

The Consumer as Captain: New England's Prospects for Health

By Neal Peirce and Curtis Johnson

BY SHEER NUMBERS and fame, New England can be called America's Healthcare Capital. Its world-renowned teaching hospitals -- among them Yale, Dartmouth-Hitchcock, and an astounding 16 located in and around Boston alone -- are just part of a super-cluster of leading physicians and health scientists. Massachusetts is center of the today's future-oriented bioscience universe and produces a third of all FDA-approved new drugs. New England has more of its workforce engaged in health care -- roughly 11 percent -- than any other region of America.

But what about the results? Are New Englanders much healthier than other Americans? Do they -- or their employers -- find their health care more affordable? And are New England states free of spiraling Medicaid costs imperiling state budgets nationwide?

The answers: no, no and no.

Where is the disconnect? All the debate seems focused on connecting people to the medical services systems. Then it shifts to finding ways to control that system's relentless rises in cost. What's rarely debated is how to assure New Englanders better health, for more of their lives.

More spending and more treatment is not making Americans healthier. The U.S. spends more than twice as much per capita on health care as the average of 22 wealthy nations. We invest far more than any other country on doctors, labs, tests, and dispensed medicine. Yet we manage to trail similar countries in health-adjusted life expectancy. Some 100,000 of us die every year from hospital errors.

Surveys show New Englanders eat a little less and exercise a little more than average Americans -- explaining their slightly better health indicators. And if they should require hospital treatment, some of America's best are located there.

Still, the region is plagued with soaring costs and mediocre results. Don Berwick, a professor at both the Harvard Medical and Public Health schools, says consistently there's so much confusion, danger, waste, and arrogance in America's healthcare system that the only way to save it is to blow it up first.

That may be an extreme view, but Dr. Berwick is not alone. The system, say such critics as Dr. John Abramson of Harvard Medical School, is failing patients -- its consumers. The driving force has become financial return for medical professionals and companies that make their living off drugs and treatment. "Doing a lot of cardiac procedures brings both prestige and income," says Dr. Abramson, "while those funds are denied to more upstream solutions like good pre-natal care, or interventions to eliminate tobacco use, or increase exercise and improve diets."

There's clear evidence that the major chronic diseases of our time -- heart disease, stroke, diabetes and many cancers -- are largely preventable by smart diet, regular exercise, moderation in alcohol consumption and not smoking. Indeed, 70 percent of health

third of the population suffering from a chronic illness that's not fixable."

Today, NEHI's CEO Wendy Everett candidly told us, upwards of 90 percent of all the healthcare dollars go to expensive hospital diagnosis, treatment, and surgical procedures -- not prevention and public health.

Sidebar Articles

The Patient as Partner (Page 3)
Better Health -- from the Grassroots Up? (Page 3)

What's the effect of all that spending? Better health outcomes? Not according to data painstakingly compiled by Dartmouth Medical School professors Jack Wennberg and Elliott Fisher. Their long study of the medical treatment of senior citizens all over the U.S. shows that the more expensive and extensive care often turns out to be worse care.

Why is that?

The system is built on perverse economics. Explains Everett, "We rarely pay people to pay attention to managing our illness; so who's supposed to check to see that you're using that home monitor to regulate your insulin levels?" But Everett notes somebody will get paid if a toe or leg has to be amputated. "The trouble is that the economic benefits of real health-improving innovations don't get distributed in a way that creates incentives for change." No one's paid to talk you out of smoking; but money is reserved for heroic efforts to stem the eventual lung cancer with chemotherapy and radiation.

Doctors doing basic care are also paid substantially less than specialists who provide the most expensive procedures. One result: a chronic shortage of primary care physicians, the "family docs" who may tap specialists from time to time but maintain a long-term understanding of their patients, providing the indispensable "human touch." Today, the American College of Physicians warns, the number of primary care physicians is plummeting under pressures of schedules, insurers and less income than the specialists can command. And there's a parallel, serious shortage of practitioner nurses -- medical care professionals able to handle many cases, at substantially lower cost than physicians.



