A Tale of Two Reports

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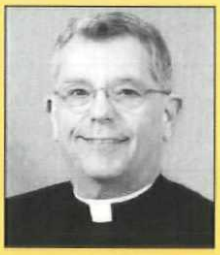
Knowing is not enough; we must apply.
Willing is not enough; we must do.
—Goethe[1]

There are many reasons for looking forward to a vacation. For me, the main reason, right after not being on an airplane, is catching up on reading I have set aside for "when I have more time." During the time I was away this winter, I read several items that relate to two of our more significant initiatives. In what follows I will share some of the more important elements of my reading. They will be provided in a summary format in order to provide a foundation for further reflection. They will be followed by a presentation of some ethical principles that should guide future reflection as we engage what has been summarized.



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Some "Take-Along" Thoughts

The first focus of my reading was the Institute of Medicine's (IOM's) report *Insuring America's Health.* It is the sixth and last report in a series issued by the IOM's Committee on the Consequences of Uninsurance. In a preface to the study, the committee's cochairs, Mary Sue Coleman, PhD, and Arthur L. Kellerman, MD, MPH, write:

> In light of the many consequences of uninsurance, and the continuing stress it imposes on the very fabric of America's health care system, this problem can no longer be ignored. Uninsurance can be eliminated, but it will require the support of the public, considerable technical expertise by policy makers, a spirit of compromise among stakeholders, and courage from our elected officials. We firmly believe that universal coverage of the U.S. population is both feasible and imperative (p. xii).

The report begins by summarizing, under the heading "Why Should Policy Makers and the Public Worry about Coverage?" the findings of the previous five studies:

- The number of uninsured individuals under age 65 is large, growing, and has persisted even during periods of strong economic growth.
- Uninsured children and adults do not receive the care they need; they suffer from poorer health and development, and are more likely to die earlier than are those with coverage.
- Even one uninsured person in a family can put the financial stability and health of the whole family at risk.
- A community's high uninsured rate can adversely affect the overall health status of the community, its health care institutions and providers, and the access of its residents to certain services.
- The estimated value across the population in healthy years of life gained by providing health insurance coverage is almost certainly greater than the additional costs of an "insured" level of services for those who now lack coverage (pp. 2-3).

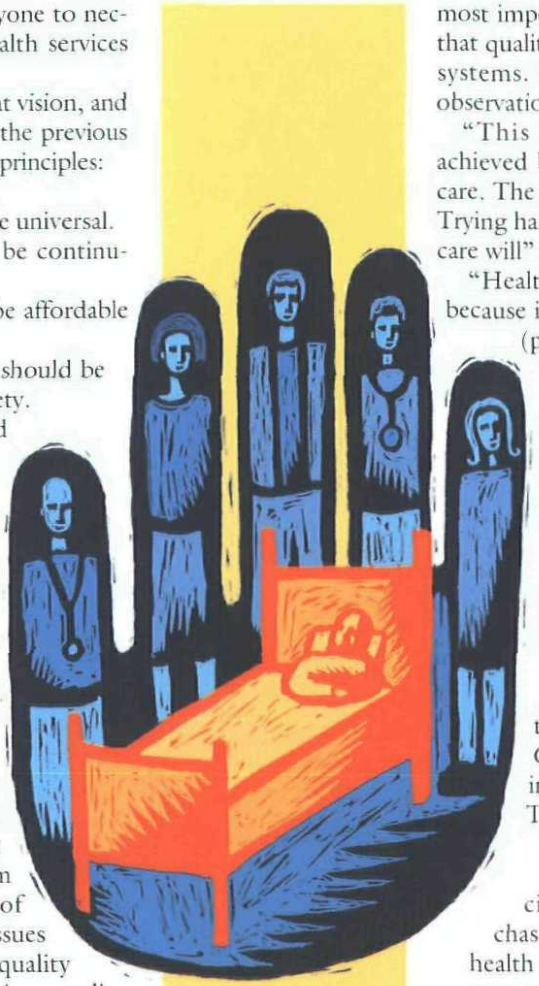
The report's authors, after reviewing earlier attempts to resolve the problem of the uninsured, conclude that "the persistence of uninsurance in the United States requires a national and coherent strategy aimed at covering the entire population. Federal leadership and federal dollars are necessary to eliminate uninsurance, although not necessarily federal administration or a uniform approach throughout the country. Universal health insurance coverage will only be achieved when the principle of universality is embodied in federal public policy" (p. 7).

