and an M.P.H. from the University of Washington and was elected a member of the prestigious Institute of Medicine in 2006.*

The United States now has perhaps the best opportunity in a generation to achieve both universal health coverage and badly needed reform of the health-care delivery system.

But we could also fail. Expanding coverage for the uninsured could be viewed as too expensive, especially in light of the current financial crisis and the rapidly increasing federal budget deficit. And any effort to reduce spending could be viewed either as a threat to the incomes of those who make up the current system, or as denying Americans their right to choose any treatment they want whenever they want it.

But these arguments reveal a persistent (and perhaps intentional) failure to recognize what has been learned from 30 years of research—a whole field of research inspired by Dr. Jack Wennberg's willingness in the 1970s to ask why rates of elective surgery varied by a factor of 10 across similar communities in Vermont. Since then, Dartmouth has led the way in establishing the fact that per-capita health-care spending—after adjusting for differences in price, demographic characteristics, and illness severity—varies by a factor of three across the U.S.

We have learned that differences in rates of elective "preference-sensitive" procedures, such as back surgery or screening for prostate cancer, are a consequence of a lack of evidence about the risks and benefits of these procedures and of our collective failure to help patients make truly informed decisions aligned with their own values and preferences. The remedy is straightforward: better evidence and support for informed patient choice. Ironically, conservatives are arguing that comparative effectiveness research is a threat to patients' freedom of choice—an Orwellian attempt to mislead the public. Even supporters of comparative effectiveness research reinforce the public's concern by emphasizing its potential to save money, when its major benefit lies in distinguishing (based on scientific evidence, not anecdote or opinion) treatments that are effective from those that are not.

The money lies elsewhere. In 2005, per-capita Medicare spending was $14,360 in Miami but $7,008 in Tallahassee, Fla.; $12,119 in Manhattan but $6,556 in Rochester, N.Y. These differences in spending are not due to differences in the incidence of illness, the characteristics of the cities' populations, or other such factors. In fact, the higher spending—and much of the nation's growth in health-care spending—is due to the provision of unneeded and sometimes harmful "supply-sensitive" care. Such care includes discretionary hospitalizations that could have been avoided with better primary care; frivolous specialist consults; and overuse of diagnostic tests.

But is that so bad? Isn't it "better to be safe" (i.e., get available care) "than sorry" (not get it), as many people claim? On the contrary, unnecessary care can be harmful. Any treatment has risks, albeit sometimes minor, and hospitals are dangerous places to be, especially if you don't need to be there. In addition, the more physicians involved in a given patient's care, the harder it is to sort out who is responsible for the big picture; too many cooks can definitely spoil the broth. In fact, 10 years of Dartmouth research has shown that lower-spending regions of the U.S. achieve equal or *better* health outcomes than higher-spending regions.

Which brings us back to the current opportunity. Stepping beyond evidence toward advocacy, I would suggest that there are three underlying causes of rising costs and uneven quality:

- A delivery system so fragmented that most providers are willing to be accountable only for the care they can fully control themselves.
- The assumption that more medical care means better medical care.
- A payment system that rewards both growth and unnecessary care.

If these diagnoses are correct, the remedies lie in the following steps:

- The development of organizations that are held accountable for the overall costs and quality of care; these can be real or virtual integrated delivery systems.
- An investment in better information—about the risks and benefits of specific procedures, and also about the performance of the delivery system.
- Reform of the payment system so it rewards

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With U.S. health-care costs at $2.4 trillion and rising, there is unprecedented urgency to the national debate about reforming the system. Previous efforts to fix the country's current model have foundered on its complexity, but this time what's widely referred to as "the Dartmouth research" may make a difference. Here are perspectives first from a current leader of that research, and then from a slate of alumni—clinicians in various specialties from all across the country.

Illustration by Bert Dodson

For WEB EXTRA audio interviews about health-care reform with random passersby in two local towns, as well as links to some of "the Dartmouth research" mentioned here and recent media coverage of it, see dartmed.dartmouth.edu/su09/we02.

Can the gaps be bridged?

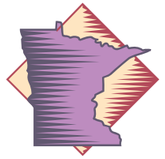
We also invited a range of DMS alumni—representing different specialties, geographic locations, and practice settings—to offer their thoughts about the prospects for health-care reform. These are not policy analysts but practicing physicians with a keen sense of day-to-day patient care. Here's what we asked them about:

Biggest problems: What, in your opinion, are the two or three biggest problems with the current U.S. health-care system?
Best aspects: What are its best aspects?
Preserve employer-based model: Do you believe the U.S. model of employer-based health-care should be preserved?
Private insurance or single-payer: Do you think it's important to retain a role for private insurance companies, or do you support a single-payer plan?
Features from scratch: If you could start from scratch in designing a health-care system for the U.S., what do you think its major features should be?
Biggest hurdle: Given current realities, what do you think is the biggest hurdle to achieving effective reform?
Can we cut cost, not quality: Do you believe it's possible to stem the rise in the cost of health care without a negative effect on the quality of care?
Short-term change: What do you believe, realistically, is most likely to happen in the way of reform in the coming year or two?
Longer-term change: Do you think there will be continued change after that point, and if so what's your best guess about what the system will look like in 10 years?
Parting advice: What single piece of advice from the trenches of medicine, especially if there's anything specific to your specialty, do you think it's important for those making reform decisions to understand?

And here's what the respondents had to say. We edited their replies slightly for clarity and needed to condense some replies that ran long (respondents' passion for the subject seemed to be limitless, but space in the magazine is not). Not everyone answered every question, and we didn't use all the answers we received but instead included a sampling of feedback representing different viewpoints. Indeed, the range was quite varied.

Dr. David Knopman, DMS '73

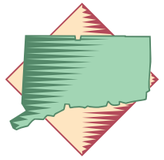
Specialty: Neurology
Location: Minnesota
Position: Consultant in neurology at the Mayo Clinic in Rochester, Minn., since 2000.



Biggest problems: The number of uninsured; the overuse of unnecessary interventions and technology, especially at the end of life; and misaligned financial incentives for procedures versus consultations.
Best aspects: In some geographic regions, the immediate access to health care without delays and impediments; the availability of specialists when they are genuinely needed.
Preserve employer-based model: No. Absolutely not. It results in discontinuity of care and places excessive burdens on small business, and the current health-insurance tax policy promotes irresponsible use of health care.
Private insurance or single-payer: There should be an opportunity for people who can afford it or choose it to purchase a higher level of service, and perhaps private insurers could function in that role.
Features from scratch: Universal care, with a strong focus on primary care. That would mean enabling the practice of primary care in all of the ways that are not happening currently: better and competitive pay relative to the specialists, better control of work conditions, better logistical support.
Biggest hurdle: Because our health-care system is such a huge enterprise and constitutes a large fraction of economic activity in the U.S., there is no way it can change overnight (a point made in a recent *New Yorker* article by a Harvard surgeon). There are huge vested interests, such as insurance companies and other intermediaries, whose business would disappear with a universal system. High-paid subspecialists would also scream bloody murder. But, in fairness to "entrenched interests," an abrupt destruction of their business model is fundamentally not fair.
Short-term change: Nothing—perhaps the age of Medicare coverage will be dropped to 55.
Longer-term change: I do not see how we cannot move to universal coverage eventually.
Parting advice: Reward clinical acumen and don't reward overuse of imaging and laboratory testing. Pay primary-care physicians better and improve their work environments, or risk having primary care in the U.S. provided by international medical graduates.

