

THE UNFINISHED BUSINESS OF THE BABY BOOM GENERATION

An introduction by John Kitzhaber, MD

Since I left office in 2003 I have focused much of my energy on the growing crisis in the U.S. health care system which I believe has become the single most pressing domestic challenge we face – not just because of the growing number of people who lack timely access to needed medical care – but because of the opportunity costs involved with spending an ever growing portion of our public resources on this one sector alone.

Since 2003, for example, the cost of Medicaid has begun to exceed the cost of primary and secondary education as the single largest item in many state budgets. This means that as the cost of health care continues to escalate it will increasingly compromise the ability of states to invest in education, housing, infrastructure and other social priorities that are crucial not just to the health of our people, but to the health of our society and our economy as well. I am concerned about the fact that the United States spends more money per capita on health care than any other nation in the world yet we rank 44th among other nations in infant mortality and 36th in overall life expectancy.

I am concerned about employers who offer coverage through the workplace – and who are being put at a significant competitive disadvantage with businesses in other countries not burdened by the spiraling cost of health care. For example, over \$1,500 of the price every car produced by GM is directly attributable to health care cost; for Toyota the comparable cost is less than \$100.

I am concerned about the sobering implications of this crisis on the future our society; on the fiscal stability of our nation; and particularly on the kind of world we are leaving to our children, by those of us who were born into the Baby Boom Generation (30 percent of the U.S population born between 1946 and 1964). Most are the children of those who weathered the Great Depression; served in the Second World War or who helped rebuild the world in its aftermath.

Not only did they win the war but they built our system of higher education, created the interstate highway system and the transmission grid. They went to the moon, cured polio, eradicated smallpox and put in place the great social programs of the 20th century – Social Security, the GI Bill, Medicare and Medicaid. As a result, our generation, the Baby Boom generation, has enjoyed more promise and more opportunity than any other generation in the history of our nation.

We must think for just a moment about what *our* legacy is going to be, about the kind of world we are leaving to our children and grandchildren. On our current trajectory it is not a pretty picture – one which poses a glaring contradiction between what we *say* we want for our children and what we are actually leaving through the decisions we are making today.

Consider the fact that last year, the United States Congress – faced with cutting entitlement programs in an election year or breaking the law – voted to raise the statutory debt ceiling to accommodate our \$9 trillion national debt. Just two months ago the debt ceiling was raised again, this time to accommodate \$10 trillion of debt.

Do you have any idea how much a trillion dollars is? The number is so staggering that it is difficult to comprehend without some frame of reference. A *million* seconds ago was last week. A *billion* seconds ago, Richard Nixon resigned the presidency. A *trillion* seconds ago was 30,000 BC, and early humans were using stone tools. America's national debt is now \$9 trillion, and it's skyrocketing, even as America's population ages.

While the administration and Congress are preoccupied with the solvency of the Social Security system, the real challenge is Medicare. The Social Security gap is around \$5 trillion – but with the retirement of my generation Medicare represents well over \$67 trillion in unfunded entitlements.

And we are financing this huge debt by selling securities to Japan and China and other countries still willing to purchase them, giving huge leverage to some of our major international competitors who at some point may refuse to continue to underwrite U.S. deficit spending precipitating a fiscal crisis of staggering proportions.

Alan Greenspan, the former Chairman of the Federal Reserve Board, touched on this issue in an interview a few months ago in Fortune Magazine. In response to the question “What should we be worried about the most right now in terms of the economy?” he replied:

“Strangely enough, I think it's politics. We have a dysfunctional political system in the sense that there are very serious fiscal problems out there, most importantly [is] Medicare. ...when the baby boom inexorably retires, given existing commitments with respect to Medicare... we either are going to have to raise taxes very sharply or cut benefits by half.

The one thing we can be reasonably sure of is that taxes alone cannot solve the Medicare problem which means that existing benefit levels cannot be sustained. They need to be cut. We know that now. No politician wants to confront this. And this is a very sad event because what's at stake here is the fiscal stability of the American government.

David Walker, comptroller general of the United States and head of the General Accounting Office, in a 60 Minutes Interview last March offered blunter assessment of our current course.

“Any politician who tells you that we can solve our problem without reforming Social Security, Medicare, and Medicaid is not telling you the truth. We have to recognize that this is not just about numbers. We are mortgaging the future of our children and grandchildren at record rates, and that is not only an issue of fiscal irresponsibility, it's an issue of immorality.”

If we fail to address this; if we fail to act boldly, then this *will* be the legacy of our generation. ***We can do better.*** We have been the major beneficiaries of the sacrifices and investment made by our parents -- by the “Greatest Generation.” Now it is our turn to ensure that we leave our children and grandchildren a world not of debt and degradation but a world of promise and opportunity.

