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The Consumer Connection

... linking consumers with health care news and information

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Health Care Reform — On the Horizon

The following remarks about the healthcare system by Senator Max Baucus and by Mayor Michael Bloomberg, made at the National Health Policy Conference, February 12 – 13, 2007, provide information on current discussions as well as insights into potential future reform proposals. Health care issues are already being reported in the media as key components of the campaigns of the next Presidential candidates.

These articles, while long, are very informative and provide impetus/hope for a change in the focus of healthcare to disease prevention and management from disease treatment, and for the expansion of health care technology including electronic medical records

Remarks of Senator Max Baucus
Before the National Health Policy Conference
February 13, 2007

In his Remembrance of Things Past, Marcel Proust wrote: "A change in the weather is sufficient to recreate the world and ourselves."

You can feel it in the air. Not just in Washington, but all across the country. The season is changing. It's inexorable. I speak not just of the newfound winter in the air. I speak of a new season of our nation's health-care debate. And this is, as Alexander Pope wrote, "no season now for calm familiar talk."

The season for a real debate on health care reform is coming. And it is long overdue. My job as Chairman of the Finance Committee is to prepare Congress for this season of reform.

America has many of the world's best doctors and hospitals. They perform the most advanced life-saving procedures. They keep alive the most fragile infants. They treat the most serious illnesses. They unfailingly expand the bounds of medical innovation. But this best-in-the-world medical system is still out of reach for 47 million Americans.

Folks across the country tell me that they have difficulty getting or paying for health care. Business leaders tell me that health-care costs are impeding their ability to compete.

We spend more on health care. But we do not get better health outcomes. We spend a quarter of American health-care dollars—about $400 billion—on non-medical costs. Most of that is just paperwork.

It is time for a season of reform.

I have studied the innovative proposals being put forth. I am optimistic. I see consensus forming on the horizon. The climate is about to change.

What we need now is an extensive and thoughtful dialogue in Congress. This year, the Finance Committee will start the dialogue. Health care reform is going to take time. But I am in this for the long haul. We need better health care, so that all Americans can have the prospect of long, happy, and productive lives.

So what ideas will grow in this new season for health reform?

Victor Hugo advised: "Change your opinions, keep to your principles; change your leaves, keep intact your roots."

I see five principles of reform. From these roots, we can grow a better health care system.

The first principle is universal coverage.

We are the richest country in the world. But America remains the only industrialized nation that does not guarantee universal coverage. Even the Slovak Republic has universal health coverage. And the number of Americans without health insurance coverage continues to grow.

Last year, another one and a half million Americans joined the number of the uninsured. That brings the total to 47 million people. That's nearly one in six Americans. Nearly one in five Montanans do without health insurance. The share of Americans without insurance has increased in each of the last 13 years.

Every American should have a right to affordable health coverage. Individuals should have the responsibility to get that coverage. And the society should help those who do not have the means to buy insurance on their own. We should sign up every newborn baby for health coverage, at the hospital. Insurance from birth will improve the health, quality, and productivity of that child's life. It's right for the child. It's right for our health care system. And it's right for our nation's economy. Guaranteeing all Americans a healthy start is just one example of how we can do better.

The second principle is sharing the burden.

Neither the employer-based system nor the individual market can fulfill the demand for affordable, portable, quality coverage. The way to ensure affordable coverage is to create pooling arrangements. Purchasing pools would bring together large numbers of small purchasers—both individuals and small businesses—and allow them to take advantage of group rates for coverage. Purchasing pools help the market work. Pools benefit those in need of health insurance. And pools open a new market for insurers.

Pools offer choice. And pools simplify the comparison of health plans. They provide a single forum for leveraging multiple funding sources—public and private. And they offer administrative economies of scale. Pooling has its challenges. A pool must offer affordable premiums in order to bring coverage to the uninsured. But a pool must also be cohesive and stable to attract insurers.

Making pools work will require good rating rules, to ensure that people are paying fair amounts. And making pools work will require subsidies, so that those in greatest need can afford to participate.

