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Access is not enough. *Health insurance must be accessible and affordable for all Americans not only because it is socially just but also because it will help our country achieve a system that is effective and efficient. Insurance for all is essential so that more care is provided at earlier stages, when it is most effective and least costly. But we can't stop there. Access alone will not drive the improvements needed to increase safety, reduce waste, enable coordination and promote quality. Consider, too, that in recent years nearly 40 percent of insured Americans reported having trouble getting the care they needed. Providing access to all without a greater focus on prevention and significant improvements in the delivery and value of care is simply not affordable or sustainable.*

Insurance for all is essential because today's lack of access to preventive and early stage care drives up costs in the United States Many people present for care at the later stages of disease that are more difficult to treat effectively and more expensive than those diagnosed earlier. People also present in the most expensive settings (emergency rooms) because they lack other access to care. Insurance for all that provides access to preventive and early stage care will improve efficiency. It will also make every patient a paying customer. The focus can move away from shifting cost burdens to someone else, to the truly important efforts of enabling health and improving care.

But today, many Americans still face obstacles in receiving quality care, regardless of insurance status. Thirty-eight percent of insured individuals reported that they or a family member had problems accessing health care.[1] A growing number of patients report being unable to schedule timely appointments with their physician, leading to emergency departments' overflow and overuse. Disputes over what insurance covers also undermine actual access. Moreover, access to effective and high quality health care is undermined in today's system by care delivery that lacks coordination, lacks shared information, and has far too many errors and far too much variability in quality. Insurance alone will not fix these fundamental problems.

Americans – young and old – should have the tools they need to become healthier. Affordable, accessible, high-quality health insurance is certainly one of those tools. However, it is only one element of a much larger toolkit. Indeed, insurance for all will drive overall costs up unless we also restructure health care delivery, changing the culture in ways that will drive dramatic and ongoing improvements in health care and in enabling health.

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[1] "Underinsured in America: Is Health Coverage Adequate?" *Kaiser Family Foundation.* Available: http://www.kff.org/uninsured/4060-index.cfm.

Value and quality in care are paramount. *For any solution to have lasting impact, it must drive dramatic improvements in health care and health outcomes while increasing efficiency. The point is not to reduce costs at the expense of health. We need to enable innovations that drive up value to have the best health outcomes for our investment, and that should be our primary measure of value. We must reduce overuse and inappropriate care and deepen investments that truly make a difference to health. The United States already spends more per capita than any other nation — more than we need to — on health care. With proper redesign, we can have better health outcomes, better health for the population as a whole and improved efficiency at the same time. Fundamental improvements in value will be accelerated when doctors, nurses, insurers, researchers, communities and individuals — in a word, everyone — works toward these aims. The goal of improving value aligns everyone's interests.*

The goal of health care reform must be to improve health care value for individuals. This means enabling health and driving dramatic and sustained improvement in health care results. Contrary to popular impression, quality need not drive up costs. The goal of our health care system is not to provide more care, but to provide better health. And better health is often less expensive. There are myriad examples of improvements that would both enhance health *and* reduce spending.[2] In general, preventing the progression of a disease is less costly than the acute treatment of compounding complications. Doing things right the first time avoids the pain and expense of repeat procedures. Avoiding infections speeds recovery and reduces costs. Improving coordination avoids repeated tests and potentially harmful delays in care.

A significant amount of research examining quality has documented the economic and health hazards of poor quality. Indeed, several studies have found increased spending correlated with a lower quality of care.[3] Injuries, unnecessary care and ineffective treatments raise costs without improving health. About 1 million patients per year are injured, but not killed, by medical errors.[4] In addition to the medical expenses, these injuries lead to lost wages and productivity. Almost 30 percent of health care spending (or $40 billion over four years) for Medicare-recipients with chronic conditions may be unnecessary.[5] And only 40 percent of prescription drugs deliver their expected outcome; worse, adverse drug reactions from the ineffective drugs lead to many harmful results.[6] Incorrect diagnoses raise costs and reduce quality by leading to inappropriate or ineffective care. While the incidence of these errors is difficult to track overall, errors of negligence in diagnosis account for 30 to 40 percent of malpractice costs.