As the authors of *Insuring America's Health* look to the future, they propose a vision statement that outlines an approach to health insurance that will promote better overall health for individuals, families, communities, and the nation

by providing financial access for everyone to necessary, appropriate, and effective health services (p. 8).

Then, to guide the realization of that vision, and utilizing the research and findings of the previous five studies, the authors enunciate five principles:

- Health care coverage should be universal.
- Health care coverage should be continuous.
- Health care coverage should be affordable to individuals and families.
- The health insurance strategy should be affordable and sustainable for society.
- Health insurance should enhance health and well-being by promoting access to high-quality care that is effective, efficient, safe, timely, patient-centered, and equitable (pp. 8-9).



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Back to the Quality Chasm

Helpful though these principles are, I was more intrigued by a section in the introduction that discussed "health care reform and health insurance reform." In this brief section, the authors note the interrelatedness of delivery system reform with the strategies they propose to reform health insurance. When speaking of reform of the system they refer to issues "such as cost control mechanisms, quality improvement, health work force training, medical liability compensation systems and implementation of information technology systems to promote more effective care patterns and administrative procedures" (p. 27). It is in this context that the authors make note of an earlier conclusion, reached by the IOM's Committee on Quality of Health Care in America, that "'the American health care delivery system is in need of fundamental change' and system-wide reform." They then go on to observe that "the quality and cost of health care certainly can be affected by the health insurance system and the reverse is true." Finally, they conclude by recommending that "extension of health coverage not be delayed until the whole health care delivery system is reformed first, nor should the transformation of health care delivery be delayed until all Americans are insured."

The passage, quoted from the 2001 IOM report that is best known by its title, *Crossing the Quality Chasm*, encouraged me to read once again that landmark report.[2] Perhaps one of the most important findings of the earlier report was that quality improvement ultimately is a matter of systems. Some of the report's more pertinent observations include the following:

"This higher level of quality cannot be achieved by further stressing current systems of care. The current care systems cannot do the job. Trying harder will not work. Changing systems of care will" (p. 4).

"Health care has safety and quality problems because it relies on outmoded systems of work" (p. 5).

"If we want safer, higher-quality care, we will need to have redesigned systems of care, including the use of information technology to support clinical and administrative processes" (p. 5).

"In some areas, achieving this ideal will require crossing a large chasm between today's system and the possibilities of tomorrow" (p. 5).

To help achieve this transformation, the authors of *Crossing the Quality Chasm* laid out an agenda for redesigning the 21st Century health care system. They recommend:

- That all health care constituencies, including policymakers, purchasers, regulators, health professionals, health care trustees and management, and consumers, commit to a national statement of purpose for the health care system as a whole and to a shared agenda of six aims for improvement that can raise the quality of care to unprecedented levels.
- That clinicians and patients, and the health care organizations that support care delivery, adopt a new set of principles to guide the redesign of care processes.
- That the Department of Health and Human Services identify a set of priority conditions upon which to focus initial efforts, provide resources to stimulate innovation, and initiate the change process.
- That health care organizations design and implement more effective organizational support processes to make change in the delivery of care possible.
- That purchasers, regulators, health professions, educational institutions, and the Department of Health and Human Services create an environment that fosters and rewards improvement by (1) creating an

infrastructure to support evidence-based practice, (2) facilitating the use of information technology, (3) aligning payment incentives, and (4) preparing the workforce to better serve patients in a world of expanding knowledge and rapid change (p. 5).

In pursuing that agenda, the earlier report's authors proposed six aims, all addressing areas in which today's health care system is functioning at levels lower than it should. They proposed that health care should be:

- Safe—avoiding injuries to patients from the care that is intended to help them
- Effective—providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse, respectively)
- Patient-centered—providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions
- Timely—reducing waits and sometimes harmful delays for both those who receive and those who give care
- Efficient—avoiding waste, including waste of equipment, supplies, ideas, and energy
- Equitable—providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socio-economic status (p. 6)

Redesigning the Process

The authors of *Crossing the Quality Chasm* went on to propose 10 rules that would guide the manner in which private and public purchasers, health care organizations, clinicians, and patients would work together to redesign health care processes. The rules were:

1. *Care based on continuous healing relationships.* Patients should receive care whenever they need it and in many forms, not just face-to-face visits. This rule implies that the health care system should be responsive at all times (24 hours a day, every day) and that access to care should be provided over the Internet, by telephone, and by other means in addition to face-to-face visits.