At the same time, we must be careful that a pool does not become a magnet for only those who need coverage. Pools need stable and efficient administration. We need careful regulation and stewardship, to keep these pools functioning as they should.

To meet all these goals, pooling arrangements must be a partnership between public and private sectors. And they must be a partnership between Federal and state governments. We will all need to work together, to make this vision a reality.

The third principle is controlling costs.

Any serious proposal must reduce the rate of growth of health care costs. America cannot sustain the rate of growth in health care spending. Over the last 10 years, health spending grew faster than overall inflation. It grew faster than wages. And it grew faster than the economy.

Many talk about the need to reign in Medicare and Medicaid. I agree. We need to make these programs fiscally sustainable. But cost growth is an issue faced by the entire health care system, not just the part that the Federal government funds.

How do we get a handle on costs? First, we must better understand what is driving cost growth. At the most fundamental level, we know that more people and price inflation drive costs up. But health costs grow faster than the growth in population and prices combined. That is what makes health costs so complicated. Two other factors are contributing to excess growth: new technology and the intensity of care provided.

I do not have a magic solution. But I do know that the Bush Administration's fixation with consumer-driven care only serves to polarize the dialogue. We should not rearrange the deck chairs on the Titanic. We should bridge our philosophical divide by finding ways together to lower costs across the system. We need to act sooner, rather than later. And we should move on several fronts.

The Federal government needs to invest more in health information technology. Health IT will provide a better platform to manage costs and make the delivery of care more efficient.

Today, however, patients do not have ready access to their health records. Providers often cannot see their patients' complete medical histories, making it difficult to provide efficient care. Some providers—especially those in small groups and rural areas—have a hard time finding the money to adopt IT.

Last year, Congress came close to passing legislation to encourage IT. But compromises between the House and Senate eluded us. I will work within the Finance Committee. I will reach out to the HELP Committee. I will work to get the Senate to pass

meaningful health IT legislation again this year. And I will work to get it signed into law.

We need to share Medicare databases more readily with health researchers. Medicare is the largest single payer of health care services in America. It covers more than 40 million lives. It covers more 70 million hospital days. And it processes nearly a billion physician claims a year. Medicare collects and maintains a wealth of information on care delivered to a significant portion of the population.

Medicare is the most comprehensive resource that our nation has to study the effects of diseases and treatments. With appropriate protections, we could use Medicare data to further our understanding of what constitutes good medicine. This study could help ensure that Americans have a better than 50-50 chance to get the right health care when they need it.

We need to invest more in comparative effectiveness research. Our economy, and our history, is built on innovation. Our health system reflects that heritage. It is the most technologically-advanced in the world. But we need to know whether the care that we pay for really works.

America has been slow to adopt comparative effectiveness research. Last year, our nation spent more than $2 trillion on health care. But we spend less than one tenth of one percent of that seeing whether we are spending on the right things.

To make the right treatment decisions, policymakers, health plans, clinicians, patients, and manufacturers alike need more evidence. The Academy has a thoughtful set of recommendations in this area. I am considering them carefully. Funding for health services research is like buying a college education. It's an investment in the future.

We should reward high quality care to make sure that we get the best value for our health care dollars. Health costs and outcomes vary across the country. But greater health spending frequently correlates with poorer health outcomes.

To help control costs and improve patient outcomes, we need to pay more for quality care. My Finance Committee Colleague Chuck Grassley and I have worked together to do more of that in Medicare.

But tying payment to quality of care is complicated. We continue to work closely with physicians and other clinical experts to identify performance measures that can show the way to healthier patients. I will keep pushing until all Medicare beneficiaries get the high-quality care that they deserve.

The fourth principle is prevention. The old aphorism is true: An ounce of prevention is worth a pound of cure.

American health care tends to focus on what happens when you are sick. Whether it is hospital-based care, prescription drugs, or the latest technological advances, we look at treatment.

But we should not relegate prevention to the fringe of our health care system. We should make it the foundation. We need to encourage primary prevention of disease, when possible. And when primary prevention is not possible, we need to encourage early detection and modification of risk factors. And when illness cannot be prevented, we should focus on coordination of care. And we should seek to avoid the complications of progressive illness.