Dr. Diane Fountas, DMS '81

Specialty: Pediatrics
Location: Connecticut
Position: Private practice in Waterbury, Conn.

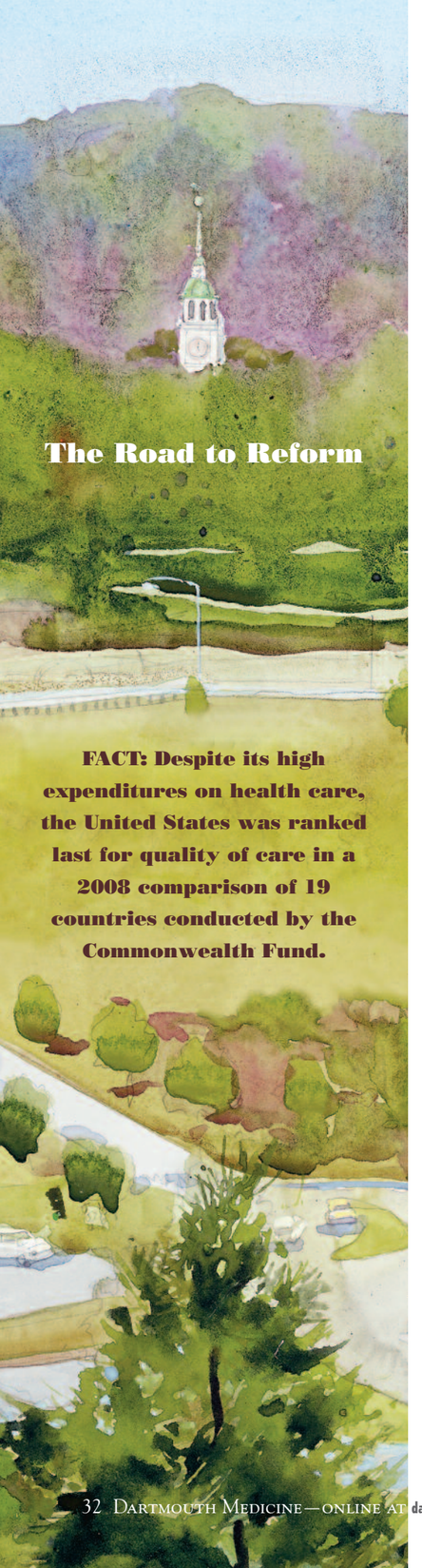


Biggest problems: Political regulation of medicine. For example, electronic medical records are being required by politicians who have no idea what goes into the practice of medicine. Also malpractice settlements; until this problem is addressed, defensive medicine and unnecessary testing won't stop.
Best aspects: The state-of-the-art medicine, the availability of knowledge to all practitioners, and the ability to get patients care no matter what.
Preserve employer-based model: Employer-based care should be one option. Employers who offer coverage should be given incentives for doing so. But employees need to start taking some responsibility for coverage; they should know how much things cost and be willing to pay for extras that patients now enjoy and expect but that are unrealistic. For example, they shouldn't be able to change a prescription because their child does not like the taste without paying for it themselves. Health care is not a right—it is a privilege, and the U.S. consumer must understand this. Many insured Americans now believe they are entitled to whatever they want. This cannot continue.
Private insurance or single-payer: I do not support a single-payer system. It would not promote excellent care and would become like other government agencies, where there is no incentive to do the very best for the patient. But private insurance companies should not be making millions off the insured. Their surplus needs to be put back into the system in some reasonable and appropriate way.
Features from scratch: First, there must be malpractice tort reform. Second, physicians, patients, and insurers must all understand that they play a part. One cannot just have what one wants without a real understanding of what it involves and what it costs.
Biggest hurdle: Getting all players to own their part in this mess. The consumer does not understand that their "requests" cost money and that lawsuits make the practice of medicine almost impossible.
Can we cut cost, not quality: Yes, I believe there are lots of places to save money that have nothing to do with quality.
Longer-term change: I am afraid we are heading into a socialized medicine model. I believe this is a quick fix from people with only a rudimentary understanding, if any, of the health-care system. It looks like a solution, but in the long run it will only create a worse system with lower quality that serves the masses less well.
Parting advice: Bean counters must not make medicine just about business. Medicine continues to be an art and needs competition and individuality to thrive and attract those who belong in the field. But I would do it all over again, despite the problems in the system, as I still believe being a physician is a precious gift.

Dr. Georgia Newman, DMS '69

Specialty: Internal medicine
Location: Ohio
Position: Private practice with one other internist in Oberlin, Ohio.

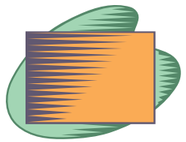
Biggest problems: The emphasis on acute hospital care over chronic and preventive care. Because of the focus on the acutely sick, we have an increasingly fragmented system often driven by specialists who deliver what I term "pieces-parts" medical care. The inflated income expectation of many physicians adds to the problem. Any system with 40 million people without health insurance has something wrong with it.
Best aspects: We have solved many medical and surgical problems through the development of new medications and understanding of diseases. We also have many more technological advances and relatively free use of them compared to other parts of the world.
Preserve employer-based model: No. It does not cover patients equally and is so expensive that many small businesses lose their profitability margin; others avoid hiring full-time workers and instead hire part-timers without benefits. It also leaves those who are unemployed without benefits.
Private insurance or single-payer: A single-payer plan is the only really efficient model of health-care delivery. Currently, each of the hundreds of insurance plans has separate authorization procedures, medication coverage, and eligibility requirements. We are probably wasting 40¢ of every health-care dollar in administrative waste.
Features from scratch: Patient-centered care with a team-based approach, supported by an electronic medical record, connected throughout the delivery system, so specialists and primary-care physicians can coordinate care and information.
Biggest hurdle: Too many self-interested players who want to preserve the status quo.
Can we cut cost, not quality: Yes. We currently give some individuals far too much care and others none at all. We need to discuss which technology is cost-effective and which is not, and which treatments, including cancer chemotherapy, are life-prolonging and worth the cost and which are not. We may need to have some hard discussions with patients who have extensive metastatic cancer or are extremely old, but are willing to experience considerable toxicity and incur the expenditure of $30,000 or more for a few extra months of life. We now have no way to curtail care without incurring a malpractice risk. We also spend millions of dollars for unproven alternative therapies. And consumer drug ads encourage patients to treat problems with pills instead of lifestyle changes.
Short-term change: If nothing more happens than an enhanced realization that sweeping change is necessary, we may be starting to get ready for change. With more people "like us" lacking health insurance or the means to pay for health care, decision-makers may be willing to do something different.
Parting advice: Primary care, with one doctor taking care of a patient or a family over time, is in danger of collapse. We may wind up replacing our small-practice delivery model for one using nurses in Walmart. But patients don't know if a problem can be handled by a nurse practitioner or if they should see a doctor. Sometimes even doctors don't know.



Dr. Mark Lena, DMS '81
Specialty: Gastroenterology
Location: Maine
Position: Member of a six-physician single-specialty practice recently acquired by St. Joseph's Hospital in Bangor and serving all of northern Maine.


