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A rally outside the Supreme Court during Florida v. HHS, which challenged the Affordable Care Act. Photo courtesy of Health Care for America Now (HCAN).

Towards Transformative Change in Health Care: An Update

By Terri Langston and Jennifer Ng'andu

EVERYTHING

What's going on now with health reform? There's a simple, one-word answer: "Everything." When Dr. Don Berwick asked Göran Henrik how Jönköping County in Sweden was improving total health system performance, he answered, "Here's the secret: We do everything."[1] In the United States as well, that's what is required and that is what is largely happening. Space prohibits covering "everything" in this article; however, we will highlight a few broad areas of work as we enter year three of the Affordable Care Act (ACA) implementation and then reiterate five critical principles that must underlie the work of philanthropies.

GOVERNMENT

As has often been said in recent months, health reform has much to do with the role of government. No less than stellar service can characterize the work performed by the staffs at the Department of Health and Human Services and the Centers for Medicare and Medicaid Services. Recent evidence includes the 644 pages comprising the final rule on health insurance exchanges (the state "marketplaces" for millions of Americans in the individual and small group markets). CMS received and reviewed more than 25,000 public comments about the preliminary ruling. CMS considers its rule a "blueprint" for establishing exchanges and leaves the states much flexibility. Both consumer representation and prohibitions on conflicts of interest are parts of the governance provisions, and "Qualified Health Plans" must have an adequate number of community (*continued on page 9*)

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Health Care Reform

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providers, including specialists in mental health and substance abuse. Some state governments are well into the arduous planning process for creating their exchanges.

Another rule enables more eligible people to enroll in Medicaid and the Children's Health Insurance Program by simplifying procedures and coordinating with the exchanges. Medicare is demonstrating savings for its beneficiaries, particularly in prescription drug costs. The program forms the basis for important experiments in raising the quality and lowering the costs of care by working toward seamless transitions from hospital to other providers and to home, by reducing medical errors and by avoiding re-hospitalizations.

Regulations on women's preventive care without co-pays and prohibition of gender discrimination in pricing will bring long-sought health care justice to women. Those who have young adult children needing insurance can extend their coverage to age 26. Finally, the Center for Medicare and Medicaid Innovation spawns new ways to tackle old and pressing problems, such as reducing preterm births and improving outcomes for newborns and pregnant women. The Federal Coordinated Health Care Office (the Medicare – Medicaid Coordination Office) works to align the two programs and create efficiencies for a population in great need whose costs are very high.

The Congressional Budget Office updated its cost estimates for parts of the ACA in March, and determined that costs for full implementation would be 8 percent (or about $50 billion) less than estimated one year ago. Detractors have taken largely ideological stances against one provision of the ACA, the Independent Payment Advisory Board (IPAB), created to slow the growth of Medicare. CBO estimates that repealing the board would increase federal spending on Medicare by more than $3 billion over a decade.

LOCAL SOLUTIONS – NATIONAL IMPACT

February saw the premiere of T.R. Reid's "U.S. Health Care – The Good News," a PBS special also available online. From New Hampshire to Colorado to Seattle, providers, stakeholders and community people of all sorts are changing health care, mostly for the better. These efforts manifest different approaches; nevertheless, most are geared toward better health care for the individual, better overall health status for the population, and lower costs (variously known as "The Three Part Aim" or the "Triple Aim" – or some might say, good sense). Some start with community health needs assessments and health partnerships on a community-wide basis, like ThedaCare health system in northeast Wisconsin or Mt. Ascutney Hospital and Health Center in Windsor, Vt. Others focus on "small tests of change" with smaller groups, like the Primary Care Coalition's Diabetic Patients' Wellness Circles that have brought health improvement to Latino women in Montgomery County, Md. To test a basic premise of the ACA, Virginia Commonwealth University studied a cohort of uninsured, low-income people enrolled in a community-based primary care program for three years. Inpatient costs fell each year, as did emergency department visits, and costs per year per patient fell from $8,899 to $4,569.[2] Easy as it may sound, this is extremely hard work: our health system does not make it easy to align high quality with lower costs, but the work in communities is promising.

EQUITY – THE SOCIAL JUSTICE ASPECT OF HEALTH

The theme of the Grantmakers in Health (GIH) annual meeting in March 2012 was "Health and Equity for All". In an essay for the conference, GIH noted: "Key to the concept of health equity is the principle that all population groups should have an equal opportunity to be healthy, regardless of their relative social advantages and disadvantages."[3] Small, medium and large foundations are working to address the "upstream" factors in health conditions as well as the social determinants of health. Those foundations that have had the hard conversations and developed the strategies afford examples to others, for the gaps in equity are so wide that it is impossible to do too much in this area:

> *Con Alma Health Foundation (CAHF) was founded 10 years ago based on a health equity framework before the term 'health equity' became 'cool.' Our founders knew: There is more to good health than lifestyle choices, genes and access to health care. Individual health is often seen as a person's own responsibility to make the right choices to stay healthy. But … the choices we make are limited by the choices we have.*[4]

With coverage expansions, emphases on prevention and chronic diseases, diversification and expansion in the health professions, and the requirement to collect data on quality performance measures by race, ethnicity, primary language and other demographic data, the ACA offers a platform and support for communities addressing our greatest moral challenge in the field of health justice. It requires a commitment to enter implementation with the will to overhaul long-term, systemic ills in health care, rather than simply establishing new coverage pipelines on the pathway to the same inequity.