Prevention should be based on good evidence. If a preventive measure is found to do what it's supposed to do and is cost-effective, all insurers should cover it. And it should be part of the quality assessments of providers.

Take the example of immunizing kids. It's a standard of preventive care. But if insurers do not cover all recommended immunizations, how can we expect people to take this basic preventive step?

We need to reward efforts to prevent disease. Take the example of obesity. Obesity seriously threatens good health. Obesity increases the risk for diabetes, heart disease, hypertension, and other conditions. Two-thirds of American adults are now overweight or obese. And the trends for children ages six to 19 tripled in a generation. And now, one in three American children is overweight or obese.

As a result, some predict that one in three children born today will develop diabetes. Obesity may make

this generation of American children the first in modern history with a shorter life span than their parents.

Since the year 2000, obesity-related health costs have exceeded $100 billion a year. Taxpayers pay half of obesity-related health costs through Medicare and Medicaid. Obesity now drives increased health spending more than tobacco or alcohol.

The evidence is not complete on the best ways to deal with obesity. But the research was not complete in the early anti-smoking efforts, either. We must take steps to combat obesity, even as the research proceeds.

The fifth principle is shared responsibility.

We want universal coverage. But the first question is: Who will pay? Who will bear the burden of a new system? Will employers, individuals, governments, or stakeholders? This is a shared responsibility. And all should contribute.

Upon these five principles, we can build consensus on system-wide health reform. I am confident that the growing perception of a new season of health care reform will bring people with disparate views to work together. Everyone will give and everyone receive. That is the only way to bring about system-wide change. Conventional beltway wisdom has been that the politics of health care dictate that only incremental changes are possible. I disagree. For health care, the season of incremental change is coming to an end.

I am inspired, and I hope to inspire others, to join in a Congressional dialogue. This year, the Finance Committee will embark on a series of hearings, roundtables, and Member forums to highlight the complex issues. We will plant the seeds of an informed dialogue. The signs on the horizon tell me that this new season is coming. We can no longer wait.

Until we can tackle comprehensive coverage, I recognize that we have the responsibility to make the current system work as well as we can. Thus while we are laying the groundwork for broader reform, we can protect and strengthen existing health care programs.

This year, Congress has an historic opportunity to strengthen the health of our nation's children. Improving and expanding the State Children's Health Insurance Program, or CHIP, is the Finance Committee's first health care priority this year. We must give CHIP enough money to maintain coverage for those whom it already serves. We must work to reach the six million uninsured children now left behind—those who are eligible for CHIP or Medicaid but not covered. We must support state initiatives to use CHIP to cover more children. We must improve the quality of health care under CHIP. And we must not increase the number of Americans without health insurance.

Together with Senator Grassley I will work to improve the health of millions of American children, this year. I expect that the Finance Committee will mark up legislation in the late spring.

Small businesses in this nation are facing very difficult times. As health costs have risen, small employers have struggled to continue to provide coverage. But fewer are able to do so. Just half of employers with three to nine workers offer coverage.

Low coverage rates among small employers hurt their ability to attract workers. Low coverage rates increase the ranks of our nation's uninsured. And low coverage rates increase costs for everyone due to cost-shifting for uncompensated care. Small businesses are not unique in facing rising costs. And all of us want broader solutions for our health system. But small businesses do have fewer coverage options. And they have fewer resources than larger businesses.

I plan to take action this year to help small businesses provide health care coverage. I will work to find ways to make health coverage more affordable and accessible for small businesses. Small business health care must stop being a campaign issue. Surely we can do better. We can all roll up our sleeves and get this done.

The Medicare drug benefit was long overdue. Many diseases that exist today are treated or managed with prescription drugs. And that's why I helped to write the law to create the drug benefit in Medicare. We've had some good news so far. Premiums are lower than initially projected. Four out of five enrollees report that they are satisfied with the program. But that means that one in five enrollees is not satisfied.