Biggest problems: Lack of access. Many patients in this rural area have to travel up to four hours for specialty care, and it may take months for them to be seen once a referral is made. Most specialists are in the southern half of the state, mainly because of the major disparity in income potential. This makes it difficult to recruit new doctors in our area. Lack of insurance coverage is the second-biggest problem. We have a high percentage of uninsured and Medicaid patients; reimbursement for an hour consult doesn't even cover overhead.
Best aspects: The people who go into medicine. I think the vast majority do it for the right reasons and are bright, compassionate people.
Preserve employer-based model: Yes, but something needs to be done to cover the uninsured—perhaps something along the lines of the Massachusetts model. Too many people don't seek health care in time because of lack of insurance or extremely high deductibles. So their disease is more advanced and in the long run costs the system more.
Private insurance or single-payer: The idea of a single-payer system seems attractive on the surface, but there are always pitfalls and inefficiencies when the government is involved. One need only look at Medicaid and Medicare. But private insurance needs to be regulated more, as it seems geared towards limiting "loss." A melded system involving the best aspects of both would be ideal.
Features from scratch: Universal care and tort reform. Coverage for all would help to avoid cost-shifting and would lead to lower costs individually.
Biggest hurdle: The self-interests of insurance companies. Public perception seems to include doctors as being against any changes to the status quo, but in truth I think most physicians would welcome a system where everyone is covered and where we don't have to worry about ordering the proper tests without amassing huge debt for the patient.
Can we cut cost, not quality: I believe there are a lot of inefficiencies that contribute tremendously to costs without improving quality and outcomes. Fear of malpractice suits certainly contributes to over-testing and higher costs. Duplication of services in the name of competition between hospitals also contributes to higher costs.
Short-term change: I think the Obama administration will put a low-cost, government-sponsored health-care product out there, which may help bridge the gap for the uninsured. I suspect special interests will water down any sweeping changes.
Longer-term change: I wouldn't even want to speculate!
Parting advice: Any changes should be slow and gradual (a lesson Hillary Clinton learned painfully), but initiated within an overall framework of eventually covering all citizens with affordable, excellent care.

Dr. Stephen Ruyle, DMS '84
Specialty: Urology
Location: Colorado
Position: President of a Denver-based 19-physician single-specialty private group practice—the largest urology group in the western U.S.

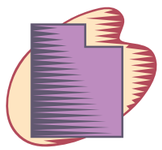



Biggest problems: The fact that too many people are uninsured or underinsured and cannot obtain access to or afford quality medical care. The high cost of care versus the quality of care compared to other industrialized countries. The lack of emphasis on health maintenance, preventive medicine, and patient responsibility.
Best aspects: The best health-care technology and pharmaceuticals in the world, highly trained providers, and quick access to care for those with insurance.
Preserve employer-based model: The employer-based model should be preserved only if costs can be controlled and U.S. businesses are not put at a competitive disadvantage with the rest of the world. As an employer who provides health insurance for our practice's 130 employees and their families, I see the degree to which the cost of health care is becoming a large burden for our practice.
Private insurance or single-payer: I support a hybrid program where private companies exist but are more regulated. I would like to see an independent rating service provide timely evaluations of all private companies based on cost, overhead expenses, executive pay, and comparative extent of coverage. Our group discontinued our insurance with United Health a few years ago when it was disclosed that the company's CEO was making an outrageous salary.
Features from scratch: I'd reorient the emphasis from the end of life to the first 18 years of life. I would like to see universal care for all children, including vaccinations, education regarding nutrition and exercise, and programs to discourage cigarette and drug use. I would also like to see much less emphasis on costly measures to prolong life for a few months in the elderly.
Biggest hurdle: Entrenched and well-financed groups that lobby state and federal governments—such as the Trial Lawyers Association and insurance companies. Also Americans' perception of what they want from a health-care system; the current attitude of many patients is "I will do what I damn well please in life, and doctors, nurses, and hospitals will be there to bail me out when things go wrong." I'd like to see much greater emphasis on patients taking responsibility for their own health.
Can we cut cost, not quality: Yes, if the willpower can be mustered to cut the waste in the system. Colorado has had great success in decreasing malpractice costs with tort reform; nationwide tort reform would be one area of savings. And Medicare has overhead of less than 10%. Why do private insurance companies run overheads of 45% to 50%?
Short-term change: I believe we will only see minor changes, such as the recent expansion of coverage for low-income children. And holdouts on electronic medical records will be eliminated.
Longer-term change: It is hard to predict, but hopefully some sort of universal care will eventually become available. Scientifically based care should become established. And Medicare eligibility will probably become based on 21st-century life expectancies.

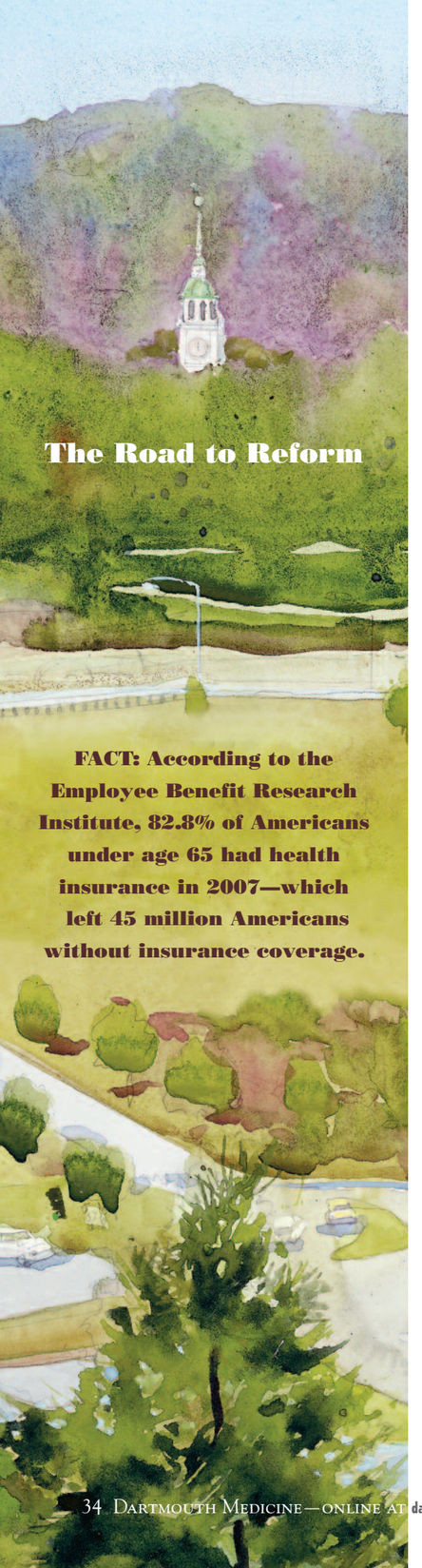
Dr. Carolyn Walsh, DMS '91
Specialty: Internal medicine
Location: Virginia
Position: Since 2007 in a solo private practice in Landsdowne, Va., that operates on a fee-for-service basis; patients pay for care at the time of their visit and submit any insurance claims themselves.