According to NEHI's CEO Dr. Wendy Everett, upwards of 90 percent of all the healthcare dollars go to expensive hospital diagnosis, treatment, and surgical procedures -- not prevention and public health.

outcomes are directly connected to lifestyle and environmental decisions, says the highly respected New England Healthcare Institute (NEHI). Add in the right use of primary care, early intervention and aggressive public health programs, and we'd no longer end up -- as Dr. Jim Squires of the New Hampshire-based Endowment for Health notes -- "with about a

So powerful is the money in today's system that a large number of community hospitals that produce quality service at lower costs are dissolving into large hospital firms or disappearing altogether. In many cases, a patient needing medical attention would get safer and more effective treatment at one of these smaller facilities, but how would any patient know?

Comparisons between hospitals and their quality of care are starting to show up on the Internet (example: www.healthgrades.com), but most of the data is still largely protected from public view or just plain too bewildering to understand. And when sick or injured, who's in the mood for slow contemplation of hospital outcomes data?

Meanwhile, the entire system soaks in commercial incentives and misleading commercials for drugs, claims Abramson. "We talk about giving patients good information. I question whether most doctors have good information." Author of *Overdo\$ed America*, Abramson's convinced that financial incentives have seriously compromised medical education and practice guidelines – even the independence of the Food and Drug Administration. Notice, he says, that MRI tests are now advertised during telecast football games.

If there's any consensus on changes to be made to the system, it's that good, solid, reliable information is the foundation to build on. Pressure is on to computerize all individual medical records and while keeping them private, make them portable. And to use information technology to catalog tests and treatments that actually perform best – something called "evidence-based medicine," a particularly powerful tool if both medical professionals and patients are kept in the information loop.

To get everyone in the loop, the Rhode Island Quality Institute is linking all the healthcare providers, insurers and governments together around providing and coordinating the spread and use of better information. What might this effort mean? We could avoid "the needless repetition of tests...and get to a system all the doctors and clinics and hospitals can access," says Dr. Pablo Rodriguez, associate chief of obstetrics and gynecology at Women and Infants Hospital in Providence. This winter, Rhode Island's Gov. Don Carcieri weighed in with his support by investing \$20 million to accelerate the information system, believing it will, among other things, reduce costs.

Using information to improve quality is also on the agenda of every major New England health plan. Charles Baker, CEO of Harvard Pilgrim Health Care, told us: "The demand for better performance will have enormous impact on a medical guild that hasn't focused in a systemic way on differences in health outcomes. The genie is out of the bottle now. It just needs to be better fed."

How could New England feed this genie? First, a fierce focus on changing the system's backwards incentives. There must be ruthless

calculation of which procedures actually pay off in better health. One or more health plans could lead – re-engineering their award systems to compensate only medically proven best practice choices, ones with a track record of actually improving patients' health.

Would that kind of reform be difficult? Yes! In a medical system encrusted with familiar approaches, encumbered with lofty egos, it would be much more difficult than rocket science. But if innovation, leading, are what New England's all about, there's never been a greater need.

To improve access to healthcare, Providence's Rodriguez suggests New England states could work together to clear paperwork and create

Taking these steps require states to collaborate to get to scale that matters, and to line up political support. And it will require the kind of passion that former Maine legislator Sharon Treat has shown in taking her campaign for affordable prescription drugs national.

The alternative: watching the slow-motion reel of an inevitable train wreck. Health care imperils everyone's budget. Employers that can are ducking out from providing medical coverage. And, as Theresa Alberghini DiPalma of Vermont's Fletcher Allen Health Care Center puts it, "Medicaid is on a course to swallow the rest of state government." The system is simply not sustainable.

Medical system changes, however, won't achieve much unless accompanied by a major shift in personal lifestyles. Arkansas' Gov. Mike Huckabee found that out when he shed 110 pounds after being told he had type II diabetes and would probably be dead in a decade. Huckabee launched a campaign for a healthier Arkansas, including school tests so all parents know about their children's body mass, curbing sugar-laden drinks in schools, and food stamps accorded more value when they're used to buy fruits and vegetables.