My goal in the Finance Committee is to ramp up oversight of both the plans and of CMS. Now that the program is in its second year, we have experience and data to probe. Congress can use your help. Your research and analyses can help. You can tell us what works well, and what doesn't. In addition to over-sight of the drug benefit, the Committee will explore meaningful alternatives to the law's prohibition of the government's negotiating drug prices. Last month, we held an informative hearing. And I plan to move forward with legislation soon.

This year, we will also consider ways to better reach people eligible for the low-income subsidy. And we will seek to improve consumer protections for beneficiaries who participate in the drug benefit. The Bush Administration

is fond of calling the new drug program an "unparalleled success." I prefer to think of it as a work in progress.

This year, we will also explore Medicare Advantage in the Finance Committee. We will start with a comprehensive review of the program. Since the Balanced Budget Act of 1997, plans have cycled in and out of the program in response to legislative and regulatory changes. The Medicare Modernization Act of 2003 significantly increased Medicare Advantage payment rates in every county in the country. Some counties experienced a resurgence of health plans as a result of the infusion of new funds. Others have seen health plans for the first time.

This resurgence in Medicare Advantage is not free. MedPAC estimates that Medicare Advantage plans are paid, on average, 12 percent more than fee-for-service care. MedPAC recommends that payment should be reduced to equal fee-for-service costs, not exceed them.

Others argue that we are buying valuable extra benefits for people who choose to enroll in Medicare Advantage plans. Many who enroll are low-income. We need to take a close look at what we are buying in the Medicare Advantage program. We need to find out whether the extra payments are worth it.

So I predict a change in the weather for health care reform. I predict a season of serious dialogue. And I predict a constructive year for CHIP, small business heath, and Medicare. This year, let us truly change the climate of the health care dialogue. Let us recreate the world of health care, and ourselves. And together, for health care, let us bring on a warm new spring.

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Remarks of Mayor Michael Bloomberg Before the National Health Policy Conference

February 12, 2007

"You Get What You Pay For: Let's Pay For Prevention"

The proof is in the national example New York City has set by making restaurants and bars smoke-free, and in beginning to phase out the use in our restaurants of artificial trans-fats that increase heart disease and stroke. The proof is also in the numbers—the record numbers of New Yorkers who have stopped smoking, who are being screened for colon cancer, who are getting free and fast tests to learn their HIV status, and who are taking other steps essential to living longer and healthier lives.

It's all part of a public health policy we introduced that we call Take Care New York—a simple program of ten steps, like the ones I've just described, that every New Yorker, and indeed every American, can follow to significantly improve his or her health.

And in New York, it's working. For the first time since World War Two, the average New Yorker has a greater life expectancy than the average American. That means that if you want to live longer, come to the Big Apple! We'd love to have you be one of the more than 44 million visitors we host each year, or the record number of people from around the world moving to our growing city.

Take Care New York is just one part of a true sea change in health care in our city—one where we're redirecting our resources to bring about a shift. It's a shift from simply responding to and treating illnesses to actually preventing them.

That's a transformation that our whole nation needs to make, too. And that's the message that I want to focus on today: American health care, like New York City's health care, needs a big dose of preventive medicine.

Now, we all agree that our health care system is on life support. Health care reform has become Topic A—here in Washington, in state capitals from coast to coast, and in all the news stories about high taxes and unnecessary suffering.

But this national conversation on health care is, I think, missing the biggest point. It's focusing on two facts with one common feature: The number 16. (And it's not "Sweet 16," either. Far from it.) We spend 16% of our Gross Domestic Product—almost $2 trillion a year—on health care. And that even with all that spending, 16% of our people—47 million Americans—have no health insurance at all.
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Now certainly, both of these problems merit a lot of attention. But there's a third issue that's even more fundamental: not only do we have a health care system that's breaking the bank, and one that is leaving one out of six Americans uninsured, it is also providing decidedly ineffective care.

It's time to face facts. Even though we have the most expensive and most advanced health care institutions in the world, we have to face the fact that we trail 45 nations in life expectancy—nations that don't spend anything close to what we do on health care, or nations with health care systems that we've traditionally disparaged.

