FOUNDATION FOR AMERICAN HEALTH CARE LEADERSHIP℠

AN AFFILIATE OF WYE RIVER GROUP ON HEALTHCARE

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"A National Perspective on Local Strategies"

Keynote by
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Good afternoon. I want to thank David Gobble and Stephen Kendall for inviting me to be a part of this unique and timely conference, and have the opportunity to support Ball State's goal of developing a curriculum to teach an interdisciplinary approach to designing for health. Also, thanks to Kelly Stanley for continuing to demonstrate to me the unique assets and creativity of 'middle America.'

In my remarks this afternoon I'd like to focus on three areas. First, I will share with you some of what we have learned in our work with leaders in communities across the country about the steps we will need to take as individuals, as organizations, as communities, and as a country, to create a health care system that better meets our needs, and is more aligned with our value system. Second, I will highlight some considerations for communities working together to enhance to the health, broadly defined, of their citizens. Third, I will share some observations about Muncie and its assets and challenges when it comes to community health.

Wye River Group and its affiliated Foundation for American Health Care Leadership are not-for-profit, non-partisan organizations, which serve as catalysts to bring a diverse spectrum of healthcare interests--purchasers, providers, payers and patients--together in a neutral environment to encourage honest discussion and debate. We recognize that each sector has a unique view and a significant vested interest in how we reshape healthcare in this country. So, promoting better understanding of different perspectives, through open dialogue that explores shared values and builds trust, is a critical first step in developing a viable vision for national healthcare policy. Leaders have to first agree on principles—basically, guideposts for the debate--before constructive conversation can take place on important medical, economic and ethical issues.

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For over two and a half years, we have been working with leaders in 12 very different communities across the country. These 12 communities reflect very broad diversity in terms of geography, size, population demographics, competition, regulation, and healthcare quality and cost. In each community we interviewed 25-30 leaders from across the healthcare and business spectrum about their ideas on health care in general, health policy and the health of their community. We hosted healthcare leadership roundtables which focused on issues that people, including health care executives, don't often talk about, such as the social contract for healthcare, the characteristics of a well-functioning healthcare system, and how best to engage communities in solving their own healthcare challenges.

Our goals are quite simple: 1st to learn about healthcare values that guide the thinking of community leaders and citizens, and their conclusions about what works and what needs to be fixed. 2nd, to create mechanisms for this thinking to inform the national policy debate. 3nd to identify creative, collaborative community-based initiatives that address healthcare problems and could be replicated in similar communities. Finally, to use the power of multi-sector, multi-state support to bring about public policy changes that will enable communities to better meet their healthcare needs.

So what did we hear? Compared with the national debate, we found that community discussions were less polarized, less partisan, and more focused on finding practical solutions. We discovered a surprising degree of interest and willingness at the local level to offer honest viewpoints about the values and principles for health care, to bring up frustrations and specific concerns, and to pursue collaborative efforts.

It will come as no surprise that most believe we do face a major crisis in healthcare, one marked by rapidly rising costs, widespread problems with quality, and limited access for many, which will only get worse if we don't take definitive action NOW. The good news is most felt the time is right and there is a window of opportunity to engage policymakers, the health care industry and the public in discussions aimed at constructive change. There is a strong sense that healthcare leaders are more motivated than they have been to discuss problems and work together on solutions. But this opportunity won't last. By 2011, when the first edge of the baby boomer generation will reach 65, we will be facing a true crisis driven by the demographics of our aging population with its burden of chronic disease, if we don't start planning as individuals and as communities.

A social contract for healthcare

Most community health care leaders agreed that our country has developed an effective social contract in other areas of public policy, such as education. But currently, there is no equivalent in health care that is well-articulated and broadly understood. Some felt that we have multiple social contracts that are conflicting; a Medicaid director pointed out if there is a social contract, it has a huge hole in it.

As a result, people do not know what they can and should realistically expect from the health care system. Nor do they understand their responsibility to contribute. If people

viewed healthcare in a similar way to education, as a common good, they would understand that using healthcare resources wisely benefits both individuals and communities. There is a general consensus that we should more explicitly define rights and responsibilities but not necessarily codify them in a formal "contract." One leader said “I’m not sure we have a right to healthcare, but we have a right to health.” The comment that seemed to resonate the most suggested that rather than say health care is a right, call it a privilege to which everyone should have access. Even those who believe healthcare should be a right acknowledge that we need to answer the question, a right to what?

Leaders recognize that expectations and demands of the public are often out of line with reality, but that the healthcare system itself has fostered those expectations through marketing. The sense of community interconnectedness and interdependency that existed perhaps a century ago has been replaced with sense of entitlement. We need to find a way to reacquaint people with their place as part of the community and convince them that it is in their best interest to think of healthcare as a shared resource. Health care is both a public and a private good—the challenge is sorting them out.