Recognizing health care value as paramount aligns the interests of all stakeholders. Achieving better health outcomes is better for patients, less expensive for payers, improves productivity for

[2] M.E. Porter and E.O. Teisberg, *Redefining Health Care* (Boston: Harvard Business School Press, 2006), pages 24-32 and 107-111.
[3] K. Baicker and A. Chandra, "Medicare Spending, The Physician Workforce, and Beneficiaries' Quality of Care," *Health Affairs* Web Exclusive (April 7, 2004): W4-184-197; E.S. Fisher et al., "The Implications of Regional Variations in Medicare Spending, Part 1: The Content, Quality, and Accessibility of Care," *Annals of Internal Medicine* 138, no. 4 (2003a): 273-287; E.S. Fisher et al., "The Implications of Regional Variations in Medicare Spending, Part 2: Health Outcomes and Satisfaction with Care," *Annals of Internal Medicine* 138, no. 4 (2003b):288-298; J.E. Wennberg and M.M. Cooper, eds, *The Dartmouth Atlas of Health Care in the United States* (The Trustees of Dartmouth College, Chicago: AHA Press, 1999), <www.dartmouthatlas.com/atlaslinks/99atlas.php>.
[4] S.N. Weingart, R.M. Wilson, R.W. Gibberd, and B. Harrison, "Epidemiology and Medical Error," *British Medical Journal* 320 (2000): 774-777.
[5] "Executive Summary: The Care of Patients with Severe Chronic Illness: A Report on the Medicare Program by the Dartmouth Atlas Project," Center for the Evaluative Clinical Sciences and the Dartmouth Medical School, May 2006.
[6] C.L. Bennett et al., "Evaluation of Serious Adverse Drug Reactions: A Proactive Pharmacovigilance Program (RADAR) vs Safety Activities Conducted by the Food and Drug Administration and Pharmaceutical Manufacturers," *Archives of Internal Medicine* 167, no. 10 (May 28, 2007): 1041-1049.

employers, takes stress off families, and supports the goals of physicians and other health care professionals. Thus, not only can we afford the pursuit of better health, we can’t afford not to pursue improvements in health care value.

Focus on cultural change. *We haven't paid enough attention to cultural barriers within the health care system to achieving our health care goals. Meaningful reform must address more than the symptoms of a broken system. We must surmount the culture of the current health system that protects the status quo and empower all quarters of our community to produce real change. Health care delivery must be reorganized to suit patients, not the industry. Care should be well coordinated and easy to navigate. Health plans must be refocused on enabling health rather than limiting care. Employers and communities must redirect their efforts toward supporting health. These changes are essential to enable health stewardship and needed improvements in health and health care.*

Successful health system reform depends on one critical factor: the need for a significant shift in our health care culture. Our current culture, which discourages thoughtful resource stewardship, is grounded in a fragmented system of health-care delivery, one structured around separate medical specialties, discrete treatments, and individual episodes of illness or injury. Many proposed reforms are largely new expressions of the old culture that surrounds health care—a culture often characterized by cost shifting, the denial of responsibility, a lack of coordination, and a dearth of preventive care.

Changing this culture is the key to health system reform that will drive improvements in value. In health care, value is created at the level of helping prevent, care for, or resolve an individual's medical circumstances or condition.[7] When an individual's medical problems are resolved effectively and efficiently, or when prevention enables an individual to avoid becoming ill or injured, value is created. So the culture and organization of services needs to be redesigned from the perspective of a patient's medical circumstances.

But the health care system is currently organized around medical specialties, the doctor's perspective. The result is poor coordination of care, difficulty accessing and scheduling needed care, lack of communication and sharing among the clinicians, repetitious tests, and far too many errors. Instead, the organization and culture need to be patient-centric, coordinating the care and information that the individual needs throughout the full cycle of care (that is, prevention, monitoring and assessing risk, diagnosis, preparation and treatment, and ongoing rehabilitation or long-term disease management). A system that organizes care along the full cycle will be in a position to capture the benefits of prevention and early diagnosis. Such a system would recognize that the expense of cholesterol-lowering drug therapies is cheap compared to the $50,000 cost of a heart attack, or the $250,000 cost of congestive heart failure.

Health care delivery by medical condition (or co-occurring medical circumstances) requires coordinating and relocating the medical specialties and services that are needed to treat that condition. A cancer patient will find that the medical oncologist, surgeon, radiologist, and imaging and lab facilities all occupy the same premises and work together as part of the same team. Institutions such as the M.D. Anderson Cancer Center, which have already made this

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[7] A medical condition is a set of interrelated health circumstances best cared for in an integrated way. It includes not only a disease, but also its common co-occurrences, such as diabetes with hypertension or vascular problems. From the patient's perspective, this interrelated set of circumstances *is* his or her medical condition. Not all health circumstances are interrelated: an ulcer and a broken arm are two medical conditions because they do not typically occur together and integrating care is not critical to improving results. See M.E. Porter and E.O. Teisberg, Redefining Health Care (Boston: Harvard Business School Press, 2006), pages 105-107.

change, have found that redesigning health care delivery around medical conditions enables dramatic leaps in learning, quality, waste reduction, and efficiency.
Every stakeholder in the health care system can participate in this cultural and structural change. For example, drug and device manufacturers working in conjunction with clinicians can orient their businesses around improving results for medical conditions over the full cycle of care. Some, such as Novo Nordisk and Genzyme, attempt to ensure that their products are embedded in the right care-delivery processes and are actively working with physicians to improve those processes and to improve results.[8] Health plans, too, could organize around the individual's perspective and accelerate their learning on how to enable effective care with improved outcomes. Individuals in a reformed health care system could truly become active partners in enabling their own health and improved results.