We also have to face the fact that the health care institutions that we are so proud of are not only costly, but do an inexcusably poor job of controlling silent killers like heart disease and diabetes. And, finally, we have to face the fact that, by itself, insuring the uninsured won't automatically produce the health improvements we have a right to expect from additional investment in health care.

Health coverage for all is a worthy goal—but it grossly over-simplifies the problems we face. Politicians love to propose magic bullet answers to our biggest challenges. But in the real world, simple solutions to complex problems just don't exist. And as with many other societal problems we face, money isn't everything. If it was, we would now, after all the grand governmental announcements of solutions, and initiatives—with their attendant voter-pleasing press conferences—we'd all be living to 125!

Just look at the number one killer in America: heart disease. What are some of its principal medical causes? Out-of-control hypertension, diabetes, and cholesterol levels. But amazingly, today, nearly nine out of 10 Americans who have any of those three conditions already have public or private health insurance coverage.

So there must be something else wrong, another essential problem, one that we've not yet tackled, but which is a real killer. And that is, that we're not buying health care that produces the kind of results that really matter.

In health care, as with everything else, you get what you pay for. And right now, it's not stretching the truth very much to say that we're paying for a disease care system, not a health care system. We're managing how we die, not postponing it.

That means that if we want a healthier, greater-life-expectancy nation, we've got to change, and start paying for prevention, as well as for treatment. Currently, this is precisely what we are not doing.

Instead, we've developed a system that rewards costly procedures at the expense of preventive care that can be cheaper and is often more effective.

Want an example? Aspirin and blood pressure pills that cost pennies can prevent heart disease and many of the nearly one million heart attacks Americans suffer every year, and also avoid $84,000 bypass operations.

Yet while I see plenty of acute care facilities built with the help of generous donors across our country, I don't recall seeing new dispensaries that give away free or low-cost preventive medicines being dedicated. Perhaps that's because ''grateful patients'' are more generous than those who are lucky enough never to become one. The fact is that 95% of medical expenditures in the United States are for curative care, and only 5% are for prevention.

Want another example? It's estimated that more than 100,000 Americans die every year from medical errors. That's an unspeakable tragedy. But what's more inexcusable than the toll taken by these sins of commission is the even larger number of people victimized by medical sins of omission—who die from the failure to take basic preventive health steps. And the fault lies not with individual doctors, and generally not with their patients, but with the skewed priorities and politics of our entire health care system.

Just last month, Dr. Lynne Kirk, the president of the American College of Physicians, correctly diagnosed our problem. We are, she told Congressional Quarterly, facing 'the collapse of primary care medicine in America.' And the reason is as plain as dollars and cents—not a lack of funds, but a drastic misdirection of where we spend them. Doctors shun primary care and instead pursue other branches of medicine—because that's where they can earn more money. Fewer and fewer medical students, most of whom come out of school saddled with huge debt burdens, are going into primary care. They just can't afford it.

Now, I'm not a psychiatrist, but I think I know the clinical term that describes this: it's nuts. What we're doing is encouraging expensive forms of treatment and discouraging less-costly disease prevention.

We're breaking the bank, and certainly not getting our money's worth.

The bad news is that, left unattended, it's going to get worse. This collapse of primary care comes at a time when we need to provide more, not less, preventive care to the baby-boomers who are America's growing middle-aged bulge.

We give older Americans Medicare. We've made progress, although not enough, in covering children. But frankly, your health begins to need extra preventive attention when you reach your 40s, and we do nothing special for this expanding group. What they need is preventive care that will

help them avoid heart disease, cancer, stroke, and other debilitating conditions that, because they're now middle-aged, they are at increased risk of developing. If we wait to treat them until they reach advanced stages of these diseases, we're cheating them—and ourselves, too. And that's why we must begin to ''pay for prevention''—to fundamentally re-order our priorities, and reward primary and preventive care that keeps people out of hospitals in the first place.

Now, the good news is that the essential pre-requisite for creating a 'pay for prevention' system is within our reach, if we redirect our efforts toward what works, and away from what's always been done! A heavy political lift, but a necessary one if we want results.