Personal responsibility/system accountability

We heard a strongly voiced view that individuals need to be actively involved in making key choices about health-related behaviors, and healthcare-related decisions. This was a topic of considerable discussion in Muncie. But as one physician participant pointed out, “It is a massive paradigm shift to begin asking patients to become active and engaged in their own health instead of functioning as passive recipients of care.” Most everyone recognizes that any effort to increase personal responsibility for health and health care must be linked with efforts to educate and actively reach out to patients, particularly those who are underserved.

The flip side to the personal responsibility message is that we need much more accountability in the health care system for delivering high value care and at the community level to enable people to make good choices and adopt more positive health behaviors. "In essence, the bar has been raised on expectations of accountability."

This demand for accountability is heightened by the widespread belief that there is a serious void in leadership in the healthcare industry. Trust is a critical pillar of a well-functioning healthcare system, but health care institutions have lost a great deal of credibility with the public and skepticism about motives is prevalent. We heard comments from respected leaders about the tremendous fragmentation in healthcare with each interest group moving forward in whatever direction they feel is appropriate—essentially in "random acts of clinical improvement.″ One business CEO put it this way, “We in business and I as an individual don’t trust you as an industry.”

We also heard that, although some policy and financing issues must be addressed at the federal level, there is great faith in the ability of different communities to develop creative approaches that recognize the distinct problems and the specific strengths of

each community.

So what do we do about it?

As a start, we must decide as a society what we REALLY want from healthcare. What are the trade-offs? Who is willing to make them? And these conversations need to begin at the community level. A rural hospital CEO put it well, “The problem policy-wise in the U.S. is grasping what health is [to us] as a society. Another participant chimed in, “Right now we’re not talking about where we’re going. We’re just talking about who’s going to pay.”

We need to shift our thinking and recognize that the federal government is not going solve our problems in healthcare. There is little chance that the answers to the health care crisis are going to come from Washington, where more time is spent talking politics than policy, and as the CEO of one of the nation’s largest trade associations put it, "debating extremes rather than finding consensus." In a pluralistic nation where values and priorities differ from one community to another and from one generation to another, a “one size fits all” approach that is determined at the national level is less likely to be embraced.

What has been tried for the last 60 years won't work. The common failure is that efforts were built around the idea that we could do this from Washington. People looked at what emerged and found it incomprehensible. We need to turn this approach on its head, by bringing the American people together, looking at things differently, and involving them in discussions of key choices.

Communities are the logical place for initiating change. All healthcare is local. Although we can and should create replicable models, each community is unique. Policies determined at the community level are more likely to be based on the actual conditions in a community, where people know what works and what doesn’t. Health care leaders from different sectors are more likely to work together productively within their own backyard than they do in the polarizing atmosphere of Washington. And community-based discussion is much more likely to pull in participation from “the grassroots” and reflect a community’s values and priorities.

There is general consensus that the best approach is to start by carefully defining problems, and priorities from the unique perspective of a community. For example, the problem of access to healthcare does not look the same in Muncie, as it does in San Diego or Jackson, MS. In some cases, access is defined by insurance coverage; in other cases by availability of adequate providers of different types to address healthcare needs. Access may refer to culturally appropriate care or to the logistics of getting to a care provider. Access also implies much better integrated and coordinated services, not just health care but social and community services.

To restore trust in the healthcare system, the public needs to see leaders working collaboratively in their best interest. Despite the fact that more unites the health care stakeholders than divides them, typically, each sector brings its own narrow perspective

to policy discussions, rather than advancing what would be in the best interest of the community. Health care leaders need to stop pointing the finger of blame at each other and cooperate on a common agenda. Each individual or organization only owns a piece; so no one feels responsible for the whole. Industry leaders need to systematically think and plan beyond the fire at their feet, collaboratively. But collaboration is an unnatural human act, until we address one of the root causes of dysfunction, that is, clearly mal-aligned financial incentives in our non-system—for physicians, hospitals, payers and patients. Current payment polices hamper providers from focusing on prevention as the right thing to do and from collaborating to improve community health.

Communities at Work

Now I'd like to move from the 30,000 foot 'policy' level and talk about how communities can play a role in helping to create 'health' or 'design for health' by looking at a specific impending healthcare crisis.

While the healthcare delivery system is important to health, it is neither the only contributing factor nor even the most important in creating health. Furthermore, while most healthcare leaders and policy experts, as well as the public tend to focus on concrete issues like financing, the reality is that the greatest challenges relate to cultural issues—individual, organizational and societal. One of the reasons that radical change in healthcare is intolerable is that it defies the speed of cultural change. If we are going to create change, nationally or at the community level, we have to recognize this.