Cultural change is a difficult undertaking in a system where professional values are ingrained into organizations over time. Yet such change is possible, even on a large scale. The Cleveland Clinic is progressively reorganizing its multi-hospital health system—1,700 staff physicians and 3,000 independent physicians—into this new structure.

We are receiving a poor return for our financial and social investment in health care. Only by shifting the culture underlying our health care system can we make real progress toward a system that is affordable and sustainable, and delivers quality health care to every American.

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[8] Porter and Teisberg, *Redefining Health Care*, pages 289 and 293; Novo Nordisk, New UK diabetes centre to improve quality of life, 2007, available at: www.novonordisk.com/sustainability/Learn_more/Around _the_globe_subsites/UK_diabetes_centre.asp.

Health span, not life span. *Life span is how long we live. Health span is how long we live with the best possible health. Our goal is better health, not more treatment. That said, health care should focus more on early health and less on late disease. To achieve that goal, we will need a much greater focus on prevention, and this must be brought to bear everywhere: at work, at school and at home. Incentives must be changed to support and encourage people to stay healthy. We must move to a system that prevents illness and protects health for as long as possible and for as many as possible. This should be accomplished through better coordination of care so even individuals with chronic illnesses stay healthier longer and have fewer complications. This alone should decrease health care spending while providing a national health benefit in the form of increased productivity.*

Individuals are living longer but they are not necessarily living well. The focus on increasing lifespan to the detriment of the quality of that life has resulted in great disparities in the amount of time, effort, and resources devoted to treating late disease rather than early health improvement.

- Ten to twelve percent of all United States health care spending, and 27% of all Medicare spending, is devoted to treatment of people in their last year of life.[9]
- Up to 30% of Medicare spending for people during their last two years of life is unnecessary and does nothing to improve their health.[10]
- In 2003, the cost of treating seven common chronic diseases – cancers, diabetes, heart disease, hypertension, stroke, mental, disorders, and pulmonary conditions – equaled $277 billion.[11] That same year, these diseases attributed to over $1 trillion of lost productivity due to missed days and lower worker productivity.[12]
- In 2007, the absenteeism rate was 2.3%, costing some large employers $760,000 a year in direct payroll, a number that doesn't take into account the additional costs of lower employee productivity[13]

Over the past decade, researchers have increasingly focused on identifying factors that could lead to living healthier lives, including income, education, employment, insurance status, diet, exercise, and geographic location. The Public Agenda for the Alliance for Aging Research and the American Federation for Aging Research found that there has been an increased emphasis on keeping people productive longer, as opposed to simply prolonging their lives.[14] Reforms to our healthcare system should promote this emerging view on health.

Emphasizing health span over life span will result in better long-term health outcomes in the United States. Indeed, the increasing life expectancy and decreasing rates of disability among today's elderly can be directly attributed to the healthier childhoods of successive generations, a trend that can continue if health span is increasingly emphasized. We should combine prevention, innovation, and technology to improve the long-term health in the nation.

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[9] Barnato AE. "End of Life Spending: Can we Rationalise Costs?" Critical Quarterly 49:3 (Autumn 2007), 84-92.
[10] "Executive Summary: The Care of Patients with Severe Chronic Illness: A Report on the Medicare Program by the Dartmouth Atlas Project." Center for the Evaluative Clinical Sciences and the Dartmouth Medical School, May 2006.
[11] DeVol, Ross, and Arman Bedroussian. "An Unhealthy America: The Economic Burden of Chronic Disease." Milken Institute, October 2007. Available: http://chronicdiseaseimpact.com/state_sheet/USA.pdf.
[12] *Ibid*.
[13] "CCH Unscheduled Absence Survey." Available: http://hr.cch.com/press/releases/20071010h.asp.
[14] USA Today, February 2006

Turn information into insight. *Information technology and biomedical research form the backbone of our health care system. We must minimize barriers to innovation and use information more effectively to better understand disease and therefore better treat it. The time has come to use information technology across the entire health care spectrum and to introduce tools that will protect privacy while driving efficiency and improving health outcomes. If we want better health, we must define it. To define it, we must gain insight by measuring outcomes and identifying what works. And once better health is measured, we should reward those who are achieving it best. Better information will help us meet our objectives.*