Biggest problems: The exorbitant cost to employers and patients. To receive adequate reimbursement, those who provide care (physicians, labs, hospitals) request high fees because they know they'll receive only a portion of it. But this inflated fee is also what people without insurance are asked to pay. Variation in premiums is also a problem. So is accessibility to care, because of physicians sticking with a form of scheduling that does not allow for same-day visits. People like and need to be evaluated by their physician when they are sick. But for practices to cover overhead, let alone try to make a profit, they need to see a lot of patients, and leaving empty slots on the schedule could undermine the financial viability of a practice.
Best aspects: The technology—lab testing, imaging, and communication and research tools (such as the ability to use the computer to do a MedLine search when a patient has a challenging diagnosis)—is amazing.
Private insurance or single-payer: Insurance companies make the product they are selling appear the best on the market and do what it takes to sell their product so they can make a profit. A single-payer system would theoretically provide health insurance to everyone. But having only one organization handling all the administration and all the money would likely lead to inefficiencies and may not withstand the corrupt practices that seem to become involved when a lot of money is at stake. The lack of competition would likely have a negative effect. Something in between employer-based coverage and single-payer coverage is my vote.
Features from scratch: This is a tough one. One of the first things is for people to understand health insurance. Policies are very complicated, and it is difficult for people to understand what is covered, what is not covered, and why. People have become accustomed to copays without knowing the true cost of a service. Even physicians may not know the true cost of a service. So there should be education about the cost of insurance and what different insurance plans cover, in very easy-to-understand language without hidden aspects. Also, eliminate penalties for preexisting conditions. And eliminate the middle man—have the patient pay the fee to the physician at the time of the visit.
Biggest hurdle: Understanding insurance. It has become so complicated that it is a daunting task to understand your own health insurance, let alone policies for an entire nation.
Can we cut cost, not quality: It is definitely possible. If everyone pays for their own tests, then perhaps less unnecessary testing will be done. Physicians should talk with patients about the necessity of a test and how the results will affect the treatment plan and likely outcome—with input from the patient. The same goes for prescribing medication; I help patients find the best drug at the best price, which allows for sustainable treatment.

Dr. Sarah Goodlin, DMS '80
Specialty: Geriatrics
Location: Utah
Position: Practices at Latter Day Saints Hospital in Salt Lake City and also delivers private home care.

Biggest problems: Our current system fails to guide patients and their families through their medical care. When they develop chronic illness, we fail to teach them how to best manage their illness to reduce its long-term impact. When they are old and frail, physicians don't help them negotiate their care and maintain function and independence (as much as possible).
Best aspects: We have remarkable technology, medications, and skilled interventionists that can make amazing improvements in conditions that just a short time ago were fatal or caused significant suffering.
Private insurance or single-payer: Health "care" dollars enrich administrators and huge cor-



porations rather than care for people. Although it has flaws, Medicare spends more money on care than any other payer.
Features from scratch: Preventive care with public education and motivation to reduce the overwhelming rates of obesity and inactivity. Self-management for those with chronic illnesses. Guidance for frail, demented individuals and their families. Assistance for persons near the end of life in maintaining comfort and dignity.
Biggest hurdle: Private insurers and health-care companies that profit from providing care.
Can we cut cost, not quality: Yes, but profits will be negatively impacted.
Parting advice: A tidal wave of elderly individuals with longstanding and unfortunately often inadequately managed illnesses will soon live to advanced age, frailty, and dementia. We need to prepare to provide them state-of-the-art care and provide guidance for their families. This is the most time-consuming medical and psychosocial care, if done well, but our current "system" incents care to be provided superficially.

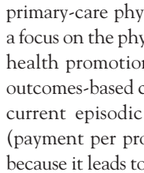
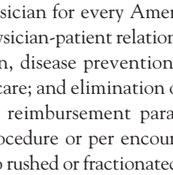
Dr. Richard Parker '85
Specialty: Internal medicine
Location: Massachusetts
Position: Member since 1988 of the academic group practice based at Harvard's Beth Israel Deaconess Medical Center.


Biggest problems: Overutilization. In plain English, we doctors do too much to patients. If we keep doing this, we will end up providing more "care" to fewer people with worse overall outcomes.
Best aspects: Expanding coverage is of course a good thing, but rhetoric about "cutting costs" will remain just rhetoric unless the Congress has the backbone to cut into the profits of current "winners" in the system, including some doctors, hospitals, insurers, and pharmaceutical and biotech companies.
Preserve employer-based model: Maybe, but only if it can be linked to truly cutting costs.
Private insurance or single-payer: I fully support a single-payer plan, and any rational observer of the rest of the Western world would recognize this as the best plan from both a public-health and a fiscal perspective. I don't see a need for private insurance companies, except if they're willing, they could be part of the solution in a single-payer plan.
Features from scratch: Universal coverage; malpractice reform to get rid of defensive medicine; and fairly capitated budgets to give doctors and hospitals the correct incentives to provide the correct care—not the most care—for each patient.
Biggest hurdle: The vested interests of insurers—both for-profit and not-for-profit—and some overcompensated doctors, hospitals, and pharma and biotech firms. They are not about to give away their profits.
Can we cut cost, not quality: Definitely. We could give much better care at lower rates. Look at the work of Elliott Fisher!
Short-term change: Very little. A great deal of grandstanding and breast-beating, while the vested interests work feverishly behind the scenes to protect their fiefdoms. I do not see courageous leadership in the Congress, and I think President Obama will be stymied by the economy and is too smart to get burned on this third rail of politics. He would rather see Congress take the fall on this issue.
Longer-term change: Ten years is a long time. It is possible that Americans would rather go down with the ship of excessive health-care costs than bite the bullet and make the real changes. I can only hope that people, specifically Congress, have the guts to make the big changes one of these days.
Parting advice: The best care is not the most expensive care.

Dr. Jeral Ahtone, DMS '75
Specialty: Emergency medicine
Location: Texas
Position: Practices at Texas Health Presbyterian Hospital, a community hospital in Kaufman, Tex., outside Dallas.


Biggest problems: Access. Access. Access. A large number of people lack access to health care or preventive care because they have no health insurance and no hope of getting health insurance. This includes the underemployed and the chronically ill who do not qualify for Medicare or Medicaid. And access to specialized care in a timely manner, if it's available at all, is a problem even for those with insurance.
Best aspects: The dedicated people who actually deliver care. Nurses, lab and x-ray technicians, patient-care attendants, housekeeping and dietary staff, and many others don't get enough recognition for their work. Physicians can order all the procedures and tests they want, but these individuals are the ones who get the work done.
Preserve employer-based model: No. On first inspection it seems to be a reasonable model, but closer examination reveals the flaws. There are too many exceptions: small business not needing to insure employees, hiring people as part-timers (and working them as full-time employees with overtime), large businesses holding employees hostage to their health insurance because of preexisting conditions, hiring of individuals as independent contractors to avoid giving benefits, etc.
Private insurance or single-payer: There will always be a role for private insurance companies, but as long as they answer to stockholders it will never be the best solution. A single-payer plan by itself will probably never be a reality.
Features from scratch: Basic access for all. The emphasis should be on public health, preventive medicine, routine care, and emergency care. Since this a nation where all people are not "equal," there would need to be a provision for individuals to purchase additional benefits. This would likely be through private insurance companies. They could fund the "care on demand" that happens so frequently in our current system. In order for any new system to actually work, much groundwork needs to be done—for example, tort reform on a national level.
Biggest hurdle: Too many stakeholders who fear they'd lose money. The roadblocks will take many different appearances, but in the end it is about money.
Can we cut cost, not quality: It is possible, but not under the current system. Again, there are too many stakeholders who'd lose money.
Short-term change: Lots of talk, and maybe even a few more rules that primary-care providers will need to follow. But the system is just too fragmented at this time to get everybody on the same page within the next two years.
Longer-term change: I am cynical regarding the talk of change. The policies that one political party institutes rarely last through the next administration. The constant turnover in Washington means progress will be very slow. There is no real push from insurance companies, pharmaceutical companies, for-profit hospitals, lawyers, or high-paid medical subspecialists to change the current system. There's not anything in health-care reform for all of them.