While each of the New England states may have some elements of an Arkansas-like plan in place, couldn't the states together do it even better? Imagine a coalition of its distinguished public health departments, hospitals, universities, businesses, sports leaders and the region's media -- united in defining agendas for better health, demanding more rigorous exercise and nutrition standards in schools, pushing for walkable environments, crusading

against smoking and substance abuse, and helping low-income immigrant workers in hospitals and other service industries make a successful transition away from fast-food, fat-heavy, high-temptation America.

And why stop there? Earlier articles in this New England Futures series might have also been labeled as "health" stories. When we extolled the New England town with its walkable centers and neighborhood sidewalks, we were showcasing the region's legacy assets for a healthier way of living. When we argued for a diverse energy strategy, and a transportation network that could result in a lower dose of petro-particulates in the air New Englanders breathe. And we've suggested that locally grown, natural foods – in strong demand by students at Yale and other universities across the region – are a path to a healthier diet and economy.

It's time to connect those dots. And maybe it's time to resurrect the ethos of the sturdy New Englanders of past times, who weathered raging blizzards, storms at sea, thin soils and the challenge of farming on rocky hillsides. People trim, creative, resilient, triumphant. Captains of their own health. Why not again?

TOP TEN RANKING: Health Care Workers as a Percentage of Total Workforce

Rank	State	Percentage of Workforce
1	Rhode Island	12.55%
2	Maine	12.25%
3	Pennsylvania	12.04%
4	North Dakota	11.80%
5	West Virginia	11.72%
6	Massachusetts	11.64%
7	South Dakota	11.31%
8	Connecticut	11.15%
9	Vermont	10.88%
10	New York	10.64%
23	New Hampshire	9.08%

Source: Federal Reserve Bank of Boston, based on U.S. Bureau of Labor Statistics -- State and Area Employment Statistics.

cross-state licensure for medical professionals. Why not also add in inducements to encourage more physicians and nurses into the dwindling primary care practice?

If federal Medicare and Medicaid waivers are warranted, it's time to use the collective clout of the region's 12 U.S. Senators and House delegation. New Hampshire's Sen. Judd Gregg chairs the Senate Budget Committee. Rep. Nancy Johnson of Connecticut is the lead Republican chair on health care policy for the Ways and Means committee.

Governors should turn crisis into opportunity and seek federal government waivers to mix Medicaid funds with their own programs in order to cover people caught in the gap between employer-based insurance and Medicaid. New England would have the money to work on raising quality care while slowing down cost increases, expanding coverage and investing in community-based health programs that pay off in a healthier population. A new emphasis on primary care could be part of the mix. Let New England prove Americans can be both patients and consumers if treated with dignity and shown honest information about the likely consequences of various treatments. And that the region has the courage to lead the nation in critical reform.

The Patient as Partner

By Neal Peirce and Curtis Johnson

No one welcomes serious illness or injury, but when it happens, you'd be fortunate to be close to Griffin Hospital, set in a middle-class neighborhood of Derby, Conn., just 12 miles west of New Haven. Walk in the door and you meet culture shock -- not the familiar white plaster and steel sheathing of Medical America, but warm wood colors and carpeted floors. Quickly it's clear the difference isn't just cosmetic. This 160-bed community hospital focuses on a healing strategy made possible by medical professionals sharing responsibility with patients.

Most hospitals are designed around the presumed professional preferences of the doctors and nurses who do the work. Not Griffin. It's a welcoming place, tastefully lit, with an open library full of medical information, and rooms that feel more like bedrooms than hospital wards. Scary medical equipment is confined to back corridors. Those large nursing station fortresses are dissolved into desks distributed so every patient sees a nurse through the door.

Visiting hours are 24/7. Even the family dog's welcome, if that lifts the spirits of the sick. There are overnight rooms for family and close friends that the Ritz-Carlton would be proud of; sleeper sofas added to lounges, and small kitchens where a family can cook a dinner.

All that is different enough. But here's the transformative turn that Griffin made in the road. Bill Powanda, vice president of the hospital and a former state senator, defines it as trust and responsibility. He enthusiastically describes how patients respond when their medical charts are written in plain English and kept within eyesight.

This kind of institutional behavior turns conventional medical practice on its head. Haven't we heard for generations -- doctors know best?