The United States spent $116 billion on medical research in 2006.[15] Innovations resulting from these investments have made enormous contributions to health and increased longevity. Studies find that the value of increased longevity in the U.S. is almost as large as the combined value of all other goods and services consumed by Americans.[16]

The costs of new treatments are often assumed to be one of health care's problems. But this is simplistic; more medical spending is neither always better nor always worse for patients. Critical insights develop from considering both spending and the benefits it achieves. Also, aggregate spending is driven by the both the costs of care and the number of people seeking the care. Demand may rise because the value of an improved treatment is high, so more patients benefit. But when value is not understood, the usual assumption is that more care is better, so demand may rise simply because physicians or facilities are available.[17] Better data and insight must underlie health care. Insightful analysis enables good decisions by all parties about what treatments make sense for patients, how to improve care and outcomes, and how to prevent disease or complications.

For example, innovations in treating cardiovascular disease account for 70% of the increase in longevity since 1965.[18] Given the improved capabilities in cardiovascular care, demand and spending have risen. Costs per cardiovascular procedure, however, have risen less than the rate of inflation, so in real terms, costs have decreased. In short, we are achieving better outcomes at lower costs per patient, or in other words, higher value.[19] It is not unusual for spending to increase when value increases. We spend more on computers today than we did two decades ago, although the costs of computer capability have decreased. For both computers and healthcare, spending may be a great investment or unnecessary. We cannot reasonably assess any innovation by looking only at costs or spending without also considering benefits.[20]

In addition to new products and procedures, medical research includes a wide array of other types of innovation. Reorganizing care delivery, improving processes of care, enhancing safety

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[15] Research America, *2006 Investment in U.S. Health Research*, August 2007, available at <www.researchamerica.org>.
[16] W.D. Nordhaus, The Health of Nations: The Contribution of Improved Health to Living Standards (New York: Lasker Foundation, 1999), available at <www.laskerfoundation.org/reports/pdf/healthofnations.pdf>. This does not include the benefits of reduced sickness or improved quality of life.
[17] E.S. Fisher and J.E. Wennberg, "Health Care Quality, Geographic Variations, and the Challenge of Supply-Sensitive Care," *Perspectives in Biology and Medicine* 46, no. 1, (2003): 69-79; J.E. Wennberg, "Variation in Use of Medicare Services among Regions and Selected Academic Medical Centers: Is More Better" Duncan W. Clark Lecture, presented at the New York Academy of Medicine, New York, January 24, 2005, available at <www.dartmouthatlas.org>.
[18] D.M Cutler, M. McClellan, J.P. Newhouse, and D. Remler, "Pricing Heart Attack Treatments," NBER working paper W7089 (Cambridge, MA: National Bureau of Economic Research, 1999).
[19] Porter and Teisberg, *Redefining Health Care*, see chapter four, especially pages 98-111.
[20] See Porter and Teisberg, *Redefining Health Care*, pages 140-147, for further discussion of these issues.

and reducing errors creates enormous benefit. Preventable adverse events are among the leading causes of death in the U.S.—between 44,000 and 98,000 deaths in U.S. hospitals annually, at a cost estimated between $17 billion and $29 billion.[21] Yet, AHRQ, the government agency responsible for research on improving quality and reducing errors, as well as on organizing, financing and managing care delivery has a research budget of about 1% of the NIH budget.[22] The nation needs more emphasis on measuring outcomes and supporting organizational innovation. Only then can we achieve the breakthroughs that will enable quality care for all Americans: the innovations that will change the culture and structure of care delivery to coordinate prevention, disease management and acute care.

Developing actionable insight requires us to look at the health outcomes and costs for medical conditions over the cycle of care. For example, the expense of imaging technologies is often lamented; the real question, however, is not just what the imaging costs, but also what improvements in outcomes it enables over the *full care cycle*. For example, imaging that enables very early detection of breast cancer changes the costs and the outcomes of treatment. Very early stage treatment is less complicated, often less costly, and has cure rates of almost 100%. A full cycle perspective gives critical insight.

Information technology can accelerate improvements in clinical practice. IT alone is not a solution, but it can powerfully enable coordinated teams who are organized to improve health outcomes. It can also speed the circulation of new knowledge. The IOM reported that results of clinical trials take an average of 17 years to be adopted by the average physician.[23] Even the greatest advances in care have no value if they are not used in practice. Further, IT facilitates the tasks of collecting, analyzing, and sharing information on the results of treatment, giving clinicians the opportunity to build robust clinical insight more rapidly.

