

Opportunity knocking

By Matthew Hanscom Davis

There is a bright side to the United States' current public-health crisis. Our delayed investments in infrastructure, our unaffordable and inaccessible system of care, and our inconsistent delivery model have created a unique opportunity for improvement. I enrolled last fall in the master's-degree program in public health at the Dartmouth Institute (TDI) for Health Policy and Clinical Practice so that I could play a part in this opportunity.

My previous experience in environmental policy had cemented my conviction that the environment and public health are inextricably intertwined. For example, while working for Environment Maine, a nonprofit advocacy group, I used research on the link between childhood asthma and tailpipe emissions to help convince the Maine legislature to adopt more stringent auto emission standards.

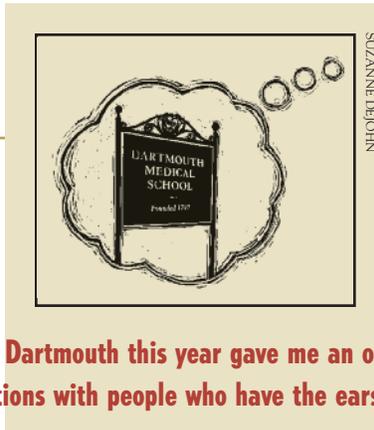
Public: At TDI, I hoped to learn more about such connections, as well as about how to better communicate them to the public—and I have not been disappointed. With its outspoken, cutting-edge researchers, TDI has taught me about the structures and economics behind the problems our country faces, as well as about the policies and types of leadership that may improve our nation's health. My perspective may be biased by the fact that several of my professors, including Drs. John Wennberg and Elliott Fisher, meet regularly with congressional leaders and top government officials, but it seems to me that our chance of achieving substantial reform is unprecedented. Another professor, Dr. Paul Batalden, has taught us to embrace this type of opportunity in pursuing continual improvement.

Some important changes are already occurring. President Obama and Congress used the stimulus bill to improve our long-ignored public-health infrastructure, including \$7 billion for upgrades to wastewater and drinking water treatment facilities. Many gains in health around the world have resulted from such efforts, so our leaders are wise to place public-health spending high on the list of priorities.

It may seem counterintuitive that increasing spending on public-health infrastructure can decrease overall health-system spending, but the evidence shows that public-health programs do save money. For example, we learned in one class that acute gastroenteritis costs the U.S. billions of dollars annually. But almost half of such cases result from contaminated water, which often can be traced back to inadequate treatment systems. Investing money now in water treatment could save both more money and a lot of stomachaches.

Root: Population-wide prevention efforts are more effective the closer they are to addressing the root cause of a disease. As Dr. Adewale Troutman, an associate professor of public health at the University of

The Student Notebook essay offers insight into the activities or opinions of students and trainees. Davis, an M.P.H. student at the Dartmouth Institute for Health Policy and Clinical Practice, was chosen by his classmates to speak at the 2009 Class Day ceremony.



SIZANNE DEJOHN

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Louisville, said at a recent New Hampshire Public Health Association meeting, rescuing babies floating down the river is not as effective as running up-river to stop people from putting them in the river in the first place. Let's hope the nation's leaders continue to focus on upstream solutions.

Another effort involving TDI and DHMC is a pay-for-performance project currently in a pilot phase. Medicare is rewarding coordinated networks of health-care providers for delivering effective and efficient care. Dr. Barbara Walters, the project's coordinator at DHMC, spoke to TDI students about working with federal regulators to improve care and achieve savings for Medicare, while also achieving financial rewards for DHMC. This kind of program works by inverting existing incentives—favoring preventive and primary care, rather than procedure-intensive specialty care. Regulators, researchers, and providers still need to work out the right quality measures and payment levels, but hopefully in coming years this pilot will prove its worth and be expanded.

Another concept—the “medical home”—may also be part of reform efforts. In this system, individual patients rely on a primary-care physician to deliver basic care and coordinate all specialist services. This approach could improve quality by ensuring that care is managed from one location—an improvement on the current disjointed care system. It would give patients one place to turn to keep tabs on chronic conditions and long-term health. The payment mechanism would recognize these coordination efforts, which might reduce the use of expensive specialty care and duplicative tests. Of course, there are still some concerns, such as how best to facilitate the coordination of different types of care and whether the current supply and distribution of primary-care physicians is adequate to support this model.

Role: And it's essential that informed patient choice be a part of any changes to the system. As TDI faculty such as Drs. James Weinstein and Dale Collins have emphasized in their lectures, patients are the most important participants in the health-care system, although currently many patients play little role in choosing their care. Patients deserve to be thoughtfully educated about their options and assured that their values will be taken into account. Patients who make truly informed decisions tend to choose less aggressive care—often reducing medical intensity by as much as 30 percent—and are more satisfied with their treatment and its outcomes.

Studying at TDI this year has allowed me to explore the connections between environmental quality and public health, to learn about the problems that beset the nation's health-care system, and to discuss potential solutions with people who have the ears of Congress and the White House. Soon, I'll have a chance to use these experiences to help bring about much-needed improvements. For me, as well as for the nation, it's a time of exceptional opportunity. ■