Well, sometimes, but not always and not alone. In many cases, doctors make decisions about procedures or medications knowing less about the odds of success than major college football coaches know about the likely outcome of any

play they run. The Griffin practice, by contrast, is to check first for proven best practices, applied for suitability with any given patient. There are small conference settings spread around the halls, where it's typical to see several doctors and nurses conferring on a case -- and as often as possible with the patient. The hospital provides patients and families with choices of different diagnostic tests, complete with the odds of getting a correct diagnosis and of experiencing bad side-effects.

healthcare rating company, this year named Griffin in the top 5 percent of hospitals nationally for clinical excellence.

The Griffin way is spreading through a national Planetree Alliance of like-minded patient-centered hospitals that Griffin leads. Others in New England include Berkshire Medical Center (Pittsfield), Martha's Vineyard (Oak Bluff, Mass.), Stamford (Connecticut) Hospital, Copley (Morrisville, Vt.), and the Bishop Wicke Health Center (Shelton, Connecticut).



Griffin Hospital, in Derby, CT, has received national recognition and acclaim for creating a facility and approach to patient care responsive to the needs of patients.

Interestingly, none of New England's famed big medical hospitals, known for their highly specialized faculties, have yet joined the alliance (though New York's prestigious Presbyterian Hospital has). The omission is worrisome, since the Griffin/Planetree model could be part of the path to a better health care system. Like famed institutions, Planetree hospitals seek to respond and operate on proven best medical practices, and they're on board with recent years' push to avoid errors by creating, storing and then being able to access accurate, extensive electronic records on each patient. But they go the critical step further to involve patients early and consistently in decisions about their treatment options.

That's not to say top-drawer institutions aren't making some parallel moves. Take Dartmouth-Hitchcock. There, a patient with a back problem watches a 45-minute video in the Center for Shared Decision-Making. Often for the first time, he or she sees the significant odds that surgery is not likely to be more effective than a combination of physical therapy and medications. Decisions against surgery are then 30 percent higher than in traditional consultations with a physician. With spinal surgery costs ranging upwards of \$70,000, the potential savings are immense.

Choosing surgery might be profitable for the medical center, but Dartmouth-Hitchcock sees value in changing the relationship between doctors and patients. One has to wonder: Couldn't this become the New England norm, not the exception?

This open, shared system works, says hospital CEO Patrick Charmel, adding: "We get very high ratings from patients. Our costs are lower because we don't do unnecessary tests and treatments, we don't make as many errors, so our malpractice insurance doesn't cost as much."

The Griffin formula of collaborating rather than dictating, and putting the patient's experience first, is not every physician's preference. "Some docs left us," admits Powanda. But the staff is enthusiastically signed on; in fact, Fortune magazine has listed Griffin as one of the "100 Best Companies to Work for in America" for six years running, with a ranking of fourth in 2006. HealthGrades, the leading independent

Better Health -- from the Grassroots Up?

By Neal Peirce and Curtis Johnson

Can better health for New Englanders bubble up from the grassroots, community levels-- rather than from organized medicine?

Check with David Weed, the psychologist who helped to spark creation of Partners for a Healthy Community in Fall River, Mass., and that's precisely the conclusion you reach.

Fall River's need is crystal clear. Once a prospering "needle trade" city, it suffered a body blow from flight of textiles to the South. Present-day Fall River is still plagued by high unemployment, high poverty, a negative self-image, and Massachusetts's third highest heart attack rate, third highest asthma rate and high and rising levels of obesity and diabetes.

But Weed and his allies perceived other potentials -- volunteer interest, a great place to raise a family, and a passion for kids doing sports -- not just watching. From the mid-'90s on they asked city government to start a "healthy city" organization, akin to movements sprouting in cities across the U.S. In 2003, on the occasion of Fall River's 200th anniversary, Mayor Edward Lambert agreed and Fall River's

Partners for a Healthy City Fall River was launched.

Today, Fall River is the poster child of healthy community efforts supported by Massachusetts' Department of Public Health. To start, over 1,000 residents participated in visioning sessions to select Fall Rivers' top goals -- safety and reducing substance abuse, the environment, recreation and health education topping the list. So far some 98 supporting activities have been identified, many helped by \$500 "micro-grants" to get neighborhood initiatives rolling.