Without information, we cannot develop insight about what is working or how to improve health and care. The nation must do a better job of collecting outcome data for all medical conditions and using that data to speed learning and improve health care.

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[21] Institute of Medicine (IOM), *To Err Is Human. Building a Safer Health System* (Washington, D.C.: National Academy Press, 1999).
[22] Research America, *2006 Investment in U.S. Health Research*.
[23] E.A. Balas and S.A. Boren, "Managing Clinical Knowledge for Health Care Improvement," *Yearbook of Medical Informatics* (Bethesda: National Library of Medicine, 2000), pages 65-70; cited in Institute of Medicine (IOM), *Crossing the Quality Chasm* (Washington, D.C.: National Academy Press, 2001), page 13, available at <www.iom.edu>.

An effective health care system is a transparent one. *Stewardship and individual health empowerment require the right information and tools. Health information should be timely, accessible and user-friendly, particularly to individuals. It must be available to us at the right place and at the right time to make the right decisions for our health. This information must enable individuals and clinicians to consider and compare the full spectrum of care, not just isolated procedures. Individuals must have the right to any data on their health that exist electronically at no charge or nominal cost. Such transparency needs to extend to health costs and quality as well. Insurers, hospitals, doctors — all health care stakeholders — should share their performance and health outcome information so that they can improve and individuals can make well-informed decisions regarding their health care choices, especially when it comes to early health, wellness and prevention.*

According to the Institute of Medicine, today "individuals are asked to assume new roles in seeking information, advocating for their rights and privacy, understanding responsibilities, measuring and monitoring their own health and that of their community, and making decisions about insurance and options for care." Without information, decisions are merely guesses. Empowering individuals requires giving them information that is relevant, accurate and understandable. In fact, everyone involved in health care needs such information—physicians and other care providers, health plans, drug and device suppliers, employers, and government at various levels. In today's fragmented care systems, ensuring that all parties have the right information is nearly impossible.

The present system lacks information on cost and quality. And the needed information is not just hidden from view; it rarely exists. We need information on the risk-adjusted health outcomes and costs over full care cycles, or appropriate episodes of time, not just the results of a surgery or the cost of a drug or other separate pieces of care. To enable informed decisions by all parties, we need publicly available comparative information about the quality of results for patients with similar medical circumstances, for different treatment approaches, and for each clinical team. Transparency enables clinical teams to understand what they need to improve and when they are improving; it enables them to identify from whom they should want to learn; it enables referring physicians to make informed choices, and it will help individuals to understand their choices.

Transparency of results (outcomes and costs) across the cycle of care will enable better decisions. It is a fallacy to limit or avoid expensive treatments if they are effective in preventing compounding problems. Similarly, the value of acute care needs to account for the health improvements or cost reductions in long term care or disability. On the other hand, many treatments are not effective in improving health or quality of life. Transparent information is essential to understand what works – and what doesn't.

It is not enough to require and track compliance with established good practice. The information about results must be published and identified by provider teams. In Minnesota compliance with best practices in care for patients with diabetes was reported for several years before doctors began measuring outcomes, and compliance was high. But the percentage of patients that achieved an array of five health outcome measures more than doubled in the first two years of

public outcome reporting.[24] Clinical teams need help understanding and adopting best practices, and they need to be transparent about the outcomes they actually achieve with patients.

Even when patients do not use the available information, the very act of reporting spurs improvement in both the outcomes and the method of measuring. For example, in response to public reporting of heart surgery mortality rates, The Society of Thoracic Surgeons developed a sophisticated array of risk-adjusted outcome measures that shed light on results and best practices. The society shares this information with its members to drive learning. When clinical teams have information on outcomes, they find out what they need to improve and learn from one another on how to improve. Substandard care is identified as such. The overall quality of care improves for everyone. But this example is relatively rare. Information on results needs to be collected for every medical condition and every clinical team.

Health IT has a large contribution to make in gathering data on outcomes and costs and making that information available. Merely automating records of today's fragmented care will not drive the needed change. Properly designed IT systems, however, can help clinical teams adopt a coordinated perspective on care and can facilitate an ongoing analysis of the effect of different treatment approaches on health outcomes. In addition, IT can enable personal health records that would allow a patient's health information to be shared with authorized individuals quickly, privately and securely via the Internet. Government can speed the adoption of IT with interoperability standards and common data definitions to facilitate exchange, comparison and analysis.

Outcome measures and risk adjustments are imperfect today, but we should not be deterred. Most of today's more sophisticated outcome measures had their genesis in public reporting requirements. Nothing will speed improvement in both the outcomes and the measures themselves faster than a commitment to making such measurements transparent.

[24] *MN Community Measurement 2006 Health Care Quality Report*, February 2006, page 7, <www.mnhealthcare.org>.