As the nation shapes new standards on prevention and quality, it is imperative that we seek not only to improve the experience of the average patient, but also to address what keeps the vulnerable in that space. The answer to another question will also deepen the progress on health disparities: Will promising ACA policies be backed by an equal budgetary investment that is needed to establish many of the programs that make equity real?

POTUS - SCOTUS

Even amidst such important challenges of health and health justice, the ideological warfare goes on, involving Supreme Court challenges to the ACA, referred to by opponents and supporters alike as "Obamacare." Wendell Potter of the Center for Public Integrity and MSNBC wrote of the great irony that the 56-year-old owner of an automobile repair shop in Florida, handpicked by the National Federation of Independent Business to lend her name to its lawsuit challenging the ACA, had to file bankruptcy largely because of health care debt.[5] She would have stood to benefit from the immediate aspects of the law afforded to those with serious health challenges. Come 2014, she also would have had protections from financial hardship and more options for her business.

It's sad and ironic that the ACA, the best attempt in the nation's history to address health and health care, is the target of ideological attacks. Such events, however, can bring out the best in some: at least three prominent conservative judges have spoken out in favor of upholding the law, most recently, Judge J. Harvie Wilkinson who holds that striking down the ACA would be a "prescription for economic chaos."[6] The people are divided, yet seem to be so less as a matter of health care substance than as a matter of their own discontent with the course of their lives, the course of the country and their ideological predilections.[7] It behooves us to remember that the now popular and seemingly indispensable Social Security and Medicare also had largely negative receptions in the early years of their existence.

THE CONTINUING ROLE OF PHILANTHROPY

The abiding freedom that foundations have to influence their communities and their nation requires that they listen. Recently, Alan Weil of the National Association of State Health Policy challenged health foundation staffs and trustees to do what they are requiring of the health system and its people: to lead by example.

Dr. Berwick, who calls the Affordable Care Act a "majestic" law, recommends five principles for us all to follow:

1. Put the patient first.
2. Among patients, put the poor and disadvantaged first.
3. Start at scale. There is no time for timidity.
4. Return the money. Success will not be in our hands unless and until the parties burdened by health care costs feel that burden to be lighter.
5. Act locally. The moment has arrived for every state, community, organization and profession to act. We need mobilization – nothing less.[8]

Those principles can guide philanthropy's role in reform. Ultimately, to encourage the behavior that is desired from patients, we must exhibit the commitment to support systems that are designed with their needs in mind, particularly the needs of every marginalized community. Addressing the populations with the most significant obstacles will help everyone gain better access, not to mention promoting inclusion across the system.

We must also learn from past efforts to create widespread impact. Inclusion and impact may be the most important cost saving mechanisms in health reform implementation. Instead of retrofitting old programs or creating what is good enough with intentions to "fix it later," we should contemplate what would truly effect change in the health care system and in communities. This means carving out spaces for collaboration and coordination where there were none before and supporting deliberate and diligent efforts to bring diverse voices to the decision-making table.

Yes, it's about government and it's about each of us, in each of our places throughout the country. ■

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Notes

1. Dr. Donald M. Berwick Keynote Presentation, IHI 23rd Annual National Forum on Quality Improvement in Health Care, December 7, 2011.
2. Cathy J. Bradley et al. *Lessons for Coverage Expansion: A Virginia Primary Care Program for the Uninsured Reduced Utilization and Cut Costs*, vol. 31, no. 2, 350–359, February 2012.
3. P. Braveman and S. Gruskin, quoted by Grantmakers in Health, "Health + Equity for All." March 2012.
4. Dolores E. Roybal "A Roadmap for Health Equity"(Washington, D.C.: Grantmakers in Health, March 2012).
5. Wendell Potter, "How We All Got Stuck Paying the Medical Bills of the Woman Who Sued to Kill Obamacare," *Huffington Post*, http://www.huffingtonpost.com/wendell-potter/how-we-all-got-stuck-payi_b_1338561.html.
6. Ian Milhiser, "Bush SCOTUS Finalist: Striking Down Health Reform 'Is a Prescription for Economic Chaos,'" *Think Progress*, March 13, 2012.
7. Drew Altman, "The ACA and Fluoridation: The Power of Political Symbols," *Pulling it Together*, http://www.kff.org/pullingittogether/altman_aca_flouridation.cfm.
8. Berwick, op cit., p. 22.