And this may actually be possible because of a striking development: Electronic health records—the software programs that can store and analyze patient information far more efficiently than written records do.

We already know that ''EHRs'' greatly reduce the medical errors that can result from misplaced or illegible written records. But their potential goes far beyond that. Getting preventive health value from EHRs is by no means automatic. But if we program and implement them with disease prevention as our goal, they can be crucial to rebuilding primary care in our nation.

So we need to make EHRs as standard as stethoscopes in doctors' offices across the country. That's because the essence of preventive care is information—information that patients, doctors, and other health care workers need so they can make the right decisions, at the right times.

Information technology is an area in which I have some experience—although let me make it clear that neither I nor the company I founded directly invests in, or markets, personal medical information or electronic health records.

Twenty-five years ago, my company began to sell computers that analyze financial information, and put those computers on the desks of investors. They gave people who need to make critical decisions the information they want when they need it. Virtually every other industry has undergone a similar information revolution. But it's a revolution in which health care still lags.

Today, most businesses—down to the smallest corner grocery store—have better information about their sales and inventories than even affluent medical practices have about their patients. The truth is that the U.S., which is the leader in so many other areas in medical technology, is woefully behind other industrialized nations in implementing electronic health records.

But we now have it in our power to change that. And in the process, we can both improve health outcomes and re-engineer our health financing system. There are two key reasons why.

First, electronic health records are interactive technology. They help doctors deliver better preventive care. Take high blood pressure, for example. Nearly 50 million people in this country have uncontrolled high blood pressure—a condition that puts them at risk of heart disease, stroke, and early death. Let's say that a patient with high blood pressure comes in to see her doctor. The doctor calls up her electronic chart on a desktop computer. And it will remind the doctor to monitor the patient's blood pressure, review her progress with her, and to adjust the patient's medication as needed.

In short, EHRs can bring information directly to the point of care, at the moment it's needed, where and when it can do the most good. They can also prompt the doctor to reach out when the patient ought to come in, but doesn't.

Think about it: you get notices for preventive maintenance from your dentist, your veterinarian, even your auto mechanic. Why not your doctor, too? EHRs can generate those notices-automatically.

There's a second reason that EHRs are key to rebuilding preventive care. It's because they can also tell us how well doctors do in keeping people healthy. And that in turn allows us to build in financial incentives for preventing illness.

Take the example of high blood pressure again. With EHRs, doctors can know exactly how many of their patients have high blood pressure. They can see for what percentage of their patients they're doing a good job of helping to keep it under control. And they can know what treatments are working best, and improve the care they provide.

Without EHRs, there is simply no way to accurately evaluate doctors' performance. But if—and only if—we implement prevention-oriented EHRs, then private insurers and Medicare and Medicaid will be able to make meaningful measurements of physicians' performance, help them improve it, and recognize and reward them when they do.

Combine the power of information technology with this ability to accurately evaluate and reward performance. It gives you the right prescription for our ailing health care system. It will establish promoting health as our guiding principle and allow us to put our money where it's needed: in preventing illness, in keeping people out of hospitals. and in providing financial incentives for helping patients live longer and healthier lives.

I'm very proud to say that New York City government has long been a national leader in instituting electronic health records. And our Administration is building on that leadership. About ten years ago, the 11 public hospitals of our Health and Hospitals Corporation began instituting EHRs. They have drastically reduced the problems of faulty prescriptions and missed or repeated x-rays and lab tests. Now we're going even further. Under the strong leadership of president Alan Aviles, who is with us today, HHC has also created a system wide 'e-registry' of patients. That registry gives HHC's primary care doctors the tools to drive better care for patients with diabetes, asthma, depression, and other serious conditions. Over the past two years, for example, HHC has been able to significantly reduce pediatric asthma emergency room visits and admissions.

It's certainly true that no good deed goes unpunished. As its reward for this improved asthma care, HHC is now grossly underpaid for its intensive chronic disease management efforts, while losing all the revenue that would have been associated with those additional ER visits and admissions.

It's a sad commentary on health care financing in America that improved preventive care like that actually hurts HHC's bottom line. But in the long-run, it's going to produce better health for New Yorkers—and that's the most important bottom line for us.