Equity in health, not just in health insurance. *From heart disease and diabetes to cancer and childhood diseases, Americans face crippling disparities in both the occurrence of disease and their successful recovery from it. Better stewardship should include pathways to reducing these financially unsustainable health differences based on ethnicity, gender, income, region and language. Transparency is critical. When outcomes are measured and discussed, disparities in care will be unmasked and intolerable.*

There are significant racial, gender, and geographic disparities in disease prevalence and outcome in America. These disparities cannot be explained by insurance status or income alone. The Institute of Medicine report on disparities noted that the majority of studies found that racial and ethnic health disparities persisted even after adjusting for socioeconomic differences and health care access.[25] For example, some racial and ethnic groups are at much greater risk for many chronic diseases.

- Hispanics are 1.5 times more likely to have diabetes than whites.[26]
- African-Americans are at higher risk for diabetes, hypertension[27], and asthma[28] than whites and Hispanics.
- Heart disease, the leading cause of death for all racial and ethnic groups, and stroke (the principal components of cardiovascular disease or CVD) are the first and third leading causes of death in the United States.[29] CVD accounted for 30% more deaths among African Americans than white adults in 1998.[30]

In some cases, disparities appear to arise from interactions with the healthcare system, such as in treatment or screening.

- In a study of Medicare managed care enrollees funded by The Commonwealth Fund, after adjusting for age, sex, Medicaid insurance, income, education, rural residence, and heath plan, researchers still found that racial disparities were still significant for diabetic eye exams, beta blocker use, and mental illness follow-up measure.[31]
- Studies based on gender have found that although heart disease is the number-one killer of women, women are less likely than men to receive diagnostic or invasive cardiac procedures and experience worse outcomes following a CABG or PCI procedure. In addition, women have been found to undergo cardiac revascularization procedures when they are older and more seriously ill than men receiving these procedures.[32]

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[25] Smedley BN, Stith AY, Nelson AR, ed. "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care." Institute of Medicine. National Academies Press, Washington, DC; 20003.
[26] "National Diabetes Fact Sheet." Available: http://www.cdc.gov/diabetes/pubs/pdf/ndfs_2003.pdf.
[27] "Racial/Ethnic Disparities in Prevalence, Treatment, and Control of Hypertension – United States, 1999-2002." Available: http://www.cdc.gov/MMWR/preview/mmwrhtml/mm5401a3.htm.
[28] "Asthma Prevalence and Control Characteristics by Race/Ethnicity." Available: http://www.cdc.gov/mmwR/preview/mmwrhtml/mm5307a1.htm.
[29] "Cardiovascular Disease." Available: http://www.cdc.gov/OD/OC/MEDIA/presskits/conf/cvd.htm.
[30] "Chronic Disease Overview." Available: http://www.cdc.gov/NCCdphp/overview.htm.
[31] Schneider, E. et al. "Racial Disparities in the Quality of Care for Enrollees in Medicare Managed Care," *JAMA*. 287(10): 1288-1994, March 13, 2002.
[32] Holmes JS, Kozak LJ, Owings MF. "Use and in-hospital mortality associated with two cardiac procedures, by sex and age: national trends, 1990-2004." Health Affairs 26(1): 169-177, January/February 2007.

Despite modest overall improvements in breast cancer survival rates for women with advanced disease over the last two decades, the rates for black women have not improved and the difference in life expectancy between white and black women continues to widen.[33]
In 1998, 49% of Asian women received Pap tests, compared to the national average of 64%.[34]
African-Americans are much less likely to receive critical cardiac care, including diagnostic procedures, revascularization procedures, and thrombolytic therapy.[35]

In addition to gender and race/ethnicity, language plays a significant role in inequitable care. Language can play a significant role in communication with providers, understanding access to health care systems, and following through treatments. Research examining only Medicare beneficiaries found that those with limited English proficiency had worse access to a usual source of care and were less likely to receive preventive cancer screenings.[36] Considering that Medicare beneficiaries generally have similar plans and economic backgrounds, this difference is particularly striking.

Disparities also exist for Americans in living in rural settings. In general, urban teaching hospitals have better technology, more resources, and more providers than rural hospitals. As such, it can be expected that individuals living in areas with access only to rural hospitals could experience worse care than those living in areas with access to urban hospitals. Research suggests this is the case – one study found that for 8 of 12 hospital quality indicators, there were statistically significant differences between urban and rural hospitals, with 7 of the 8 indicators favoring urban hospitals.[37]

Improvements in healthcare must produce improvements in health disparities. A healthy America needs to provide health to all Americans.