No one who watches television or reads a newspaper today can fail to appreciate that we are in the midst of an epidemic of obesity, one that is developing across the globe. In the US, Indiana is a leader. In 1985, Indiana was one of only 8 states with obesity rates as high as 10%-14% of the population. 12 years later, it was one of 3 with reported obesity rates of 20%-24%. In 2003, 31 states were in this category and 4 had rates higher than 25 percent. 2/3 of the population is overweight or obese and the prevalence of overweight has doubled among children and tripled among adolescents in a little over 20 years.

To address this crisis, we are going to have to focus on prevention, not treatment. Blame won't work. Personal commitment and community action can.

Why are we becoming obese? Fundamentally, obesity is the natural response of human physiology to the modern environment we've created through technology, combined with policy, culture, the built environment, the commercial environment—all of which play against our susceptible biology to cause obesity.

We've changed how much, what and where we eat. We consume far too many calories, especially from energy-dense foods, refined grains, added sugars and fats. This is especially true among the poor, who tend to choose processed food and "fast food" because it is cheaper and often more accessible. Everything is being super-sized, because culturally we want 'more for the money'. We're also eating out more. In 1970, a

third of the food budget was consumed outside the home. Now it's well over fifty percent.

Automation and mechanization have reduced physical activity on the job, leisure activities are sedentary, and we resort to cars to get around. Even when individuals are highly motivated, choosing to bike or walk is not easy in today's 'built' environment. What makes it more difficult in a society like ours that runs on instant gratification--eat it now, pay for it much later--is that there are essentially no immediate tangible benefits or rewards, for 'doing the right thing' with regard to behavioral changes like healthy eating and active living. It takes time to see or feel the effects.

So, what seems to be a simple matter of reducing calories consumed and increasing calories burned to create energy balance is actually a complex social issue that requires multi-faceted solutions to reverse the trends. Education creates awareness about appropriate choices, but even combined with behavioral change models it won't suffice. Rather, we need to adopt an ecological model where change efforts work on individuals, social environments, physical environments, economics, and policies.

So who should be responsible for launching the fight against the obesity epidemic? According to a public opinion poll, health care providers should be central in it. But people also see a very significant role for community institutions, like schools, and employers and government. So it's really everybody's problem in the public's mind. If you ask specifically what should be done, people say they want more public space where people can exercise, government-funded campaigns on the health risks of obesity and on eating right and exercising, and they support requiring restaurants to provide nutritional information. There's less support in this country for taxing junk food, and less interest in limiting advertising, though some European countries are making significant strides in these areas.

There is also a lot of interest in reaching kids. Many believe that schools should provide healthier lunches, get tough on controlling school vending machines, require regular physical education, and provide more education about the risks of obesity and the importance of exercise and eating right.

But the public is less clear on one very important issue. 50 percent say obesity is a private issue that should be dealt with in terms of personal responsibility. But the other 50 percent say it's a public issue that requires public policy intervention.

Once policy issues are addressed, what other elements are important to creating community-based efforts to address obesity, or other health-related issues? To reiterate a key message of this conference, health promotion and behavioral change need an inter-disciplinary and inter-sectoral approach. So, in addition to the healthcare system, we need to consider education, recreation, safety, business, urban planning and transportation, all of which impact our health to a very large degree.

Successful campaigns need strong leadership and adequate funding. Messages need to be clear, simple, relevant and aligned with cultural values and other social circumstances. They need to be tailored for different audiences and delivered using a variety of media to reinforce and leave a lasting impression. To leverage resources, it is necessary to create partnerships, alliances, and collaborations. And it takes time, in fact, 7-10 years is necessary for broad based social cultural change.

There are some noteworthy efforts that can serve as models for communities that want to take charge.

America On the Move is a national effort, delivered locally, to promote the message of 'small changes.' It uses a framework that looks at the individual, the community, and the environmental, and the factors influencing decisions around eating and physical activity behaviors. 90% of the American population is gaining between one and two pounds a year. A little more physical activity and a reduction of intake by one hundred calories each day, is enough to stop weight gain in 90% of people. AOM now has twenty state affiliates, with programs for faith-based groups, for health professionals that can be used with their patients, for schools, and for other groups. The motto is to reach consumers where they are.

Cardiovision 2020 is a community-based effort modeled after an extremely successful program in Finland which drastically reduced mortality from cardiovascular disease. It is a community self-help program that emphasizes informed choice. It's mission is partnering with clinicians and community organizations to develop information systems, environment, skills, and encouragement to help individuals reduce their risk of cardiovascular disease. Health goals are supported by the community environment. Residents can walk or bike everywhere, there are safe physical activities available for all age groups, the schools offer and promote healthy foods and phys ed, and restaurants provide nutritional information.