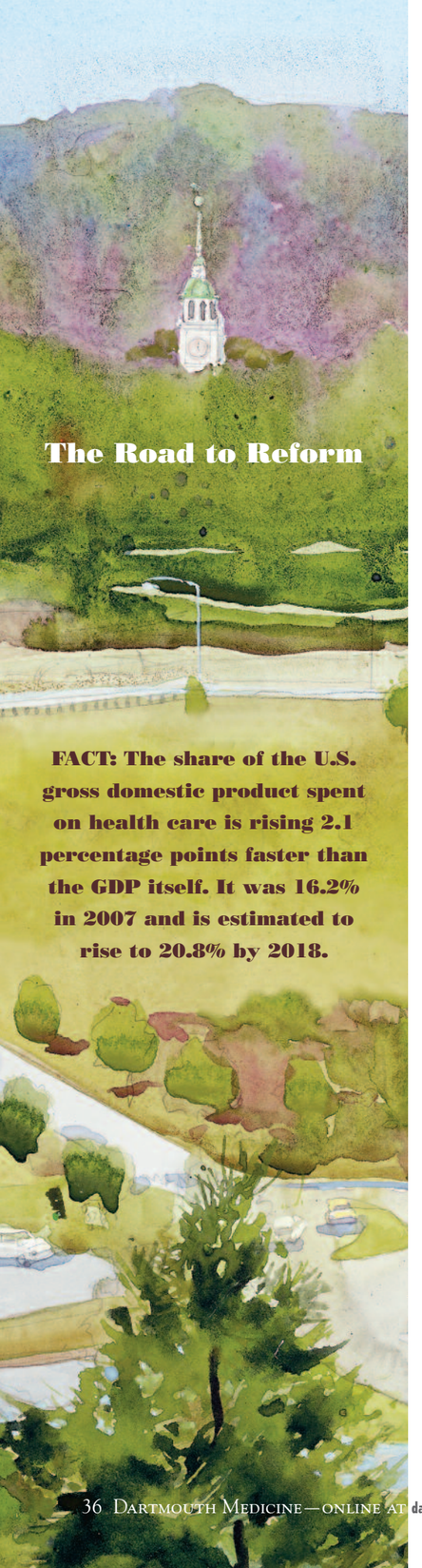
Dr. Peter Putnam, DMS '97
Specialty: Pediatrics
Location: Missouri
Position: Member since 2001 of a private physician-owned primary-care group practice in suburban St. Louis.

Biggest problems: Lack of coverage/access for all Americans and the already high and still rising cost of health care.
Best aspects: Ability to perform medical miracles on a regular basis that were unimaginable even a decade ago.
Preserve employer-based model: I don't think it should be entirely replaced, since it provides coverage already for millions of citizens. But it needs to be augmented for those who lose jobs and extended for those who do not currently have jobs or other health coverage.
Private insurance or single-payer: I think private insurance can be part of the solution, but the private sector alone cannot (and should not be expected to) solve this problem. Its motivation will be profit maximization rather than health maximization. At the same time, the government alone should not be in charge. The best solution would be some partnership between the two.
Features from scratch: A medical home, with a primary-care physician for every American; a focus on the physician-patient relationship, health promotion, disease prevention, and outcomes-based care; and elimination of the current episodic reimbursement paradigm (payment per procedure or per encounter), because it leads to rushed or fractionated care that is not coordinated and it may contribute to overutilization of unnecessary services.
Biggest hurdle: The fact that all involved parties (patients, doctors, health insurers, pharmaceutical companies, etc.) will be required to give up something (money, opportunity, freedom of choice, etc.) if a new, equitable, higher-quality, lower-cost system is to achieve its goals. It will be a challenge for these disparate groups (even the groups themselves are not homogenous) to sacrifice their current advantages in order for everyone to succeed. It will require courage and leadership to become a reality.
Can we cut cost, not quality: Absolutely, if we base the system on thoughtful, comprehensive primary care that focuses on outcome-proven diagnostics and treatments.
Short-term change: I think an honest accounting of the problems and current conflicts of interest can be elucidated in the next two years. From there, a new or enhanced system can begin to be designed/rebuilt.
Longer-term change: It will require continued change past the next few years, once the ship is set on a new, right course.

Dr. David Roberts, DMS '75
Specialty: Neurosurgery
Location: New Hampshire
Position: Chief of the section of neurosurgery at Dartmouth-Hitchcock Medical Center, where he's practiced since 1982.


Biggest problems: The lack of universal access and the expense.
Best aspects: The incredible technological advances and the people.
Preserve employer-based model: I believe access to affordable health care should be a right. I'm not an economist, but basing coverage on employment seems a rather indirect and probably inequitable way to pay for it.
Features from scratch: Universal access to high-quality care, with the opportunity for individuals to pay for additional services or personal preferences.
Biggest hurdle: There is too much money at stake for too many vested interests.
Can we cut cost, not quality: It's standard procedure today to cloak every restriction of resources in the mantle of higher quality. There is no question that not everything that



is more expensive is necessarily better, but it is at least equally true that not everything that is cheaper is higher quality. There are likely segments of the health-care industry that have been very profitable but have not directly contributed to patient outcomes that can be trimmed without affecting the primary mission.

Short-term change: I'm afraid any reform will be modest.

Longer-term change: I believe there will be continued change, hopefully eventually with universal access to care and likely with a greater role for nonphysician providers.

Parting advice: For a long time, the problems with U.S. health care have been in the spotlight. I think it's important for those making reform decisions to understand the strengths of our system as well. It's for a reason that people from all over the world come here for health care, for medical education and training, and for research opportunities.

Dr. Lucienne Bouvier, DMS '92

Specialty: Obstetrics and gynecology
Location: California
Position: Has practiced since 2002 in Milpitas, south of the Bay Area, with the Kaiser Permanente system—a large, integrated, multispecialty group practice.

Biggest problems: The fact that health care is provided only to those with a job that offers health benefits or to low-income citizens. U.S. health care mostly runs on a for-profit model, and the distribution of resources—drugs, procedures, hospitals—is based on where profit can be made rather than on need. The vast majority of the system isn't integrated; there is little coordination of care between hospitals, doctors, labs, etc. Finally, our system doesn't emphasize prevention; for example, insurance companies rarely pay for a visit to a nutritionist, even though prevention of obesity (and smoking) would significantly reduce their cost burden.

Best aspects: The U.S. has a wealth of ingenuity that makes us leaders in innovating new drugs and procedures.