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[33] "Study finds dramatic difference in survival rates among white and black women with advanced breast cancer." Available: http://www.mdanderson.org/departments/newsroom/display.cfm?id=dc83392e-c515-43b3-a5de3f10cc0acf77&method=displayfull&pn=00c8a30f-c468-11d4-80fb00508b603a14.
[34] "US Minority Health: A Chartbook." Available: http://www.commonwealthfund.org/usr_doc/collins_usminority.pdf?section=4039.
[35] "Racial/Ethnic Differences in Cardiac Care: The Weight of Evidence." Available: http://www.kff.org/uninsured/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14017.
[36] Ponce NA, et al. "Language Barriers to Health Care Access Among Medicare Beneficiaries." *Inquiry*. 43(1) 66-77, Spring 2006.
[37] Lutfiyya MN, et al. "A comparison of quality of care indicators in urban acute care hospitals and rural critical access hospitals in the United States." *International Journal for Quality in Health Care*. 19(3): 141-149, April 18, 2007.

We shouldn't have to tell our children that they won't live as long as we will. *It is almost unfathomable that with our nation's wealth and technological prowess, our children face shorter life spans than we do. But that is what current trends predict. Rising rates of obesity and diabetes are just part of the brick wall being placed in the path of longevity for future generations of Americans. We must reverse this trend. Our policies must take into account the overall health of our people as well as the health of each individual.*

A 2005 JAMA study "A Potential Decline in Life Expectancy in the United States in the 21st Century" took issue with the Social Security Administration's estimates predicting further growth in life expectancy. The authors argued that basing the predictions on historical data failed to account for trends in health and mortality in the current population – specifically they say "…we see a threatening storm – obesity – that will, if unchecked, have a negative effect on life expectancy."[38]

By mid-century in the United States, it is projected that pediatric obesity might shorten life expectancy by 2 to 5 years.[39],[40] Any approach to reforming our health system must be undertaken with the overall goal of improving the overall health of Americans, particularly our children.

Today, one in three children is overweight or obese;[41] and in some minority populations, this proportion approaches one in two. The consequences of obesity are considerable threats to the vitality of out nation – today and in the years to come. 60% of overweight children ages five to seventeen have at least one risk factor for cardiovascular disease, including high cholesterol, high blood pressure, and abnormal glucose tolerance.[42] Other consequences include greater risk of asthma, type II diabetes, and sleep apnea. Between 1979 and 1999 discharges for diabetes nearly doubled and obesity related hospital costs increased almost four-fold (from $44 to $160 million in 2006 dollars) for children ages 6-17.[43]

Being overweight puts children at risk for disease in adulthood. Being overweight as a child significantly increases the risk for heart disease in adulthood as early as age 25.[44] The growth in childhood obesity will cause more than 100,000 additional cases of heart disease in US by 2035.[45] No generation wants to be the first to tell its children that they may have shorter and less healthy lives. But if current trends continue that will be precisely the dilemma we face. Any restructuring of the healthcare system must ensure that this prediction does not become a reality.

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[38] Olshansky, S.,Jay, et al. "A Potential Decline in Life Expectancy in the United States in the 21st Century" *New England Journal of Medicine*. 352(11): 1138-1145, March 17, 2005.

[39]Ludwig DS, Childhood Obesity – the shape of things to come. *N. England J Med*. 2007; 357(23):2325-7

[40] Olshansky, S.,Jay, et al. "A Potential Decline in Life Expectancy in the United States in the 21st Century" *New England Journal of Medicine.* 352(11): 1138-1145, March 17, 2005

[41] Ludwig, David. "Childhood obesity – The shape of things to come." *NEJM*. 357:2 (2325-2327), Dec 6 2007.

[42] Dietz W. Health consequences of obesity in youth: Childhood predictors of adult disease. *Pediatrics* 1998;101:518–525.

[43] Extrapolation to 2006 dollars is based on calculation in Wang G and Dietz WH, (2002). Economic burden of obesity in youths aged 6-17 years: 1979-1999. *Pediatrics*, 109(5): E81-7.

[44] Stein, Rob. "Overweight kids at risk as adults." *Washington Post*. Dec 6 2007: A02.

[45] Bibbins-Domingo, Kirsten, et al. "Adolescent Overweight and Future Adult Coronary Heart Disease." *New England Journal of Medicine*. 357(23): 2371-2379, December 6, 2007.

Health in all policies. *Health is fundamental to every sector of our economy. Recent research has shown that many factors outside of health care have a huge impact on health. From agriculture policy that influences the food on our dinner table to national environmental decisions that put us at risk for disease, every choice we make brings us closer to, or moves us further from, our national health goals. Therefore, every policy, large and small, and every decision, personal and political, should take into consideration its impact on health. No compromise should be reached without analyzing its health footprint.*

Factors outside the health care system often play a large role in determining one's health status; therefore, not all determents of health can be controlled by policies within the health sector. In turn, better health boosts economic growth.