The main focus, says Weed, isn't on such targeted health activities as blood pressure screening or smoking cessation. Instead, it's to connect to and expand Fall River's often unheralded asset base. Under the media radar, the Police Athletic League was running a floor hockey league with several hundred children, boys and girls, ages 6 to 16, involved four nights a week and Saturdays in vigorous physical activity. Healthy Communities celebrated that effort. When the local diabetes association wanted to get adults into more physical activity, Healthy Communities supported a popular ballroom dancing teaching effort.

Coalitions and partnerships are the name of the game, says Weed: "Other than drug dealers and fast food restaurants, there's practically no organization we aren't open to working with."

One major target: getting local high schools to think beyond team sports to focus on life-long health practices for all students, including a cardiovascular assessment of all sophomores with recommendations on how to improve their numbers. Team sports obsession is dangerous, says Weed: "You can easily end up with a few dozen players working out hard while 90 percent of kids pork up on soda while watching the games."

A quick glance across New England reveals a variety of standout healthy community programs. Vermont's five-year-old Champlain Initiative is pledged to "bend" back such unhealthy trends as disturbing local levels of obesity, poor nutrition and eating habits and sedentary lifestyles -- critical factors in high local levels of



Photo: David Weed, Fall River Healthy City Coordinator

The Healthy City Fall River initiative engages local citizens in healthy activity designed to improve the quality of life in the city.

diabetes and heart disease. The Franklin Community Health Network, in one of Maine's most depressed rural counties, has focused hard on anti-smoking efforts (especially among young mothers and families) and now can claim Maine's lowest smoking rate.

Connecticut reports strong initiatives in such communities as New London, Meriden, Bridgeport, New Haven and Danbury. "Healthy Valley 2000," a program coordinated by Griffin Hospital to enhance health across the six-town Naugatuck Valley, led to the valley winning one of the ten highly-coveted All-America City awards from the National Civic League in 2000.

New Hampshire's Foundation for Healthy Communities has initiated a "Walk NH" program to encourage kids 6 to 12 to walk the equivalent of the state's length (190 miles) or width (70 miles) as a way to get in shape for life, an antidote to the sedentary pastimes of TV, video games or Internet surfing. Rhode Island has an Initiative for Healthy Eating and Active Living designed to cut back sharply on the 56 percent of Rhode Islanders reported overweight or obese.

Across the region, interest in farmers' markets and locally grown fresh foods is mounting. Former Massachusetts Agriculture Secretary Gus Schumacher spots a promising trend in new prepaid contracts between local farmers and schools, universities, hospitals, government cafeterias and restaurants -- a way to deliver economic security to imperiled small producers.

Healthy communities initiatives across the country embrace all these trends-- exercise, healthier foods, civic activity, and replanning towns and regions for enhanced walking opportunities. Rare is the New England community in which at least one effort isn't underway.

But is it all enough? David Weed worries not: "Too many of us still don't have a good conception of what good prevention is all about. We look toward the experts to 'fix' things. We're good at 'fixes.' But so good the health system is costing 14 percent of our gross national product. The trends are killing us -- financially, and literally."

The answer? Partly, Weed agrees, it's better personal health decisions. But without civic involvement, building on community assets, he suggests, we'll never succeed

About the Writers and the Project

Journalists Neal Peirce and Curtis Johnson have reported for newspapers on the unique strategic issues facing two dozen metropolitan regions nationwide. Peirce is a syndicated columnist (Washington Post Writers Group) who has also written two books on New England. Johnson is a public policy analyst and a former community college president and Minnesota government official. They co-authored the book *Citistates*.

These articles are the kickoff of a New England Futures Project aimed at identifying key 21st century challenges facing the six-state region. Citizen reaction and participation, leading to a shared regional agenda, are key to the project. Your input is welcome at www.newenglandfutures.org.

To find out more, contact:

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INSTITUTE for SUSTAINABLE COMMUNITIES

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Journalists Curtis Johnson (left) and Neal Peirce, are co-authors of the "New England: New Century - New Game" series.