BEST CARE ANYWHERE

Why VA Health Care Is Better Than Yours

SECOND EDITION

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Preface to the Second Edition

A month after *Best Care Anywhere* first appeared in January 2007, the *Washington Post* began an exposé on problems at Walter Reed Army Medical Center in Washington, DC—a series for which it later won the Pulitzer Prize. The facility is a U.S. Army hospital, as its name indicates, run by the Department of Defense, not by the separate cabinet agency—the Department of Veterans Affairs (VA)—whose virtues I had described in my book. Nonetheless, this distinction was lost in much of the reporting on the scandal, leaving many Americans with the impression that the VA was neglecting grievously wounded warriors. As media and congressional investigations mounted, my publisher and editor pretty well gave up on the book, as they later told me. Meanwhile, I endured blogosphere ridicule for having written one of the worst-timed books in years.

Yet slowly, by word of mouth, the book and its paradoxical message began to attract positive notice and to exert some influence behind the scenes. For example, in an odd loop the loop, when reporters around the country started visiting their local VA hospitals looking for scandalous conditions like those described by the *Post* at Walter Reed, they often came away

as impressed as I had been in researching my book. The VA received an unexpected burst of positive coverage, in which *Best Care Anywhere* was often cited. That coverage has continued to build; the *Wall Street Journal* is the latest organ of the mainstream media to discover the virtues of the VA's model of care.[1]

Behind the scenes, people in high places, as well, became aware of the quality revolution at the VA that I had described. For example, in the spring of 2007, I was twice summoned to brief the health-care staff of then leading Democratic presidential candidate Hillary Clinton. Afterward, her standard speech on health-care quality came to include two paragraphs on the transformation of the nation's long-tarnished veterans' health-care system and its lessons for improving quality in health care generally.

Through a well-placed friend and colleague, a copy of the book was also slipped to candidate Barack Obama before he boarded a long flight to Hawaii. Whether he read it, I do not know, but he, too, began making positive references to the VA in his health-care addresses. Peter Orszag, then director of the Congressional Budget Office and now Obama's head of the Office of Management and Budget, began ordering up studies from his staff on the lessons of the VA's quality performance.[2]

Interest stirred in some Republican circles as well. Michael Cannon, director of health policy studies at the libertarian Cato Institute, took exception to the idea that the VA—the nation's one undeniable example of fully socialized medicine—should stand as a model of twenty-first-century health reform. But he acknowledged the VA's emergence as a quality leader in health care and wrote thoughtfully for the *National Review* about how the agency's performance might be replicated in the private sector.[3]

Already resigned to the seemingly irresistible trend toward more government spending on health care, at least a few "Blue Dog" Democrats began quietly consulting with me about whether the VA's proven efficiency might offer clues for containing health-care costs generally. Speaking invitations at Yale, the University of Pennsylvania (Wharton School of Business), and other universities, as well as increasing sales to university bookstores, also signaled increasing academic interest. Through the initiative of academics in Beijing University, the book is also being translated into Chinese. (As the U.S.'s prime creditor, China is particularly interested these days to learn if a model exists, such as a civilian version of the VA, for containing the spiraling cost of the U.S. health-care system, because otherwise, China worries, we won't be able to repay our mounting debts.)

Interest in the book also began to spread among the larger veterans' community. Organizations such as the American Legion are often heard in the media and in Congress complaining about the VA's shortfalls, as is their role. They are particularly upset, and rightly so, about how difficult it can be for veterans to establish eligibility for VA care. But they are also tenacious in their advocacy for the VA and its ongoing quality revolution in ways that offer fascinating soundings into the deeper currents of American health-care politics. During the summer of 2009, I had the great honor of addressing a large audience of American Legion officials at their annual convention in Louisville, Kentucky. Looking back at me was an assemblage of many middle-aged and older vets, mostly drawn from small-town, Red-State America. Steeped in patriotic traditions and bedecked with its symbols, they spontaneously stood and cheered when I suggested that they

tell their neighbors about today's VA—and about the ability of "socialized medicine" to deliver the "Best Care Anywhere."

Yet it is fair to say that outside of the very different worlds of health-care policy wonks and veteran service organizations, the VA's reputation remains mixed at best. This divided reputation is partly due to the VA's long history, particularly during the Vietnam era, as a deeply troubled institution. That legacy still affects its image. Many Americans simply have not heard of the VA's quality transformation, and even when they have, they remain skeptical because of their generally dim view of government.