How we meet this challenge will be the defining issue of our time. It is the unfinished business of the Baby Boom generation – and it is inescapably intertwined with the crisis in the U.S. health care system.

Executive Summary

Introduction

It has been almost 16 years since the Clinton Administration undertook an effort to reform the U.S. health care system. The dramatic collapse of that effort made federal policy makers shy away from the issue for more than a decade. Over the past several years a number of states – including Massachusetts and California – have stepped up to fill the void left by Congressional inaction. And now, health care reform has once again taken center stage in the upcoming presidential election. It is doubtful, however, that this renewed interest in the plight of the U.S. health care system will lead to meaningful reform and substantive change.

All of the leading presidential candidates have proposals for how to deal with the crisis in our health care system (see Kaiser Family Foundation website which compares the proposals of the presidential candidates proposals <http://www.health08.org/sidebyside.cfm>). The one thing that all of the presidential candidates have in common is a focus on financing and on the insurance system. There are certainly philosophic differences between the approaches being pursued by the various candidates, but they all seek to ensure that everyone has the ability to purchase health insurance coverage. In other words, this is being defined as a financing problem – and the debate involves competing ideologies about who will pay to give the uninsured access to the current system.

But the problem is the system. The problem is not how we pay for health care but rather what we are buying – and how that care is organized and delivered. The problem is within the system itself

Dr. Donald Berwick (founder and CEO of the Institute for Health Care Improvement) has an excellent analogy to explain this by comparing the performance of our health care system to that of a car. He points out that every car has a maximum speed. You can take your car – your new Corvette, your old 1985 Honda Accord, your Prius, your Dodge Ram pick-up, or whatever vehicle you own – out to the Bonneville salt flats and put the pedal to the floor. And each car will eventually reach its maximum speed. If you want it to go faster, what do you do? Do you yell at it? File an incident report? Provide an incentive? No. You either modify the car or you get a different car. The maximum speed is a function built into the car itself.

By the same token the inefficiencies and poor performance of the U.S. health care system are also built into it – they are a function of the system itself and cannot be changed by simply changing the way we pay for it. So until we shift the focus of the debate from how we finance health care to how we can maximize the efficiency and effectiveness of the system through which care is delivered we simply cannot successfully meet the challenge before us.

A “system” by definition, involves a number of interdependent parts. What we refer to as the “health care system” was not designed as a system but rather was accreted over time in pieces

that work pretty much independently of each other. The only real interdependence is how the responsibility to finance care is shifted around from individuals to providers to employers and government and back to individuals again.

Furthermore, our current system evolved around an acute care “infectious disease” model – that is, episodic medical interventions of high intensity. But increasingly, the demands on the system are for the management of chronic conditions – something that will increase dramatically as the population ages. And our system, if you can call it that, is clearly not organized to deal with this reality.

Consider for example, that within the current system, over 45 percent of those with chronic conditions need care that is not delivered and over 22 percent experience a serious medical error. The case-mix adjusted death rates vary by 400 percent among U.S. hospitals and at our 77 top-rated hospitals resource utilization in the last six months of life varies by over 500 percent.

So if we want to meet this challenge we need to start by looking at the system itself and by deciding what we want it to do; defining its purpose. This is the essential first step in meaningful health care reform – agreeing on a shared Vision.

Agreeing on a shared vision, however, is much harder than it sounds because of the sheer number of economic stakeholders in the health care debate, each of which will be affected in some way by any reform strategy. The list is enormous: the uninsured; workers with good employer-sponsored coverage; seniors on Medicare; those with disabilities and other special needs; employers – both large and small, those offering and not offering coverage; doctors, hospitals, nurses and other providers; insurance companies and health plans; the pharmaceutical industry; and medical device manufacturers.

When any proposal to change the system is put on the table each stakeholder does quick mental calculus, and often concludes that moving from the current system to the proposed system would disadvantage them economically. Thus, each of these stakeholders becomes an advocate for or against a proposed vision for a new health care system based on how they think it will impact them economically – particularly in the short term. These competing economic interests are thus able to effectively block any serious consideration of a solution that poses a clear and present danger. They fear that if that particular strategy is even discussed it will legitimize it and thus increase the likelihood that it might actually be adopted.

So how then can we put together the politics of meaningful reform? We need to start by acknowledging a number of facts that have to be put squarely on the table.

First we need to understand and acknowledge that today there are millions of people whose jobs depend on the current dysfunctional structure of the U.S. health care system. One out of every eleven jobs in America is in the health care sector. One out of every seven dollars in our economy is related to health care. Nobody wants to lose their job.