The impact of some policies (i.e., environmental policy) on health has been well documented[46]. For instance, a strong relationship between outdoor air pollutants and asthma has been established – power plants, emissions from chemical plants and oil refineries, diesel emission particulates and certain pesticides have all been found to produce environmental triggers for asthma. Efforts to reduce downtown traffic congestion in Atlanta during the Olympic Games resulted in decreased traffic density, which was associated with a prolonged reduction in ozone pollution and significantly lower rates of childhood asthma events.[47]

A 2002 study found that the costs to society of environmentally attributable diseases in children was $54.9 billion - $43.4 billion of which was attributable to lead. Food, marketing, housing, and environmental policy all play a role in reducing this threat to children:

- Ban of use of lead in residential paint by CPSA (1978)
- Phase out of lead in gasoline by EPA (1986)
- Eliminate use of lead in domestically canned foods (USFDA)
- Healthy People 2010 calls for total elimination of elevated blood lead in children

An econometric study by former Harvard researcher demonstrated that strict enforcement of lead abatement statutes reaps enormous dividends, health wise and financially, concluding "although the initial costs of making these units lead safe may seem prohibitive, the costs of not intervening are staggering.[48]

Linking community planning to goals of increasing population health and decreasing sedentariness can be employed. Physical activity can be encouraged by providing sidewalks, safe bike paths, and parks. "The European countries with the highest levels of walking and cycling have much lower rates of obesity, diabetes, and hypertension than the United States. The Netherlands, Denmark, and Sweden, for example, have obesity rates only a third of the American rate, while Germany's rate is only half as high. Moreover, the average healthy life expectancies

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[46] http://content.healthaffairs.org/cgi/content/full/24/2/339?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&fulltext=agricultural+policy+and+health&andorexactfulltext=and&searchid=1&FIRSTINDEX=0&resourcetype=HWCIT

[47] Friedman MS, Powell KE, Hutwagner L, Graham LM, Teague WG. "Impact of Changes in Transportation and Commuting Behaviors During the 1996 Summer Olympic Games in Atlanta on Air Quality and Childhood Asthma," JAMA vol 285:897-905.

[48] Brown MJ. The Costs and Benefits of Enforcing Housing Policies to Prevent Childhood Lead Poisoning. Med Decis Making 22; November/December 2002.

in those 4 European countries are 2.5 to 4.4 years longer than in the United States, although their per capita health expenditures are only half those of the United States."[49]

Agricultural policy, food policies, and other food- and nutrition-related sectors, such as manufacturing, marketing and trade of foods, can influence the diet of a population. For instance, healthy and nutritious food choices, such as vegetables and fruits, should be made readily available and reasonably priced. Freedom of choice can exist along empowering consumers to make the healthiest choices. The lack of access to affordable, healthy food choices in neighborhood food markets is a barrier to purchasing healthy foods.[50] One study by UNC found that African Americans' intake of fruits and vegetables increased 32 percent for each additional supermarket located in their neighborhood. Also, more residents in an African American neighborhood limited their intake of fat when they had access to a supermarket compared with residents in a neighborhood without any markets."[51]

Finally, smoking can be influenced by a variety of factors and policies, including tax, agriculture, clear labeling, and marketing restrictions. Consumer demand can be lowered while farmers can be incentivized to stop growing tobacco in favor of more healthy crops or land use. Tobacco Trust Funds can be used to help tobacco farmers switch crops. In North Carolina, a growth in wineries has in some cases been attributed to an increasing number of tobacco farmers switching to grapes.[52] Maryland paid farmers to give up tobacco. Using monies from the National Tobacco Settlement, from 2002, farmers were paid to stop growing tobacco and many turned their land into other purposes: crops, livestock and other products, including grains; fruits; wine grapes; vegetables, organic and traditional; livestock; herbs, and flowers.[53]

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[49] Pucher J, Dijkstra L. "Promoting Safe Walking and Cycling to Improve Public Health: Lessons from the Netherlands and German." AJPH Vol 93, no. 9 (September 2003):1509-1516
[50] http://www.cdc.gov/nccdphp/dnpa/obesity/childhood/contributing_factors.htm
[51] Communities And Health Policy: A Pathway For Change, Judith Bell and Marion Standish , health affairs 24, no. 2 (2005): 339-342
[52] http://www.tobaccotrustfund.org/
[53] http://www.washingtonpost.com/wp-dyn/content/article/2007/02/28/AR2007022800006.html