Point of View

Where We've Gone Wrong

Robert Stone

EVERYONE WHO IS a regular reader of this journal knows the metrics: projected health care spending of \$4.3 trillion in 2017,¹ \$1.2 trillion of avoidable expense associated with chronic disease,² and an average of \$5,400 per employee per year of recoverable health-related productivity costs.³

Some of these costs are associated with the anticipated increase in population; some are related to the development and implementation of new technologies; but most of these costs are associated with the inescapable truth that our health system does not work to make our population healthy. Just as we are all aware that health care in this country is increasingly more expensive, we also are all aware that the odds of getting the right care, particularly for chronic diseases, are no better than the flip of a coin.

For the past 50 years, countless experts have watched—either in awe or horror—as the cost of care in this country has continued to rise, apparently inexorably. Why? Because one of our industry's *inconvenient truths* is that nothing we have tried to check those costs has proven to have any lasting impact. None of the variety of experiments, either economic or systemic, has had any continuing effect on arresting the increasing trend, let alone actually reducing the cost of care. By and large, whether aimed at payment mechanisms, limiting access, restricting utilization, controlling unit prices, or shifting risk, these experiments have failed. New experiments—often billed by advocates as the panacea for the American health care crisis—like health information technology, pay for performance, pay for quality, medical home, universal coverage, and others that are highly touted in both the halls of policy and the pages of the press, are likely to fail as well. We all know what it is called when we expect a different outcome from doing more of the same thing.

Simply put, until we focus on the root cause of the problems that continue to be manifested by our fixation on an acute care-centric delivery system, until we break down the silos that characterize that system—and that each silo defends as if the Saracens were ready to storm the ramparts—solutions will remain outside our grasp.

The challenge we face in attaining the goal of affordable, quality health care for all is only to a limited degree about

reducing the cost of care for people who are already sick. “America,” as my colleague Ben Leedle puts it, “is a machine for generating chronic disease.” Unless and until we stop feeding that machine, we have no hope of meaningfully changing the cost trends that we have watched climb steadily upward for the last 50 years.

The solution will require a major shift in our national health care policy and a new focus on depriving our chronic disease machine of fuel. Debates about whether to provide coverage to 25 million or 42 million uninsured Americans will not achieve that objective. Arguably, providing access to the system for that largely uncared for segment of the population will actually make the cost situation worse. Arguments that the system could do it better if one component or another was paid more are equally specious, and providing incentives for elements of the system to do what they are already being paid to do is just bad public policy.

There are 3 approaches that need to be followed if we are to effectively shut off the fuel supply to our chronic care machine. First, we must find ways to keep healthy individuals healthy. Second, we must find ways to help mitigate risk for those whose risk results from modifiable lifestyle behaviors. Third, we must assure access to optimized, evidence-based care for those who have progressed to chronic disease or persistent conditions. All of these efforts must be coordinated and integrated in a person-centered manner that assures simple navigation of the system and system-wide awareness of each individual's state, wherever or however care is rendered.

It's a simple formula to articulate. It won't be as simple to effect. The barriers are legion. Politically, this approach will require something more than the 3% of our now \$2 trillion health care bill that is currently spent on health, wellness, and prevention activities. And the payoff, while large and relatively quick—up to \$7,400 per individual per year in reduced cost and productivity gains by year 5³—is, unfortunately, somewhat longer than the election cycle.

Systemically, this approach will require recognition that, from a health perspective, individuals live in multiple “homes”: medical, work, and personal. None of these is superior to or more important than the others, and making the

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transition from one to another seamless and transparent will be a critical success factor.

Societally, this approach will require a common commitment to health and well-being. This may be the greatest challenge of all, but even today we see efforts by governments and employers that have resulted in the implementation of reduced lifestyle-risk behaviors.

Perhaps aptly, America has been referred to as a nation of consumers. In terms of health and health care, our consumption is now greater than the total economy of any other country on earth. If we do not start down the path to less consumption soon, we will look back one day and discover that what we have consumed is ourselves.

References

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