We need to understand and acknowledge that while 16 percent of Americans have no health insurance coverage, 84 percent do. And they are not going to willingly give it up – even if isn't

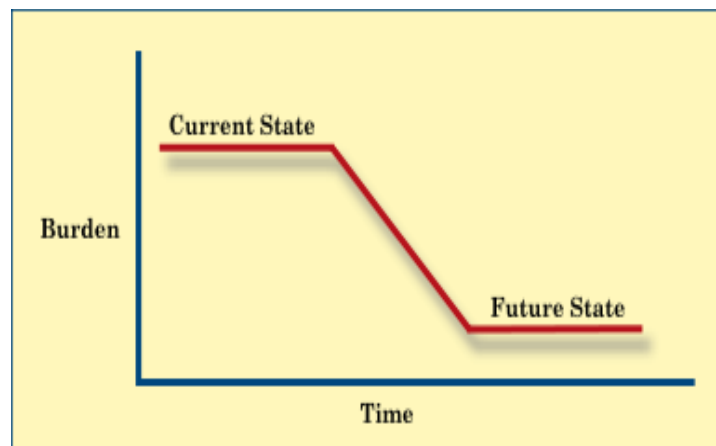
very good – because something is better than nothing. It is human nature to cling to the familiar in the face of the unknown.

We need to understand and acknowledge that there is a lot of trapped equity in the current structure of the U.S. health care system. Hospitals have invested – and continue to invest – in bricks and mortar; in imaging centers, cardiac centers and cancer centers. Many physicians have also invested in technology – in MRIs and in ambulatory surgery centers. Providers are paid well for doing things that may have little population benefit and, in many cases, for which there is little evidence to support their efficacy. Nobody is going to just walk away from all that. It simply is not going to happen.

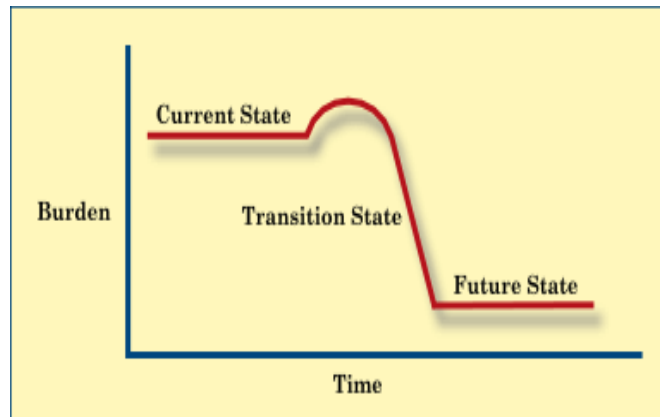
The point is that it is not only politically impossible, it is also economically impossible to move from our current system to a new system overnight no matter who is elected. It will take a decade. So in order to successfully put together the politics of health care reform, we must somehow be able to separate the process of agreeing on the vision – on deciding what the purpose of the health care system should be; and on what we want it to do – from the process of realizing the vision through the political process.

In other words, we need to create a “safe forum” in which we can acknowledge and legitimize the politics and economics of reform and make them explicit. And if we can do that – if we can create this space within which we can agree on where we want to end up – we are then in a position to design a series of incremental steps which, over time, can change the financial incentives to gradually shift the trapped equity in the current system to one that is more effective and efficient, more equitable, more sustainable and more aligned with the long term interests of our country without disrupting either the delivery system or the economy in the process.

Dr. Berwick describes this challenge by comparing the Vision of a new system (the future state) and the current system (current state) with the economic burden on the various stakeholders involved. If we could move from the current state to the future state while reducing economic burden on the stakeholders, the politics would be simple and straightforward. Everyone would win.



The problem is that – because of the significant trapped equity in the way our current system is organized and financed, the economic burden is likely to go up for most stakeholders during the transition period. And, as described earlier, these stakeholders all have a significant influence over the political process and are able individually and/or collectively to block anything that will adversely effect their short term economic interests.



The challenge is to make the politics and the economics of this transition period explicit by starting with an agreement on the future state. This will allow us to move beyond the political gridlock by shifting the focus of our discussion and the focus of our energy away from the narrow debate over how a particular reform strategy will effect a given economic stakeholder to a broader discussion; first, of what we want our health care system to do – what we want it to deliver us as individuals and as a society; and, second of how the economic impact of these changes on any given stakeholder can be mitigated during the transition state. However, without first agreeing on where we want to end up, there is no political pathway by which to get there.

The challenge here is very much like the challenge issued to the nation by President John F. Kennedy in his September 1962 special message to Congress: “I believe that this nation should commit itself to achieving the goal, before this decade is out, of landing a man on the moon and returning him safely to earth.”

When he made that challenge we had no idea how to get to the moon. We didn’t have the tools; we didn’t have the technology; we didn’t have the capacity. But what we did have was a common purpose and a powerful vision – that focused the innovation and the creativity of America to achieve this goal. And just seven years later we achieved it.