Preserve employer-based model: I think the model is doomed. Employers are offering less and less in the way of benefits because of rising costs. The burden is being shifted to employees/patients.

Private insurance or single-payer: I think the future rests in regionalized nonprofit distribution of care, maybe supported by the federal government. The wealthy will always be able to purchase additional health care, by direct payment or private insurance, but many Americans don't have access to even basic preventive care.

Features from scratch: It would be not-for-profit and controlled by doctors (not accountants). There would be easy access to care for patients, including to specialists; coordination of care between doctors and hospitals, with treatment plans based on the best available science; and centers of specialty care, rather than doctors here and there. And the system would be focused on prevention rather than fixing problems after they occur.

Biggest hurdle: Many people are afraid of what they think of as "socialized medicine." Patients think it will result in worse care than they currently receive. Insurance companies rightly see it as a threat to their livelihood. Doctors in private practice think they will make less money.

Can we cut cost, not quality: Absolutely. I work for the Permanente Medical Group. We spend about as much per year per patient as the British National Health Service, which is a truly socialized system, but we provide infinitely more services. There is huge emphasis on patient satisfaction, including fast referrals to specialists. Doctors' incomes and benefits are equivalent to those of colleagues in private practice. We emphasize best practices and evidence-based medicine but don't have some authority telling us what to do. We have sensible distribution of resources based on patient needs, rather than profits generated by technology. We have a full complement of social workers, psychiatric care, health education classes, etc. The federal government is looking at the Permanente system as a potential model for the U.S.

Short-term change: I think there will be a lot of discussion about what is the best model. Insurance companies will want to be involved in that discussion, as will doctors who don't want to lose out on their income.

Longer-term change: I fear that any attempts at reform will be aimed only at lower-income citizens and that the rest of the population won't want to pay taxes to fund it adequately.

Parting advice: The doctor and the patient need to ultimately be the ones deciding what medical care is most appropriate.

Dr. Arminda Perez, DMS '77

Specialty: Family medicine
Location: Texas
Position: Solo private practice since 1990 in the low-income Oak Cliff area of Dallas.

Biggest problems: Unequal accessibility and availability. And lack of primary care for adults, resulting in episodic care rather than health maintenance and preventive care.

Best aspects: Excellent medical education and training. Also, every subspecialty has tremendous gadgets and medications that help save lives and prevent episodic visits—for example, automatic internal defibrillators, microinvasive surgeries, and new insulins. But unfortunately, such advances are not available to everyone.

Preserve employer-based model: I believe it *can* be preserved, but I don't know if it *should* be preserved. The only way it can continue to survive is if the concept includes teaching people how to make lifestyle changes, much as we do occupational safety training. Employers could bring in providers to give advice on heart disease, diabetes, cancer prevention, smoking cessation, etc., which would reduce the cost burden on businesses.

Private insurance or single-payer: The moment a private insurance company has to make a profit for its stockholders, it will fail to please consumers. And a single-payer plan would be a monopoly and so seems un-American. A single-payer system may work better.

Features from scratch: I would place the burden of health maintenance and disease prevention on the patient, not the system. I'd require a two-year commitment in the U.S. Public Health Service or the National Health Service Corps for all medical school graduates, after their internship and any specialty or subspecialty training. I'd require effective parenting classes for both parents of any baby born to a mom getting prenatal care under Medicaid. I'd guarantee everyone two health-maintenance visits a year after assessing their risk factors. I'd stress wellness and prevention. I'd ensure ready access to medical records; some of my chronic pain patients get three or four CTs a year because they go to different ERs. Charges would be based on a sliding scale and on compliance with treatment; nothing would be totally free and patients should be held accountable and be rewarded for reaching health-care goals. And we need to teach medical personnel compassion for all patients.

Can we cut cost, not quality: Yes. We need to use proven generic drugs; branded medications can cost up to $600 a dose, but the majority of episodic illnesses can be treated with generics without affecting the quality of care. We need to eliminate duplicative testing with a good electronic medical record system. And we should eliminate durable medical equipment companies; I see too much fraud in that area.

Short-term change: I'm afraid the only change that's likely is that primary-care physicians will get reimbursed less.

Parting advice: Don't let people with profit as a goal determine health care. And remember that there are no Band-Aids.

Dr. David Levine, DMS '86

Specialty: Orthopaedic surgery
Location: Massachusetts
Position: After many years of clinical practice in the military and in an academic group, he is now vice president for clinical research at a biotechnology company near Boston.

Biggest problems: There is no cohesive system, and the incentives for both individuals and institutions are not aligned with overall public-health and public-policy objectives. As a result, resources are not efficiently deployed and administrative costs are too high.

Best aspects: Despite the systematic problems in our uncohesive "system," and the constraints of individual practice settings, I believe most doctors and nurses have strong professional values and strive to provide the best patient care. And the U.S. is a global leader in medical education, basic science research, and commitment to translational research and innovation to address serious, debilitating diseases.

Preserve employer-based model: In the context of our current pluralistic approach, yes. Whether health-care costs are paid by individuals, employers, or government, "universal care" is not "free care." The sustainability of any third-party payer system requires a sound economy and efficient administration.

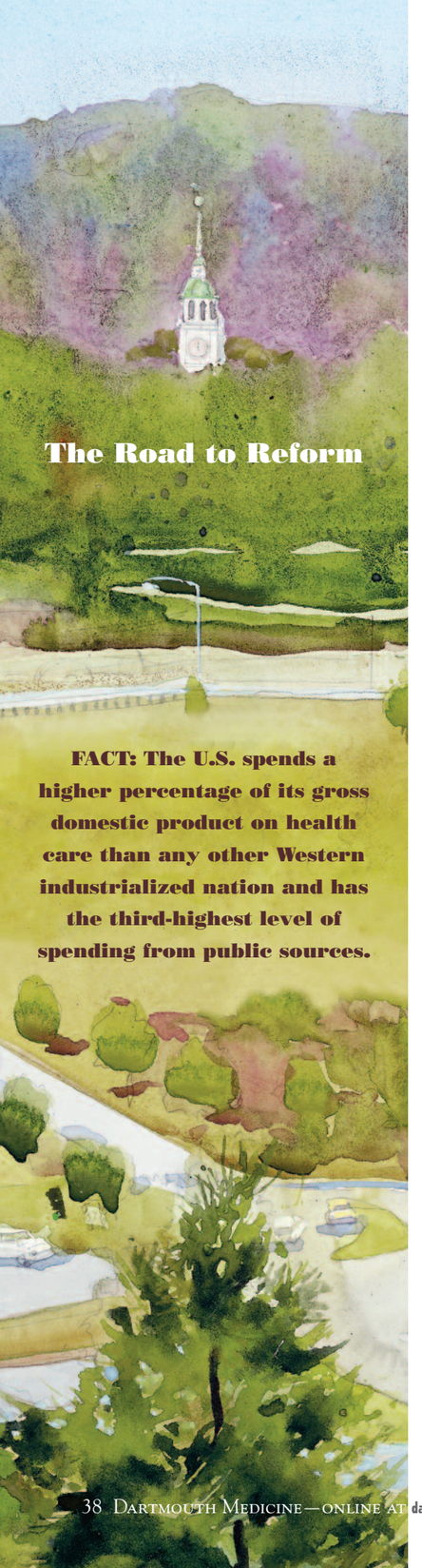
Private insurance or single-payer: This question reflects a bitter ideological debate that skirts the important issues—fear of government monopoly power on the part of private-payer advocates, and outrage at private plans' excessive administrative costs and coverage gaps on the part of single-payer advocates. The economic feasibility of retaining the political benefits of a pluralistic approach while expanding coverage requires private payers to address their excessive administrative costs. Conversely, the political feasibility of a single (largely government)-payer plan requires some flexibility and private options to address monopoly and "lowest common denominator" concerns.