On the outpatient level, our Health Department is now creating a national model for using EHRs to improve primary care in medically under-served neighborhoods. They're bringing prevention-oriented EHRs to more than 1,000 doctors serving a million patients in community health centers, hospital outpatient clinics, and in private practices. Some of our community health clinics already have EHRs-and the benefits can be dramatic. Just look at the chart behind me.

It tells the story of what happened when one pioneering health provider—the Institute for Urban Family Health, which operates 11 community health centers in Manhattan and the Bronx—instituted EHRs in 2003. It shows that fewer than 30 elderly patients per month in these 11 community health centers were getting their pneumonia shots before electronic reminders were added to the EHRs. After an electronic reminder was added, however, that number jumped to nearly 400 patient vaccinations in one single month. And vaccination rates have steadily improved ever since. Multiply this chart citywide-or nationwide-and you can see how significantly EHRs can improve public health and preventive care.

So why don't more doctors have them? The answer, we think, comes in lethargy and high start-up costs. That's where our City government came in. Starting last year, we began using $27 million in City funds to reduce the cost and increase the prevention value of computer systems bringing EHRs to the doctors we're partnering with. Participating providers are putting up an additional $13 million for this project. And I'm pleased to say that New York also recently received $3 million in Federal funds that will help us evaluate this electronic network of community-based primary care providers which, once online, will really have no match in size or scope anywhere in the nation.

Where they've been implemented, EHRs have already compiled quite a track record. Just look at our Department of Veterans Affairs—a purchaser and provider of health care for more than four million Veterans.

The VA enjoys the unusual benefit of being free of the skewed financing priorities that plague the rest of the health care system. And more than a decade ago, it began investing heavily in prevention-oriented health care and in EHRs. The result? Today, the VA is widely recognized for the excellent quality of care it delivers, at costs substantially lower than those of the health care system as a whole.

We want to hear from you—suggestions for improvements and topics, questions, even encouragement!

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Such successes help explain why, for example, both Hillary Clinton and Newt Gingrich—two people who in the past, at least, have not always seen eye-to-eye about health care—are both big EHR fans. They're both strong and respected leaders. But unfortunately, their warm feelings for EHRs haven't yet ignited Washington into action—or funding—on anything like the scale we need. And there's only so much that New York City, or any other locality, can do acting alone.

Putting EHRs into effect—and making them the heart of a pay for prevention system—must become a national priority. To get us there, the federal government should be doing these three things. First, we have to pick up the current snail's pace of implementing EHRs. In this day and age, there is no excuse for any more delay. So let's set this national goal: Five years from today, every doctor's office, clinic, and hospital in America that accepts Medicaid and Medicare must be using prevention-oriented electronic health records. And then let's make that goal a reality.

We can do that if Washington follows New York's example. The federal government should be underwriting the costs of bringing EHRs to the primary care doctors and clinics that need them—and then demanding that

these EHRs improve the measurement and delivery of preventive care. Clearly, lots of members of Congress are thinking about this issue. More than 100 bills supporting health information technology were filed in both houses of Congress last session. But proposed legislation isn't enacted legislation. And legislation that isn't backed up by funding won't make EHRs appear by magic. We need to buy the technology infrastructure now that will let us invest in health intelligently and efficiently tomorrow.

Second, and just as urgently, we've got to start redirecting what the federal government spends on health care toward paying for prevention. As we implement EHRs, we'll be able to restructure Medicare and Medicaid reimbursements to do just that, based on accurate measurements of the most important clinical interventions.

And third, the federal government has to do more to rebuild our primary care system. Restructuring Medicare and Medicaid to pay for prevention will be a great start. It will reward doctors for choosing to practice primary care.

But other measures are needed, too. They include large-scale loan repayment plans for doctors and nurses working in primary care in low-income communities, expanded primary care medical residencies, and investments in modern primary health care centers.