The VA's mixed reputation is also partly due to the fact that its mistakes tend to become national news. The recent headlines include surgical malfeasance associated with the deaths of nine veterans at the VA's facility in Marion, Illinois. In Philadelphia, a rogue surgeon, employed by the University of Pennsylvania but under contract with the VA, improperly treated prostate cancer patients with a life-threatening nuclear procedure. These examples of malpractice are egregious, but in gauging their significance, we must ask, "Compared to what?" Medical errors are demonstrably less common in the VA than elsewhere in the health-care sector, and study after study demonstrates the VA's superior quality of care. But because of the public nature of the VA, and because the VA systematically looks for and reports its mistakes, those errors are much more likely to come to public attention, through congressional hearings, press reports, and investigations by veterans advocacy groups and the VA's own inspector general. The cumulative effect on the average news consumer can be an impression that the VA is limping along from one scandal

to the next, even as its patients and health-care quality experts applaud its quality, safety, and cost-effectiveness.

Until recently, this gap in the public's understanding of the VA's story didn't much figure in practical, day-to-day politics. That's because the country's political system was caught up in a protracted debate that largely ignored reform of the actual practice of medicine. Almost all the arguments about health care in recent years have really been about heath care *insurance*—who should get it, and who should pay for it. Little thought has been given to reform of the health-care delivery system. This focus on insurance has left the VA's story, which is about a proven model of safe, efficient, digitally driven, evidence-based medicine, largely out of the conversation except in specialized health-care policy circles.

When *Best Care Anywhere* was first published, for example, a Republican White House was arguing that unsustainable health-care inflation could only be checked if Americans came to "have more skin in the game," that is, to pay more of the cost of their health care out of their own pockets. Measures such as health savings accounts and high-deductible insurance plans were supposed to encourage patients to do more comparison shopping and haggling with their doctors and therefore to create more market discipline in the system. Essentially, this remains the Republican position on health care.

Meanwhile, the dominant idea for health-care reform among centrist Democrats was and remains the "individual mandate," as championed by presidential candidate Hillary Clinton and later by President Obama and the Democratic Party leadership in Congress. The proposal, one version of which passed the House and Senate as of this writing (but which is also rapidly losing popular support), would require

all Americans to purchase health insurance; those who cannot afford the premiums would get subsidies. This arrangement would, by fiat, end or at least reduce the problem of the uninsured and also promises to prevent private insurance companies from discriminating against people suffering from preexisting conditions.

Further to the Left are people who have argued, and still argue, that health-care reform simply entails creation of a "single-payer system," specifically a policy that would extend Medicare-like insurance coverage to everyone. Short of that policy, the progressive cry has been for a "public option" that would give at least some Americans the opportunity to purchase government-provided health *insurance*, though not government-provided health *care*.

Given this spectrum of opinion, the VA model's advantages in the hands-on delivery of health care have hardly been part of the national debate. Many insiders say that this low profile is necessary. Political logic dictates, they have argued, that first we insure the uninsured, and later we worry about what we have insured them against—that is, what protocols of health care Americans should receive for different conditions and how to ensure their delivery. Less charitably, future historians may look back at the terms of our recent health-care debate and view them as part of a larger, darker cultural phenomenon of our time.

An odd feature of the last few decades of American life has been the tendency, especially among the "best and brightest," to focus not on hands-on production, whether it be of automobiles, homes, or health care, but on "derivatives" of production—the manipulation of symbols that has become the essence of finance, from securitized auto loans and sub-

prime mortgages to high-deductible or public option health insurance policies. Yet now we are reaching a moment when continuing the conflation of finance with production—and particularly of health-care finance with health care itself—has played out about as far as it usefully can.

To be sure, health insurance reform is important. Done right, it can remove some of the most egregious conditions of American life: the discrimination against the sick in insurance markets, such as my late wife, Robin, and I faced during her losing battle with breast cancer; the uniquely American phenomenon of medical bankruptcy; the tens of thousands of premature deaths among the un- and under-insured; and wasteful flows of funds going to maximize insurance company profits and to bloat administrative costs. Through adjustments in fee schedules and in the terms of reimbursement contracts with doctors and hospitals, insurance could also, at least in theory, indirectly influence medical practice for the better. But make no mistake: none of the health insurance reforms we've been so strongly debating will, by themselves, solve the health-care crisis, and expanding access to an already broken, fragmented, and overwhelmed health-care delivery "system" could well make it worse.