Biggest hurdle: Entrenched interests defending their benefits under the status quo and knee-jerk ideological responses from both ends of the political spectrum.

Can we cut cost, not quality: Yes. Strategies include cutting excessive administrative costs and improving outcomes research and its application to practice. That said, true innovation with better modalities for serious diseases will be expensive, and the current reform debate is not addressing the implications of more effective treatments targeted to specific populations.

Short-term change: I have great optimism based on Winston Churchill's observation that "You can always count on Americans to do the right thing—after they have tried everything else." We won't achieve perfection, but we will iteratively make progress.

Longer-term change: Each reform will have some unintended consequence that will need to be addressed by the next reform. There will always be somebody who games the system to the public's detriment. I'd guess we'll have a hybrid system with government-predominant core coverage and some private-payer options. I hope we're smart enough to build in clinical effectiveness from the bottom up (based on data, judgment, innovation, and patient values) versus the top down (based



on fiat and/or on obtuse economic models).
Parting advice: There will be no overnight, simple cure. We can and must make progress, but it will not be quick or easy.

Dr. Mark Constantian, DMS '70
Specialty: Plastic surgery
Location: New Hampshire
Position: Private practice in Nashua, N.H., since 1978.


Biggest problems: Insurance fraud and its fallout. Many insurance carriers practice fraud toward patients and physicians, promising services they have no intention of providing. They tell patients they love them more than their parents and will provide attentive care, but instead they ration and obstruct access to care. They promise to adhere to physician contracts and payment schedules but often do not, relying on the obstacles their appeal mechanisms create to discourage physician objections. It's a wonderful system.
Best aspects: The uniqueness of its physicians. An insurance executive once told me that doctors are the only workers who, when their reimbursement is cut 50%, will continue to produce the same product. Payers understand and exploit this trait. Many of us don't change because we can't; the desire to serve and heal is fused into our souls. Margaret Mead once asked an audience what they imagined was the earliest sign of civilization. Clay pots, iron tools, and the domestication of plants were all early signs, she said, and then she held above her head a human femur and pointed to a thickened area of bony union. "Such signs of healing are never found among the remains of the earliest, fiercest societies. In their skeletons we find clues of violence: a rib pierced by an arrow, a skull crushed by a club. *But this healed bone shows that someone must have cared for the injured person—hunted on his behalf, brought him food, served him at personal sacrifice*." (The italics are mine; I have paraphrased this anecdote from Paul Brand's *Pain: The Gift Nobody Wants*.) The spirit that motivates excellent physicians is something that insurers and the government will never, never understand.
Biggest hurdle: There are two. One is the assumption that Americans will accept less care than they receive now in exchange for lower costs and access; I don't think they will. The other is the reliance on projections—such as for physician distribution. Most projections assume that all variables remain the same. They don't account for factors like AIDS, which increased the need for infectious disease specialists and virologists; or innovations in microsurgery, which altered how we treat trauma.
Can we cut cost, not quality: Perhaps we should look at health-care costs differently. How do we know that we're spending too much? Perhaps we're not spending enough. Comparisons to other countries aren't germane because the U.S. is unique in its economic and cultural mix, as are the expectations that its consumers and providers have for service excellence and perfect results. Costs rise as time passes, but they also rise with the increase in sophistication of services. It isn't the same hamburger at a higher price, it's a new, improved hamburger, so the cost is often justifiable—or at least understandable. The only "too much" in the system is bureaucratic waste—governmental, hospital, and insurance carrier—which is staggering.

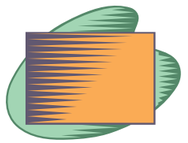
Dr. Boyd Winslow, DMS '72
Specialty: Pediatric urology
Location: Virginia
Position: President of Children's Urology of Virginia, a three-physician single-specialty group practice.


Biggest problems: The fact that consumers think, just because they or their employers pay insurance premiums, that every service is "free." Patients think anything is possible, and the press promotes this notion. But payers, whether governmental or private, can't pay for everything. So they restrict therapies, medications, etc., and levy ever-increasing deductibles and copays to restrict care. And they make this process blatantly opaque to consumers, encouraging them to believe that the exorbitant costs and limitations are doctors' fault. Then there's the parasitic role of malpractice lawyers, ready to pounce at the first perception of a misstep.
Best aspects: We may continue to enjoy, for a while, the admirable professionalism of the American physician. Most doctors I know take tremendous pride in maintaining state-of-the-art knowledge in order to offer their patients the best possible care. I think we are generally successful, as patients travel to the U.S. from all over the world.
Preserve employer-based model: No. The current system, having fallen under the spell of accountants and robber barons, is an unmitigated catastrophe. Insurance companies, many of them run by former doctors, profit obscenely from the good work of physicians, jacking up premiums and reducing benefits, while physicians in the classic mold struggle to perform as Hippocrates exhorted us to.
Private insurance or single-payer: If "single-payer" means a government entity, I think it's a terrible idea; the governmental provision of services to our populace has gone far beyond what we can sustain. At the same time, I think private insurance companies have become so powerful that they can twist the arms of regulators to permit the pillaging of what has been an excellent system of care.
Features from scratch: Consumers must understand that every service has a cost. They can't select the lowest-cost, no-frills insurance option and then expect their surgeon to use the latest voice-activated, laser-enabled, robotic videoscopic gizmo at no additional expense. Health insurance should be more like car insurance—you have to be covered for the unexpected, but you can't use it for detailing or routine maintenance. And those watching the books should not be permitted to derive immense bonuses for refusing consumers their due or for postponing disbursements to accrue interest. Private concerns can do this, but (I hate to admit it) there should be governmental oversight. Why should insurers siphon off 60% to 80% of the dollars in doctor-patient transactions? If hospitals can be run on a not-for-profit basis, so can the management system.
Can we cut cost, not quality: Yes. Medical care could cost a great deal less if we could devise a transparent way to stop insurance companies from giving multimillion-dollar bonuses to their executives and from hiring armies of untrained claims examiners who shuffle papers but ignore their primary responsibility of getting claims paid for care rendered. (If you don't think this reflects what happens, just peruse the "explanation of benefits" after your next visit; read how much your plan "saved" and try not to be embarrassed at how little your doctor received for the trust you placed in him/her.)
Short-term change: Nothing! There will be much posturing, speech-making, name-calling, and behind-the-scenes payments by lobbyists to allow private insurance companies to continue as they are doing.
Longer-term change: I am sad to admit that my usual optimism is waning. I think in 10 years we will be close to a *Mad Max* scenario.

Dr. Brian Boxer-Wachler, DMS '93
Specialty: Ophthalmology
Location: California
Position: Solo private practice in Los Angeles and at the Jules Stein Eye Institute of the University of California at Los Angeles.


