

VIEWPOINT

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The Toxic Politics of Health Care

It could be exciting. The ambitious nation that rallied to create the Marshall Plan, get to the moon first, and birth Medicare and Medicaid decides to move toward the health care it needs: universal, responsive, and affordable. But that task does not unite the nation; it rends it into political tatters. Health care reform could have been a moon shot, but instead it is a battlefield: red states against blue, north against south, coasts against the midland, and liberals, who trust in government, against conservatives, who don't.

For me, this battle became personal. When the President asked me to come to Washington, DC, to lead the Centers for Medicare & Medicaid Services (CMS), I thereby acquired responsibility for implementing much of the Affordable Care Act (ACA). Opponents of the ACA turned their general political vehemence into specific, deceptive attacks on my beliefs, hopes, capacity, and agenda. The absence of inquiry and dialogue about what I actually do believe was stunning.

Professions, patients' organizations, and public advocates should unequivocally support health care as a human right in the United States. They should argue not just to preserve the ACA, but to extend it so that not one person in the nation need fear loss of access to coverage or care.

Importance

The toxicity of politics in US health care is costing the nation dearly. It perpetuates enormous waste (the United States spends, after all, almost twice what other developed nations do on health care, with results at best equal to others¹). Even worse, it perpetuates defects in care that cause needlessly poor health outcomes for millions, due to failures of coordination, hazards to patient safety, poor access, and underemphasis on prevention.

For example, the lack of much needed conversations about public policies toward better palliative and end-of-life care harms patients. The reckless rhetoric about "death panels" ignored overwhelming scientific evidence that the preferences of patients, families, and clinicians for dignified support in the last stages of illness are much more often violated than honored.² Instead of fostering progress in the care of advanced illness, both Congress and the Administration fell silent.

The litany is long of similarly important problems in health care reform for which solutions have lately stalled

on the shoals of angry, scientifically uninformed political combat: the proper use of evidence in clinical decision making, exploring new roles for nonphysician clinicians, enormous regional variations in care and outcome, addressing the nation's obesity epidemic, maddeningly complex and anachronistic rules for physician and hospital payment, and much more.

Causes

The causes of political paralysis in meaningful health care reform are many. Some of the largest are these:

Money in the Status Quo

More than \$2.7 trillion changes hands in health care. No one who gets paid now will happily accept less. Vast financial interests create lobbying interests, who populate the corridors of Capitol Hill and CMS. In other industries, market dynamics and technological advances force the production systems eventually to

change or to wither – such as, for example, steel mills, typewriter-makers, and Polaroid. Those who make money in the health care status quo have a different option: stop the change; and they do. Support languishes for advanced practice nurses, telemedicine, and clinical effectiveness research, for example, despite the good they could do.

Unorganized Latent Majority Interests

Great models exist of better care at lower cost in the United States and abroad. One example is the "Nuka" system of comprehensive, population-based care for Alaska Natives in Anchorage. Nuka, in fewer than 6 years, reduced hospital bed-days by 53%, emergency department visits by 50%, specialty visits by 65%, and primary care visits by 20%, while achieving high levels of quality of care, patient satisfaction, and staff satisfaction.³ If a model of care like Nuka were to become the norm in the United States, patients, families, wage earners, employers, and governments would all benefit. Yet this common self-interest does not convert into a political force of the majority who would gain from change. The better-organized interests of the few, for whom the present is just fine, win.

The Silence of Professions

Few lobbyists in Washington are more powerful than organized medicine and organized hospitals. Were they to demand a new health care system, they would prevail. But their agendas, mostly, are not yet about change; they are about surviving the current storm. The primary political goals of organized medicine, for example, over the

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past few years have been restoring physician payment levels and reforming the malpractice liability system. Both are worthy aims, but they have little to do with fundamentally reshaping care. The hospital industry has focused largely on shoring up hospital payment levels, not on building the “Nuka-like” care that reduces dependence on hospitals.

Suspicion of Science

Using science to inform clinical decisions is far better than not. Yet public trust in science is eroding, and not just in health care.⁴ Many in the lay public are concerned that appeals to science are elitist, and may lead to rationing. Politics exploits the fear, and, thus, proposals to link, say, Medicare payment to the best evidence of comparative effectiveness are dead on arrival.

Duality of Self-interest

Recent job growth in the United States has stalled, with the glaring exception of the health care industry. Between 2007 and 2012, non-health care employment declined 4.2%, whereas health care employment increased 10.5%.⁵ However, better care at lower cost means, in the end, less money for the health care industry, which would slow its job growth. Economists point out that jobs based on waste are not favorable to the economy,⁶ but the case for preserving health care jobs is difficult to resist.

Ambivalence About Federalism

Local, state, and national governments all affect health care. For instance, the safety net for the poor tends to be based in communities and states, whereas Medicare is, of course, national. Because of this chimeric structure, almost any proposal for federal action as ambitious as the ACA exposes ambivalence about federalism making the politics of reform contentious. For example, there is chaotic variation among states in how Medicaid expansion and exchanges will coordinate enrollment processes under the ACA.

Ambivalence About the Poor

In any nation, poor people tend to be sicker, and sick people tend to be poorer.⁷ Therefore, any policy that extends insurance coverage to previously uninsured low-income populations is likely to in-

crease actuarial costs for the well and nonpoor. The arguments for doing so are not only moral, they are financial, because uninsured low-income people will likely incur higher downstream costs borne by communities. Nevertheless, the nation remains divided in its views of how much, and in what ways, disadvantaged populations ought to receive public support.⁸

What to Do?

Despite this disarray, the pathway to better care at lower cost remains open. The best remedy for toxic politics would be unprecedented professional mobilization, recruiting unprecedented public support for new health care. The battlefields of Washington cannot offer the vision, but professions in partnership with those they serve can.

Leaders from organizations of physicians, nurses, hospitals, integrated systems, and patient and family advocates should jointly establish and promulgate bold, quantitative goals for cost and outcomes for the US health care system, such as these: total costs—as reflected in health care premiums—should decrease to and be stabilized at 15% of the gross domestic product without a single instance of harm to patients over the next decade, while the United States should climb in the same period from its low position in value by Organisation for Economic Co-operation and Development metrics to 1 of the top 5 health care systems in the world.

The same leaders should call for an end to fee-for-service payment as the mainstay of US health care financing and explain why to the public. Only integrated care, supported by integrated payment, can pave the way toward better outcomes at lower cost.

Leaders should embrace and model total transparency about costs, quality of care, and outcomes, for both the public and private sector.

The ACA has begun the most significant tectonic shift in the nation's health care since Medicare and Medicaid arrived in 1965. Professionals have an opportunity to guide this country out of the battleground and into the creativity needed.⁹ The toxins of politics have only one effective antidote: the memory of the shared purpose of care, which is to heal. The needs of the patient come first. That is the guidepost to success for a nation whose vision is clouded at the moment by the fog of conflict.

ARTICLE INFORMATION

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