**The Brookings Institution**
**The Potential of Medical Science – The Practice of Medicine**
**How to Close the Gap**
**Remarks by James J. Mongan, MD**
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I am here this morning to talk about the pressing need for fundamental change in the way we deliver health care in the United States, and to describe some of the key elements of that change.

At the risk of being a bit provocative, particularly with this audience, I would assert that the policy debate regarding change in health care over the past four decades, has been dominated by economists, and by the discussion of various payment and financing schemes, with penalties and incentives to attempt to shape the system.

I think it is past time for those directly involved with the delivery of services and the provision of care to step forward and to speak more candidly and openly some critical truths about our field. It's past time to address the fundamental cultural and organizational change, which will be necessary, regardless of which economic levers are subtly or crudely manipulated by each new crop of health economists.

So here is how I will use my 15 minutes:

- First I'll try to capture as clearly and succinctly as I can the need for change.
- Next I'll describe the critical cultural and organizational change I believe is necessary, and
- Finally, I'll address some barriers to that change.

So first, why do we need fundamental change? Simply put as you have heard from this morning's panel the way we deliver care in this country has not kept up with the underlying advances in medical sciences and treatment. This issue was clearly addressed in the 2001 Institute of Medicine Report "Crossing the Quality Chasm". I will quote just one key paragraph from that report. "Our current methods of organizing and delivering care are unable to meet the expectations of patients and their families because the science and technologies involved in health care – the knowledge, skills, care interventions, devices and drugs – have advanced more rapidly than our ability to deliver them safely, effectively, and efficiently."

Now the specific indicators of our need to change are that the services we all deliver all too often fall short in their safety, quality, effectiveness and efficiency. The most dramatic manifestation of these shortcomings is the extraordinary and mostly unexplained variance within medical practice, as we have known it over recent decades. Dartmouth's Dr. John Wennberg, joined more recently by his colleague Dr. Elliot Fisher pioneered in the study of these extraordinary patterns of variance in medical practice decades ago. In spite of their stunning data little or nothing has been done to address this issue. The enormous range in unexplained variance in medical practice across the country is nothing less than a rebuke to medicine in seeing itself as a science. This variance has a huge impact on cost and quality, with the promise of both higher quality and lower costs if best practices were applied more evenly across clinical medicine.

So what is the core change I see as critical if our delivery system is to keep pace with the progress in medical science. The necessary change has two interrelated components – organizational change and cultural change.

First, at an organizational level we must greatly accelerate the move from thousands of small physician group practices and independent hospitals towards larger, more clinically integrated health care organizations.

Importantly I am not advocating larger provider organizations alone, but rather large organizations, which also become more clinically integrated, in good part through the real application of health information technology – and more specifically electronic medical records with decision support capabilities – to help shape practice within the organizations.

The recent progress we have seen in medical science has been matched and indeed is dependent in many ways upon the similarly astonishing advances in information technology. Yet we as a health system have fallen behind other sectors in our ability to harness these advances in information technology to the daily delivery of complex and interrelated medical care interventions.

So I believe organizational change involves two elements – structuring sufficiently integrated health systems, and harnessing those systems to effective information technology, so that we can function in a coherent clinical framework.

Organizations of a size will be necessary to make the increasingly important investments in clinical information technology systems economically feasible. As importantly, only organizations of a certain size and degree of structure can sustain a clinical culture that fosters and supports true adherence to clinical guidelines and peer review. And as a final point, organizations of some size are necessary to make meaningful pay for performance realistic.

Now some in the audience will say that I'm headed down the wrong track – that the literature, which shows a quality advantage

in large groups is still relatively thin and that the data on cost and efficiency is mixed. I would respond that the data on both quality and efficiency will become more robust as systems like our own more thoroughly harness clinical information systems as has been done at the VA and Kaiser systems.

Building a reformed system will only really be possible when we have in each area of the country a number of health care organizations of sufficient size and degree of organizational and cultural coherence so that the organizations can assume true responsibility for the quality and the efficiency of the care they provide.

I have been searching for a metaphor to capture this need for larger more integrated health systems to replace the fragmented and atomized system we know today. Crudely I have thought of the analogy of attempting to build a house out of gravel. It simply can't be done. You either need well formed bricks, or at least some way to aggregate the gravel, in order to build a structure or I would submit in order to restructure the delivery system.

Recently I saw perhaps a better metaphor, when I read a quote from Margaret O'Kane of the National Committee on Quality Assurance who said " The American health care system is like buying a car where they come and put the parts on your lawn. What we're all looking for is the entity that puts it all together and that is able to be accountable for the performance of the vehicle, rather than whether or not you got good spark plugs".