In updating the statistics for this edition, I have been reminded again and again of the continuing breakdown of day-to-day medical practice in the United States: the extraordinary levels of unnecessary and often harmful treatments; the high rates of medical errors and of untreatable hospital infections; the neglect of prevention, of primary care, of patient safety, of coordination among specialists, of basic research on what works and doesn't, of investment in simple health information technology for purposes beyond billing.

It all brings to mind a concept that encapsulates all these and other baleful trends in our health-care delivery system: iatrogenesis. The term, coined by the ancient Greeks, refers to death and suffering caused by poor medical treatment or advice. Today, iatrogenesis includes unnecessary surgery, medical errors, hospital-acquired infections, and the prescribing of unsafe drugs or unsafe combinations of drugs. According to an estimate published in the *Journal of the American Medical Association*, such iatrogenic practices minimally kill 225,000 Americans per year. This rate makes contact with the American health system the third-largest cause of death in the United States, following heart disease and all cancers.[4]

By contrast, a widely accepted 2002 estimate by the Institute of Medicine holds that 18,000 Americans die every year because of lack of health insurance. Though some believe this estimate is too low, even the direst projections would mean that iatrogenic medicine (most of it covered by insurance) kills five times more Americans.[5]

Moreover, a fair accounting of iatrogenic medicine must also include the less quantifiable but nonetheless undeniable illness and suffering induced by wasteful spending on health care itself, whether that spending is borne by individuals or society as a whole. Numerous studies now confirm that about a third of all health-care spending is pure waste, mostly in the form of unnecessary and often harmful care—amounting to some $700 billion a year.[6] That's $56 billion more than total federal spending in 2009 for Social Security, a program that, along with many other programs, may well have to be cut to cover the soaring cost of Medicare and Medicaid. Already, a nation spending that much on wasteful health care is a nation

that necessarily spends less than it otherwise could on reducing the major social and economic determinants of illness, including unemployment, lack of education, pollution, addiction, poor nutrition, auto dependency, and strains between work and family life. Whether today's U.S. health-care system is, on balance, iatrogenic—that is, contributing, directly and indirectly, to more illness than it cures—cannot be conclusively demonstrated. But it is at least a possibility, and one that becomes increasingly certain given current trends.

So the moment comes when we must move beyond the realm of mere finance and be as empirical as we can about what works and does not work in the delivery of health care. The central contention of the current administration's vision for putting America back on course, let us not forget, is that our health-care system today is so wasteful and poorly organized that we can lower costs, expand access, and raise quality all at the same time—and even have money left over at the end to help pay for other major programs, from bank bailouts to high-speed rail. It is not too much to say that the Obama administration is betting the country on this proposition, or would like to.

The proposition is not as implausible at it might sound. America spends nearly twice as much per person as other developed countries for health outcomes that are no better. The cost of health care has become so gigantic that pushing down its growth rate by just 1.5 percentage points per year would free up more than $2 trillion over the next decade, which would buy a lot of high-speed trains and much else that our country needs, from investment in green energy and infrastructure repair to the retooling of America's manufacturing base and the employment of its laid-off workers. It

could also allow for a nice-sized tax cut, if that turns out to be our preference, or for a large down payment on the ballooning national debt. But bending that health-care cost curve requires fundamentally changing the practice of medicine, not just its financing.

The VA system is hardly a perfect model for a delivery system reform. Yet its comparative effectiveness should be examined and explained if we are to have any hope of building a world-class health-care system that is not itself a major cause of death, suffering, impoverishment, and national decline.

By all rights, after all, the VA should offer the worst care anywhere: it's a gigantic, unionized bureaucracy, micromanaged by Congress and political appointees, and beset by an uncertain budget, an aging infrastructure, and a legacy of scandal. That it nonetheless outperforms the rest of the U.S. health-care system, on metrics ranging from patient satisfaction to cost-effectiveness and the use of evidence-based medicine, suggests that much of what we think we know about health care simply isn't true. The VA's long-term relationship with its patients, it turns out, more than makes up for its built-in institutional liabilities, which offers a lesson for health-care reform that we ignore at our peril. I offer this second edition of *Best Care Anywhere* in the hope that more readers worried about their own health and that of the nation will consider the meaning of the VA's paradoxical example and its implications for true health-care reform.

