

Critical Issues in US Health Care

Health Care on the Edge

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The US health care system has reached a tipping point when there is both little doubt about the kind of change that is needed and much uncertainty about how to achieve it. This issue of *JAMA*, a theme issue on Critical Issues in US Health Care, includes 3 scholarly Special Communications and 11 authoritative and thought-provoking Viewpoints that map out this dilemma and highlight potential solutions. The topics all relate to fundamental aspects of how the US health care system functions, with subjects selected in an iterative process involving the editorial board of *JAMA*. The goal was to expand the discussion beyond just cost, quality, and value.

In the first of 3 Special Communication articles, Moses and colleagues¹ present a comprehensive, detailed, and extensively referenced report that documents the anatomy of the US health system. Health care expenditures exceed \$2.7 trillion annually, doubling since 1980 as a percentage of the nation's gross domestic product. This article details how the United States spends that money each year and provides information on topics ranging from the number of health care personnel to the cost of information technology. Price increases (rather than greater provision of services) are driving increased costs, even as US health outcomes have fallen behind those of other countries. The rising tide of chronic illness is posing an unprecedented challenge.

There has been substantial consolidation in many industries; for example, the airline, telecommunications, and automotive sectors of the economy have coalesced into relatively few major business entities. Cutler and Scott Morton² describe the same phenomenon in health care, particularly the hospital industry. Since the mid-1980s, hospital markets have shifted on average from including 5 independent major hospitals to 3. These changes began before implementation of the Affordable Care Act (ACA) but will hasten as the ACA rewards the integrated care that large networks may best provide.

Measurement of quality has reached an almost frenzied state. Consumer groups, insurers, payers, licensing bodies, and various national groups all require different types of measures at the physician, patient, and hospital level. Panzer and colleagues³ highlight the demands and confusion inherent in scores of competing quality measures, which can distract from the essential task of making care better.

There is no shortage of prescriptions for improving the delivery of care, and several Viewpoints in this issue of *JAMA* present potential solutions for core challenges. Cortese⁴ provides his vision for patient-focused, coordinated care, supported by innovative technology and rewarded by financial

incentives. Although this approach should serve to improve quality, there are no data yet available to know whether the mHealth movement will indeed lead to better health outcomes. In contrast, while they are awash with data, it is not certain that the new technologies will reduce or increase the workload on physicians. Lynn⁵ calls for a shift in the focus on end-of-life care from diseases to people and for a redesign in long-term care to respect the dignity and desires of elderly individuals. Virtually everyone, including physicians, has a painful story to tell about end-of-life care in his or her family and the struggles with how to ensure "dying with dignity" in the United States. Cooper⁶ confronts an issue that has been problematic for the US health care system for decades: how many physicians are needed and what is the appropriate primary care/ specialist distribution. He calls for a greater number of physicians to meet the needs of an aging and increasingly diverse society, but with a restriction on federal support for residency, resources to train these additional physicians will be difficult to find. Few would deny the promise of these approaches. Yet model programs in these areas remain the exception rather than the rule. The time may have arrived to shorten the training period from medical school to residency to fellowship.

At the national level, progress in advancing health care is slow and halting. The Centers for Medicare & Medicaid Services is promoting accountable care and other innovations through the Medicare and Medicaid programs. However, broad changes are not on the horizon, and Congress is distracted by efforts to undo the ACA. Ironically, addressing the increasing costs of health care would reduce the pressure on the federal budget and make political conflicts in Washington easier to resolve.

What are some reasons for the paralysis? Berwick⁷ relates his firsthand experiences with the toxic politics of health care, passionately describes the fierceness of individuals and organizations with entrenched financial interests, and calls for health professionals to join together to overcome these obstacles. Levey⁸ suggests that there is broad public misunderstanding about the country's health care challenges, with the media bearing some of the responsibility.

Several Viewpoints in this issue of *JAMA* propose creative solutions to resolving the many dilemmas faced by the US health care system, each requiring leadership and resolve and challenging the status quo. Emanuel⁹ calls for a "man on the moon"-type audacious national goal of limiting health care expenditure growth to the growth of the national economy. He proposes an ambitious fiscal target, such that by 2020, per capita health care costs will increase no more than the gross

domestic product +0%. That is, by the end of the decade, health care costs per person will not increase faster than the economy as a whole. Washington and coauthors¹⁰ encourage academic medical centers to lead in the development of integrated health systems, supported by community engagement and data-driven interventions. This will require a commitment to look beyond the walls of the institutions for partners who can help patients prevent and manage chronic illness. In a thoughtful discussion on support for biomedical research, Fineberg¹¹ emphasizes the importance of a social compact for health research that provides predictable government funding, ensures evidence-based priority setting, engages the public, protects research integrity, and renews a partnership for the public good among research stakeholders. Reinhardt¹² sees enormous potential for indirect leadership by consumers empowered with access to meaningful information on price and quality. Innovations in transparency such as reference pricing can dramatically alter the orientation of health systems to cost and efficiency. He notes the insulation of the health care system from basic market forces and hopes that greater price transparency will foster fundamental reform.

At the state level, there is evidence of application of some of the principles underlying these ideas and increasing efforts and movements to change health care. There are bundled payments in Arkansas, coordinated care organizations in Oregon, health care cost targets in Massachusetts, and global budgets for hospital care in Maryland—each championed by the states' respective governor. These efforts involve states setting down the “railroad tracks” of a new health care system, such as payment structures and quality measures, while allowing for the actual activity along those tracks to be guided by local physicians, clinics, hospitals, and coordinating systems of care. However, these state efforts do not materialize out of thin air. Each reflects a substantial investment by local leaders of time, effort, and political capital.

The federal government is increasingly supporting efforts by states to move the health care system forward. The Cen-

ters for Medicare & Medicaid Services is providing data to states more readily, waiving rules that conflict with state models, and funding a wide range of innovative strategies. The Centers for Disease Control and Prevention is pushing state public health departments to align efforts with clinical transformation to address chronic illness. Even more federal engagement would be welcome. For example, the Federal Employee Health Benefit Plan and TriCare could actively participate in state initiatives. The Health Services and Resources Administration could require its grantees, including community health centers, academic institutions, and even poison control centers, to join forces with well-developed local efforts.

In a system this complex, there is always the risk that a step forward causes 2 steps back. With so much “change in the air,” it may be difficult to determine what is working and what is failing. Sox¹³ asks whether the policy focus on value within health care will pose new challenges for the care of individual patients: How can the health of the population be balanced with the health of the individual? In fact, it is the very frustration of families and businesses with the costs and chaos of the present system that supports local reform efforts. Guest and Quincy¹⁴ underscore the importance of patients becoming partners in reducing unrealistic expectations for health care; the success of efforts to reduce unnecessary antibiotic prescribing in pediatrics may provide one such model. A local process for involving the public can provide a needed boost to attempts for system improvement.

This generation's “moon shot” is an effective and efficient health care system that supports the well-being and dignity of all Americans. Total commitment to this shared goal—by health care professionals, medical societies, medical centers, insurers, policy makers, patient groups, and others—will be necessary for meaningful progress. We hope the articles in this theme issue of *JAMA* inspire renewed efforts to bring the US health care system back from the edge and, ultimately, serve to help improve the health of the nation.

ARTICLE INFORMATION

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