Let me turn now to the second change, the cultural change necessary to foster larger organizations and to allow our delivery system to keep up with advances in medical practice. Those who write on change and transformation most often cite cultural change as the most difficult change to achieve. Now in medicine, for decades, one of the strongest cultural foundations has been

physician autonomy, or the belief that the individual physician has sole responsibility for their portion of the care of their patient, and accountability only to their own professionalism. Of course they were accountable to state licensure boards, but only for extreme misbehavior. Though legally accountable to lay hospital boards, in practice, until recent decades, the hospital was seen culturally as "the physician's workshop" and woe unto the hospital administrator who tried to address practice issues. And of course, physicians have steadily resisted interference by so called "third party" payors and the government. What we are left with is the grossly flawed accountability of the legal malpractice structure, as a very imperfect check on autonomy.

Now there is something to be said for physician autonomy – when you are really sick you want to be under the care of someone who has the authority to make critical judgments about the elements of your care. But unfettered and unbounded autonomy has enabled, and in fact driven, the rather strong variance in practice I described earlier with huge consequences for quality, safety and efficiency.

The cultural transition we need in medicine – as medicine, thankfully, becomes more science than art – is a more appropriate balance between autonomy and accountability, in order to achieve reasonable boundaries around variation of practice.

Electronic medical records are a tool to decrease variance, but they are only tools. We need a transformed cultural context for the tool to be effective. We need a culture in which individual physicians cede some of their individual autonomy to a group, empowered to design the rules, algorithms, and prompts which enable electronic records to guide (though not to force) practice patterns leading to enhanced quality, safety and efficiency.

What groups should be the recipient of some degree of autonomy appropriately ceded by individual physicians? I would assert that

the best path would be that physicians cede some autonomy to colleagues in a larger group, where they have some real accountability to their peers. This is not only the most feasible change, it is the one most likely to succeed in the long run. It seems preferable to the government plunging into all framing of practice or to insurers or other proprietary groups capturing this responsibility.

The larger groups of physicians could range all the way from large tightly organized groups such as Kaiser Permanente, through large integrated provider organizations such as Intermountain Health, Mayo Clinic, Geisinger Clinic, or our own organization, Partners, through large physician group practices, to more virtual organizations of physicians in rural areas.

One more point. Although the jury is still out, I believe that the threshold level of integration that health systems need to attain in order to enhance quality and efficiency is somewhere short of a fully capitated or budgeted, employed physician model. We should recognize and praise organized systems like Kaiser and the Veterans Administration, which are far ahead of most of us in achieving clinically coherent frameworks for the care they deliver. But at the same time, I believe our general national political culture, which puts great value on patient choice; and the culture of our health system, which has so valued physician independence, means that most of us will not move to this most fully integrated model, at least in the near term future.

So in a sentence, the cultural transformation we need is to establish a more appropriate balance between autonomy and accountability, a balance, which would foster and support a move towards more organized groups of physicians.

Let me now set this cultural and organizational transformation into a national policy context. Last year I was asked to chair the newly

established Commonwealth Foundation Commission on a High Performance Health System. The Commission is made up of eighteen leaders from many parts of the health system.

To link the Commission's work to my focus today, the need for improved informatics and the need for organizational and cultural change are absolutely central to the Commission's diagnosis of our system's failure, and to our thoughts about treatment of those failures.

Following on this diagnosis, among the Commission's early recommendations are strong recommendations to "work towards more organized delivery systems, and to expand the use of electronic health records".

Let me close with a brief word on barriers to the cultural and organizational change I've described. I'll touch on three - sociological barriers, legal barriers and economic barriers.

The sociological barriers to the cultural change needed, to achieve the more appropriate balance between autonomy and accountability, are perhaps the most difficult barriers to surmount. Teaching medical students differently seems little more than a cliché. But we really do need, not only to teach but also to model, in a more thorough going way through our medical school, residency and fellowship training that medicine is, as much about accountability as it is about autonomy. We need to model a more serious questioning of unexplained variance within and across practices, and we need to model an appropriate reliance on decision support and other mechanisms to appropriately narrow that variance.

And we also need to better teach and model physicians working more seamlessly with other physicians and health professionals –

to model that medicine is, as my colleague Dr. Lee says, a team sport, not an individual sport.

The legal barriers to the formation of larger more integrated groups should be more thoroughly explored. As stated in the summary of the issue brief "the development of such provider organizations is discouraged by anti-trust policies, which reflect greater concern for protecting consumers from price increases than optimism that organized providers might deliver better and more efficient care. We should thoughtfully explore together the right balance between concern and optimism. We should recognize the need for fundamental change from practice as we know it today.

And finally, back to the economists. There is of course a need for appropriate reimbursement policies. Under current reimbursement systems there is no compelling business case either to move to larger groups or to moderate utilization. The demand for larger clinical information technology investments will begin to build a business case for larger groups. And, I believe real pay for performance mechanisms, possible only with larger groups, which reward meeting clinical improvement targets for both quality and appropriate utilization, could have a major impact on cost and quality.

So in conclusion I have attempted to set out the case for change, the major elements of that change, and a set of key barriers to seeing that change occur.

We all know that achieving the change I have described will be an enormous task. After all we are not only talking about 16% of the gross national product, but we are also talking about healing, which touches every American family. We in the medical profession owe it to ourselves, and to those families, to match the capabilities of our delivery system to the extraordinary blessings of advances in science and medical practice.