January 20, 2010,
Washington, DC

Introduction

Some years ago, *Fortune* magazine summoned me to New York for a sumptuous lunch and a serious discussion. At the end of the meal, I found myself with a plum, but difficult, freelance assignment. It was no less than to figure out who had the best solutions for America's health-care crisis, and to write them up in snappy prose that would make the story a "must read" for the country's business elite. What the magazine had in mind, I think, was that I find some dynamic, change-artist CEO who was doing for health care what Andrew Grove had once done for Intel or what Jack Welch had done for General Electric.

I accepted these marching orders with much trepidation, but also great curiosity and passion. The biggest reason was personal. Five years before, I had lost my wife, Robin, to breast cancer. I never blamed her doctors for her death. But what I saw of the American health-care system during the 10 months between her diagnosis and demise had caused me to stop regarding health care as a mere abstraction. I had become personally engaged in the question of how the American health-care system actually worked, or all too often, didn't work.

Robin was treated at the prestigious Lombardi Cancer

Center, part of Georgetown University's hospital, in upscale Northwest Washington, DC. Every time she and I entered the facility through its posh lobby, we passed a poster-sized blowup, mounted on an easel, of a recent cover of *U.S. News & World Report* that ranked Lombardi as one of the best cancer treatment centers in the country. Since I worked at *U.S. News* at the time and respected the team responsible for these annual rankings, this was particularly reassuring.

Robin and I both felt blessed that our gold-plate insurance allowed us unfettered access to all the doctors and specialists we would care to see, and that we lived within just a short drive of Lombardi's world-class facilities. I particularly remember Robin saying how grateful she was that we hadn't chosen to try to save money by enrolling with an HMO. We were lucky yuppies, and we knew it.

Yet the more time we spent in the Lombardi Center and Georgetown Hospital, the more I was disturbed by the way they managed "the little things." On the day Robin underwent her lumpectomy, for example, I had to explain to her afterwards as best I could why I wasn't there to offer her support and comfort when she awoke. The reason, though hard for both of us to believe at the time, was that no one in the hospital could tell me, despite my increasingly frantic inquiries, where she was. I had imagined that every hospital, particularly a prestigious one attached to a major university in the nation's capital, operated with advanced information technology systems that kept track of every patient's location and condition. Not true, it turns out.

I was similarly shocked at how little the various specialists involved in her care seemed to consult with one another, or

to keep up to date on the results of tests. In one emotionally devastating meeting, for example, the discussion began with various members of Robin's "team" optimistically discussing her prospects for reconstructive surgery. Robin and I were both thrilled that the lumpectomy was an apparent success and that her chemotherapy seemed to be working to contain the cancer. But well into the meeting, one doctor began to fidget, finally asking if anyone had looked at the results of a recent liver scan. The team quickly departed, leaving Robin and me in an empty examining room for 30 or 40 minutes. Eventually, a grim-faced oncologist returned. The cancer had metastasized to her liver. It looked as if she was terminal.

As I said, I never blamed her doctors for her death, but seeds of doubt sprouted in my mind about the system in which they were operating. Most of the doctors were sympathetic enough, and all were highly credentialed. But there seemed to be little attention given to managing information and coordinating care. It was as if, upon arriving at an airline gate, you were informed that the airline had lost track of the plane, couldn't find its passenger manifest, and couldn't say if it had passed its last inspection. At any given time, Robin's medical records and test results seemed to be scattered in paper files kept by different departments. If any one doctor played the role of pilot, much less air traffic controller, I had no idea who he or she was.

The experience of Robin's treatment set off unsettling questions in my mind, though I tried to suppress them. Who was in charge of quality control? Why did everything seem to be done on the fly? Why did almost every routine process—doctor visits, lab tests, chemotherapy sessions—seem to involve

interminable waits or changes in plan? I couldn't offer Robin any comfort either when she received the news that she only had an estimated 17 days to live and would have to go home from the hospital to die. A doctor had changed his mind without telling us about when he would share with us the results of Robin's latest tests. And so she received this death sentence while alone in the hospital and had no one to talk to about it for hours. In a normal business, such as an airline, being perpetually late and having to shift plans constantly are sure signs that its processes are breaking down and that something bad is waiting to happen.

Then there were all the logistical and insurance issues. When was someone going to change her IV? When could our two-year-old son visit her? How long could she stay in the hospital after she had been declared terminal? How could one arrange for home hospice care, what did it cost, and who would pay? I came away feeling that no patient should ever enter a hospital without having some kind of full-time advocate—a caring, calm, and shrewd relative or friend at least, preferably with medical training and a law degree—to help navigate all the potential perils. And I wondered why the American health-care system, or at least this one prestigious corner of it, had come to be like this.