Now before closing, let me sound a note of caution, make a clarification, and state a caveat. The note of caution concerns confidentiality of medical records. EHRs are vulnerable to security breaches; electronic data can be easily copied and widely disseminated—and that can have terrible consequences. So from the outset, we've got to build strict security measures into EHRs. In New York, I've asked our State Legislature to make intentional violation of the confidentiality or integrity of EHRs a felony. The Federal government should do the same. But information technology can be made to put safeguards into the system that limit access to records, and also tell us if anyone has looked at or altered them. We've got to be diligent in such measures; the last thing we want is for people needing health care—and often needing it badly—to avoid it because they're fearful of embarrassment or discrimination. But we're talking about saving lives. So we can't let a theoretical risk of potential problems prevent us from achieving outcomes of such great importance.

Second, I want to clarify what pay for prevention is not. It is not what is sometimes called 'pay for performance.' Pay for performance is something that the Federal government, as well as private insurers, have experimented with in recent years. It involves paying bonuses to providers, especially hospitals, for meeting measures reflecting appropriate delivery of care.

All too often, however, pay for performance focuses on what's easy to measure rather than what's truly important. It merely looks at process measures—what we do—not at outcomes. Pay for performance tends to ignore the fundamental task of reorienting health care financing to rebuild our primary care system and maximize the health value of our health dollars. That's the great challenge we must take up. And that's what 'pay for prevention' will permit us to do.

Third and finally, my caveat. It's this: Over time, paying for prevention should cut health care costs. But there are also going to be start-up expenses, in equipment, training, and transition costs, involved in retooling primary care in America. The cost of providing the nation's primary care clinicians with EHRs could be as high as $20 billion over the next five years. $20 billion is a lot of money—but in the context of a $2 trillion a year health care industry, it's a worthwhile investment. And let's not forget that what we're doing now costs money, too. The big difference is that paying for prevention will produce better results.

So we can either keep doing what we are doing now—paying for inadequate outcomes—or we can start paying for better outcomes that, in the long-run, make sense both for our health and our pocketbooks. It's clear what our choice should be: We should start paying for health care in ways that really improve the health of our nation.

At the outset of my remarks, I talked about the toll taken by our medical 'sins of omission.' And unless we change our course, those sins of omission will grow and spread throughout our society. In most cases, the effects won't be clearly visible—but they'll be a silent catastrophe of enormous proportions.

Think of it as the tragedy of absence. I'm talking about the absence in our offices and factories of men and women disabled by amputations, heart attacks, and kidney failure, all because their diabetes wasn't well-treated. Or the silence of the stroke victims left speechless, immobile, and confined to nursing homes instead of enjoying their mature years as they'd always planned and dreamed. Or the empty chairs at dinner tables in homes across our land—empty, because tests that could have detected cancer in early and treatable stages just never happened.

Americans don't have to accept that as our future. There's no question that we face a crisis in health care. And on this day—Lincoln's Birthday—let's remember that in a time of truly unprecedented crisis, Lincoln himself challenged the nation 'to think anew, and act anew.'

I say let's seize the opportunity now to think anew, act anew, and set a new course for our nation: a course that will give Americans the health care they need and deserve. And let's start on that course now.

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State Children's Health Insurance Program Reauthorization Debate Underway

The State Children's Health Insurance Program (SCHIP), created by Congress in 1997, must be reauthorized by September 30, 2007 to continue. While there is little debate about the program's importance and value, there is considerable debate about the funding level. Many are arguing for increased funding. Continuation of current funding levels into the future will not only hamper states from making progress in reducing the number of uninsured children, but will also be insufficient to maintain coverage for currently enrolled children.

In Michigan, the programs funded with federal SCHIP are:

- MIChild, which provides comprehensive health care coverage to low-income children under age 19 in families with incomes below 200 percent of the federal poverty level ($34,500/year for a family of 3 in 2007). The program currently covers about 31,600 children.
- Adult Benefits Waiver, which provides a basic outpatient benefit to childless adults with incomes at or below 35 percent of the federal poverty level (about $3,600/year for a single person). Enrollment in the program is capped at 62,000.

Projections by the Center on Budget and Policy Priorities indicate that Michigan will have insufficient funds to meet projected need by 2009.