Our challenge is to create the same kind of powerful vision and common purpose for the U.S. health care system, something that cannot be done through our current political establishment but only within a separate “safe forum” that engages both citizens and stakeholders in creating the Vision of a more equitable and sustainable system. Accomplishing this will allow us to focus our collective energy; our creativity; and our innovation – through the political process – to make the transition to a new and better future.

The Need for Support

We find ourselves at a pivotal point in the evolution of the Archimedes Movement. During its first year, the Archimedes Movement focused on building capacity at the community level; engaging citizens and stakeholders to develop a shared Vision of a new health care system; discussing the values and principles we wanted such a system to reflect. The resulting consensus around a conceptual framework for a new system – and a way to realize it -- was reflected in SB 27, the Oregon Better Health Act, which was introduced for consideration by the 2007 Oregon Legislature.

Although this legislation was not enacted – in part due to its relatively late introduction into the legislative process – the citizen and stakeholder engagement that took place around it produced the three documents (Statement of Intent, Principles and Framework) which can form an important part of the foundation for developing the shared vision necessary to bring about national reform.

The failure to enact the Oregon Better Health Act, however, has left us without the resources or the capacity needed to proceed with the benefit and system design process that are central to creating a shared Vision of new system.

Next Steps

- **Fundraising**

We are currently engaged in an effort to raise the revenue necessary to put in place the staff and infrastructure needed for continuing to engage people at the grassroots level and for creating the “safe forum” within which to conduct the design process. We are seeking financial support from foundations and from private sources.

- **Grassroots Organization**

To keep our current members engaged and committed and to continue to build the movement we are engaging our chapters in discussing, “truth testing” and refining the three documents which the movement has produced to date: (1) Statement of Intent; (2) Principles; and (3) Framework.

- **Expanding the Movement Beyond Oregon**

We are working to expand the Movement to other states – in particular Washington State and Montana. These two states are targeted because each has senators with membership in the Senate Finance Committee, which is the committee of jurisdiction for health care in the U.S. Senate. Currently both of Oregon’s U.S. senators (Wyden and Smith) and one of Washington’s senators (Cantwell) sit on this committee; and the chairman of the committee is from Montana (Baucus).

- **Website**

We are reworking our website to reflect our shift in focus from political advocacy in Oregon back to grassroots organization and policy development and grassroots organization (in

Oregon and beyond) and to the creation of the “safe forum” within which to build consensus around a shared Vision.

Creating a Safe Forum

The Archimedes Movement is ideally positioned to create the necessary environment and involve the critical players to design the vision that will propel this country toward meaningful reform. The structure to make this possible must have several levels, each with their own important role and a strong set of connections between them in order to maintain the cohesive vision.

- **The Archimedes Council** – will serve an advisory role for the Archimedes Movement. The Board of The Foundation For Medical Excellence (TFME) will have fiduciary responsibility (we operate within TFME’s 501(c)(3)) but the Archimedes Council will provide broad policy direction, review and approve the work of the Community Leadership Council (grassroots side of the organization) and the Vision/Design Council (system design side of the organization). Membership will be diverse (ethnic, gender, geographic) and will include community leaders from business, education, health care and from the faith community.
- **Community Leadership Council** – will serve as the steering and decision making body for the grassroots engagement with leadership nominated through the chapter structure in place across Oregon, and which is poised to expand into other states. Committees will be formed which focus on:
 - Outreach and growing the Movement
 - Fundraising
 - Use of the Internet and maximizing web-based technology
 - Leadership opportunities for community members
 - Speaker’s Bureau
 - Roles and action steps for members and chapters
- **Vision/Design Council** – this will be the body that will produce the Vision for a new health care system. Membership will be no more than 15 and will include:
 - hospital CEOs
 - insurer/health plan CEOs
 - employers
 - physicians
 - consumers

The Vision/Design Council will develop an 18 month work plan to create and refine a shared vision of a new system. The Vision/Design Council will appoint six subcommittees to explore the following issues and make recommendations to the Vision/Design Council:

- Employer Sponsored Coverage/Tax Benefit
- Most Effective and Efficient Delivery Models
- Healthy Behaviors and Individual Responsibility

- Integrating Medical Services with Long Term Care
- Medical Liability/Patient Safety
- Health Information Technology

The Vision/Design Council will provide the specific charge to each subcommittee; approve their work plans; and integrate the work of the subcommittees into the Vision. The Vision/Design Council will send their developing work product to the Archimedes Council and to the chapters through the Community Leadership Council for review and will seek to incorporate this input to ensure broad ownership of the shared Vision.

- The Archimedes Movement administrative staff and the website will provide all necessary communication and interaction opportunities between and among the Archimedes Council, Executive Committee and the grassroots network.