What about Muncie?

Now let's move down to the 10,000 foot level and talk about Muncie. Compared with other communities, Muncie probably has as many challenges, but has more assets than most.

Munsonians generally know their problems—needs assessments have been done since at least 1995 and the National Civic League worked with the community in 1996 to identify priorities. In some cases, important issues have been addressed, e.g., the creation of the cancer center.

There is a unique sense of pride in the community that we truly have not seen elsewhere, at least to the same extent. Respected individuals and organizations are willing to exert leadership. This conference is one example. BMH Foundation has agreed to serve as a catalyst in meeting the critical health needs of the community, starting with launch of Cardinal Access to improve care for uninsured residents of Delaware County.

With more than 50 medical specialties, CHS provides Muncie with the kind of medical center that few other communities its size have. Although some might say one regional hospital and a single medical community limits competition, the hospital is perceived as responsive to community needs and few seem concerned. Rather, the prime focus among residents and leaders is on the ability of the medical center to attract physicians and provide extensive services for the community. And CHS is working actively to be more accountable for the entire spectrum of care.

United Way has positive image and there are extensive and excellent social services programs, as well as care for the underserved, through, for example, Open Door.

The community has a history of broad collaborative efforts like TeamWork for Quality Living and UW Partners. TeamWork helped create trust among social service agencies. Partners Community Impact is a start at pushing for better coordination of those services.

Tobacco settlement monies have been put into wellness initiatives. TeamWork created "Living Healthy" 3 years ago and the community now has a great "Rails to Trails" program which can be leveraged for more activities to promote fitness.

There is a well-endowed Community Foundation with a track record of measurably successful initiatives and a positive reputation as a 'user-friendly' Foundation.

In addition to Foundation assets, Muncie is a very philanthropic community—little dollars as well as big, and there is a lot of volunteerism. Over 3,500 BSU students (of 18,500) volunteer 95,000 hours of community service.

And of course there is Ball State, with the Fisher Center on Wellness and Gerontology, a national reputation for educational pedagogy, and its partnership with and Paws to create the Professor Garfield Foundation, an Internet educational portal to augment classroom learning.

These diverse resources can be leveraged to effectively address existing challenges to community health. Muncie-Delaware County should have a strategic plan for health. Data show a high prevalence of obesity and several chronic illnesses related to lifestyle, such as diabetes and cardiovascular disease. There is also a perception of lack of access to quality health care. There is a need for more accessible mental health services, especially for the poor, given the prevalence of behavioral health components as an overlay to illness, and the importance of these services in supporting behavioral change initiatives.

While the strong social service infrastructure is clearly an asset, it has led to an influx of needy people from other counties and states, such that there is a 26% poverty rate in Center Township. 54% of kids in the county overall qualify for free or reduced lunch.

A major recognized community challenge is to bring focus to the efforts of its non-profit sector. People do not always access available social services because they are not as well organized or coordinated as they could be. Understandably, well-meaning NFP agencies want to be all things to all people, but turf issues and competition impede communication and impact efforts to support community needs. Furthermore, the hospital and providers are outside the social service network and the continuum of care could benefit from better integration.

Health system outreach into the community, especially around prevention and disease management, could be improved. Services need to be delivered with an eye toward patient access, comfort and convenience to address compliance issues and other factors that impact patients' health and health care and result in significant health disparities.

In essence, Muncie and Delaware County have a host of good initiatives and services, which will have much greater impact when better coordinated, streamlined, and communicated to various population groups. There is strong interest among community leaders in the private sector, non-profit sector and local government to move forward with a coordinated effort. I think the Partners Impact goal of improving health and human services in Delaware County, and the Cardinal Access collaboration among a number of community partners, funded and spearheaded by BMHF are solid evidence of this commitment.

Participants at our leadership roundtable last fall agreed to establish a Community Health Council that will be tasked with determining how to optimize all of the efforts that are being made to provide high-quality health care to Muncie residents. The Council will support and encourage collaboration among providers, service agencies, non-profits and other organizations. The emphasis will be on finding ways to improve communication and coordination. If progress continues, I believe Muncie will achieve the enviable vision of "healthy people living in a healthy community."

So, in conclusion, our work over the past few years has convinced us that there ARE solutions to our healthcare problems. They lie 1st in a clear definition of what health means to us as a society; 2nd, in active engagement of citizens and communities in promoting health, not just health care; and 3rd, willingness on the part of health care and community leaders to lead the kind of change efforts we need to truly create the best healthcare system in the world.