Biggest problems: The fact that insurance companies have become so powerful that they have neutered physicians in their dealings with insurers. If physicians unionized, it would allow us to better negotiate fair reimbursements with insurance companies.
Best aspects: The freedom of choice that patients have.
Private insurance or single-payer: If we want our health-care system to look like Canada's (with long waits for care and capitation), then the single-payer system would be the preferred choice. It would not be my choice.
Features from scratch: Unionization of physicians to effectively negotiate with insurance companies.
Can we cut cost, not quality: I don't see an effective way to "have our cake and eat it, too."
Short-term change: I think the administration will push for universal care, but I don't think it will survive the political process.
Longer-term change: More and more physicians will take the bold step of opting out of insurance plans and reverting to fee-for-service care and provide the superbill to the patient, who can submit it directly for reimbursement. This will have the advantage of allowing physicians to practice medicine the way they dream about, allowing the market rather than the insurance industry to dictate reimbursements, and providing a high level of care because fewer patients at a higher payment per patient equals more time spent per patient, and a return of job satisfaction for physicians.
Parting advice: I encourage physicians to consider opting out of insurance plans and moving toward "concierge medicine."

Dr. Michael Pramenko, DMS '95
Specialty: Family medicine
Location: Colorado
Position: Practices with Primary Care Partners of Grand Junction, Colo.

Biggest problems: The lack of access to basic health care for all Americans. Too many citizens must use the extraordinarily expensive emergency room for their health care. The high cost of care is the second major problem. Families, businesses, and government are finding it impossible to keep pace with the rising cost of medicine in this country. If we can't control costs it will be impossible to deliver universal health care.
Best aspects: Our incentives for innovation and the fact that we still offer the best care to the most critically ill among us (as long as they can access the system).
Preserve employer-based model: No. I believe our system should be restructured so there is an individual mandate that all citizens purchase health insurance. Of course this would require government assistance for some individuals. I do believe our tax code should incentivize employers to continue to help employees with the cost of their insurance. Funds from employers will continue to be needed to help finance the system.
Private insurance or single-payer: I believe we should continue to include a role for private insurance companies. A single-payer plan would be easier to design but harder to implement (politically). But I think we need to drastically alter how insurance companies operate. Much like we need better regulation of our banking system, we need a similar

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Reform: Elliott Fisher

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providers not for volume but for value.

Practical models that embody all three of these principles do exist. Jack Wennberg and others worked with Vermont Senator James Jeffords and his staff to develop a population-based payment reform demonstration project, under the auspices of the 2003 Medicare Modernization Act. This effort is now—finally—being rolled out in several sites.

More recently, a collaboration between Dartmouth and the Brookings Institution has led to a proposal to develop what we call Accountable Care Organizations (ACOs)—groups composed of primary-care physicians, specialists, and one or more hospitals that agree to be responsible for the continuum of care for their patients. Both Medicare and private payers would establish spending and quality targets annually. If quality is adequate and savings beyond the target are achieved, the ACO would receive a share of the savings. Studies by Dartmouth's Dr. Julie Bynum and others have shown that most physicians already practice within virtual physician-hospital networks that could easily become ACOs. Several Medicare demonstration projects have partially tested these ideas. Now, a number of provider organizations are working with our Dartmouth-Brookings team to set up full-fledged pilots of this approach. It's a concept that seems likely to be incorporated in some form in the health-care reform legislation now under discussion.

Other ideas for reforming the payment and delivery systems are also in play. Primary-care physicians advocate additional payments to support the development of "medical homes," a delivery model under which a single physician coordinates all care for a given patient. There is also interest in "episode payments," as opposed to our current system of procedure-based payments; this model would bundle all costs related to a specific clinical service (for example, a knee-replacement operation) for a specific interval (such as six months), rewarding providers who deliver more efficient care. Bundled payments to hospitals are also being discussed; these payments would cover both initial and follow-up care, encouraging hospitals to pay more attention to transitions in care and reducing readmissions.

But while all of these proposals create incentives for improved coordination of care, none would address the fundamental problem—lack of overall accountability for the cost of care—revealed by our population-based research. On the contrary, without global accountability for cost, implementing these policy proposals will almost certainly increase expenditures. For more on this topic, see "Building a medical neighborhood for the medical home" in the *New England Journal of Medicine* [go to at **dartmed.dartmouth.edu/su09/we02** and click on "Buzz about . . ."].

Many Washington policy-makers—including Peter Orszag, the new director of the Office of Management and Budget—now understand the implications of the Dartmouth research and agree that reform requires a transition toward integrated delivery systems, more comprehensive performance measures, and value-based payments. But the costs of expanding coverage to the uninsured are estimated to be between $1 trillion and $2 trillion over the next 10 years, and none of the proposed payment or delivery-system reforms discussed above can come close to achieving guaranteed savings sufficient to make that coverage expansion seem affordable.

Therein lies the challenge facing the nation. One way out might be for all providers to commit to reducing spending growth by a modest amount—perhaps one percentage point below projected increases. If that was implemented in a way that could achieve guaranteed savings—such as through regional spending caps on total per-capita Medicare spending—the savings would be substantial. Dartmouth economist Jon Skinner, Julie Bynum, and I estimated that the potential savings to Medicare alone from a 1% reduction in spending growth would be over $1.4 trillion during the next 15 years. This might be enough to close the deal on universal coverage.

A key question is whether physicians will remain on the sidelines and allow reform to fail again. I would hope that they might, individually and collectively, recognize and act on our shared interest in achieving a different health-care system—one that provides universal coverage, promotes effective integration of care across providers, and establishes payment reform that would free physicians to focus on providing better care—not just more care. The time is now. ■

Reform: Alumni Respondents

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approach to the health insurance industry. For too long, insurers have prioritized shareholder profits over patient needs. That must change. In Grand Junction, we have a local nonprofit insurance company that is part of our health-care community.

Features from scratch: Universal care with guaranteed access to quality basic health services. There would be a mix of public and private payers, but insurance companies would be smaller and locally based so they would operate with community needs as a guide. We would reform our medical education system so there are incentives to go into primary care, and structure the system around patient-centered medical homes. The system would also encourage more personal responsibility, utilize electronic health records, and restructure the tort process to reduce defensive medicine. Most importantly, the new system would reprioritize quality in health care, and in doing so we can control costs. This does mean physicians must reevaluate how we practice medicine. As *Dartmouth Atlas* data illustrates, more intensive care, with more doctors involved, often leads to decreased quality and much higher costs.

Biggest hurdle: Human resistance to change is the biggest hurdle, but the insurance companies haven't been helping much either.

Can we cut cost, not quality: Absolutely.

Short-term change: I am optimistic. My optimism is founded in the growing frustration of the American people and American businesses and their willingness to speak out. As frustration has grown, I believe it may be possible to move forward with significant and systemic reform. Our voices may now be loud enough to counteract the well-financed voices of the insurance industry and powerful politicians who don't believe the U.S. should provide universal health care.

Longer-term change: We will be in a constant state of change as new technology and new ideas shape the practice of medicine. In 10 years, I believe our system will offer quality basic health benefits to all Americans at a fair price. The alternatives are morally and financially unacceptable.

Parting advice: Physicians should embrace comparative effectiveness research and realize that more intensive intervention often leads to worse outcomes for patients. ■