A short time after Robin died, I read in the newspaper that the Institute of Medicine had issued a landmark report in which it estimated that up to 98,000 Americans were killed every year in hospitals as a result of medical errors—a toll which exceeded that of AIDS, breast cancer, or even motor vehicle accidents. The article also put it another way: It was like three jumbo jets crashing every other day and killing all on board. I was shocked, but upon reflection, not incredulous.[1]

Indentured Servitude

Another reason I was eager to accept *Fortune*'s assignment was that the American health-care crisis seemed finally to be coming to a head. As long ago as 1970, the editors of *Fortune* had put out a special issue on medical care, declaring it "on the brink of chaos." *BusinessWeek,* that same year, had a cover story on American health care titled "$60 Billion Crisis." But health care by now was close to a $2 *trillion* crisis, and that didn't even count all the indirect costs it was imposing on the economy and Americans' pursuit of happiness.

One of those indirect costs that I, along with millions of other Americans, had experienced firsthand was finding myself trapped in a job by my need for insurance. Shortly after Robin's cancer was diagnosed, *U.S. News* went through a management shakeup. The editor who had hired me was summarily fired, and I found myself on the losing side of a regime change. The jig was up, and it was time for me to go.

But, though I had several tempting offers, I had to stay and tough it out as best I could because I could not risk changing insurance plans with Robin's preexisting condition. As it turned out, I was fortunate to be able to keep my job for as long as I had to, and I'm very grateful to all involved for that. But the experience sensitized me to how many Americans are stuck in place year after year—unable to start a new business, go back to school, or even take time off to care for a loved one—just because of the way we finance our health-care system.

I was also aware, of course, of the many familiar trend lines that make our health-care system unsustainable. Two years before Robin died, when our son was born prematurely

at just 2½ pounds, I was amazed by and grateful to doctors and nurses at Sarasota Memorial Hospital who managed to keep him alive. But during the 60 days he was in the neonatal intensive care ward, I came to know other parents of "preemies" who, regardless of whether they lost their babies, were losing their homes and headed toward bankruptcy because they lacked health insurance. Since then, the number of such tragedies has only grown.

Every year, the cost of health care rises faster than the economy grows, with results that are as predictable as they are depressing. Because of its soaring price, we see millions of workers forced to forgo raises and to assume more and more of the cost of their health care, even if they are still lucky enough to have group insurance. We see the crush of medical expenses emerging as the number one source of personal bankruptcy.[2] We see once-proud corporations like General Motors made wards of the state and forced to downsize in large part because of their ruinous liabilities for employee and retiree health-care benefits. We see state and local governments raising taxes and the federal government going deeper and deeper in debt as they try to cover the exploding cost of publicly financed health-care programs. And all this inflation and economic turmoil just as the baby boomers, my generation, begin experiencing the infirmities and chronic illnesses of old age. At current growth rates, health-care spending is projected to consume anywhere from 119 percent to 142 percent of the entire real increase in U.S. per capita income over the next 75 years, sucking trillions of dollars away from other vital purposes.[3] Can health-care spending at that level even begin to ameliorate the ill health it would cause? Such a price would necessarily reduce, as it is reducing today, the amount

of time and money left for educating children, fighting poverty, cleaning up the environment, fostering community, and relieving all the other socioeconomic determinants of illness.

Health Care's Declining Pace of Progress

A final reason I was eager to take on *Fortune*'s assignment was a little-known but diabolical fact I had stumbled upon shortly after Robin died. The more I thought about it, the more alarming and outrageous it seemed to me. I discovered it after reading a study by the Federal Reserve that calculated how many hours, in different eras, the average American worker had to be on the job to make enough money to purchase various big-ticket items.

The study showcased the example of cars. Back in 1955, for instance, the average worker had to labor 1,638 hours to earn enough to buy a brand new Ford Fairlane. By 1997, the average American worker earned enough in just 1,365 hours to buy a brand new Ford Taurus, which, unlike the Fairlane, came with such standard features as air conditioning, airbags, cruise control, and power windows, steering, and brakes, and it got much better mileage. According to the study, a similar pattern of improving quality at lower real cost is true of nearly every big-ticket item for sale in the American economy.[4]

But what, I wondered, would happen if one included the cost of health care, which the study did not? It's a simple calculation, and when I did the math, the results were as devastating as they were revealing. If you've ever wondered how the nation's per capita GDP can grow year after year without most Americans feeling any richer, here's a big part of the explanation.