2. *Customized based on patient needs and values.* The system of care should be designed to meet the most common types of needs, but have the capability to respond to individual patient choices and preferences.

3. *The patient as the source of control.* Patients should be given the necessary information and the opportunity to exercise the degree of control they choose over health care decisions that affect them. The health system should be able to accommodate differences in patient preferences and encourage shared decision making.

4. *Shared knowledge and the free flow of information.* Patients should have unfettered access to their own medical information and to clinical knowledge. Clinicians and patients should communicate effectively and share information.

5. *Evidence-based decision making.* Patients should receive care based on the best available scientific knowledge. Care should not vary illogically from clinician to clinician or from place to place.

6. *Safety as a system property.* Patients should be safe from injury caused by the care system. Reducing risk and ensuring safety require greater attention to systems that help prevent and mitigate errors.

7. *The need for transparency.* The health care system should make information available to patients and their families that allows them to make informed decisions when selecting a health plan, hospital, or clinical practice, or choosing among alternative treatments. This should include information describing the system's performance on safety, evidence-based practice, and patient satisfaction.

8. *Anticipation of needs.* The health system should anticipate patient needs, rather than simply reacting to events.

9. *Continuous decrease in waste.* The health system should not waste resources or patient time.

10. *Cooperation among clinicians.* Clinicians and institutions should actively collaborate and communicate to ensure an appropriate exchange of information and coordination of care (pp. 8-9).

Patients should have unfettered access to their own medical information.

For us in Catholic health care, these conclusions and recommendations resonate with our own experience. In fact, when we completed the environmental assessment that served as the context for the development of our current strategic plan and asked the ministry to describe elements of a "preferred future," the issues of the unin-

sured and reform of health care delivery were top priorities. Consequently, "access" and "access to what" are addressed by three of our measures of success. Two of the measures were part of our original 2003-2005 strategic plan. They are:

- Still committed to our goal of universal coverage, we have played a leadership role in the passage of legislation that results in coverage for at least 15 percent of the uninsured population.
- Grounded in our moral imperatives, and working with others, we have developed principles for transforming health care delivery to best meet the needs and changing demographics of persons and communities—and we have encouraged a national policy dialogue regarding the same.

Recently CHA's board adopted an additional measure of success that commits the association to mobilizing the ministry to play a major leadership role in a national effort to achieve our ultimate goal of ensuring that the necessary legislation is passed to ensure affordable and accessible health care for all as soon as possible.

Ethical Foundations

We are fortunate, as we pursue the realization of these measures of success, to have as both a resource and a guide our church's rich tradition of ethical reflection. Aware of our measures of success and of the various IOM reports, colleagues on your CHA staff have begun to identify what they understand to be the values that should guide our efforts to achieve coverage for all and transformation of health care delivery:

- *The inherent dignity of all persons* Because each person is created in the image of God, each one is sacred and possesses inalienable worth. For this reason, individuals should be treated with profound respect and utmost regard from conception until natural death. One of the most important ways of respecting human dignity is to ensure that all persons have their basic human needs met so as to promote their well-being and flourishing. Health care is one of those basic human needs.
- *Health care as a fundamental human good* Health care is one of the fundamental conditions required for human flourishing. For this reason, it cannot be considered a mere commodity, dependent on one's ability to pay. Because it is a basic human good, a moral society has an obligation to provide access to basic and compassionate quality health care, regardless of age, income, illness, or condition of life.
- *The social and interdependent nature of persons* Because persons are made in the image of a triune God, they are social by nature and achieve their flourishing only in communion with others. This interdependency of all human beings grounds their responsibilities for each and for all. The health of individuals and the health of society as a whole are inextricably linked. Persons have a right and duty to participate in the health care system to meet their own needs and serve the common good.
- *Promotion of the common good* Because persons are social by nature, each has a responsibility to work for and contribute to the "creation of those conditions of social life by which individuals, families, and groups can achieve their own fulfillment in a relatively thorough and ready way."[3] A just, efficient, and effective health care system is one of those fundamental conditions of social life essential to human flourishing. Each member of society has a responsibility for its development, its maintenance, and its functioning.
- *Equitable distribution of societal resources* Just as individuals have an obligation to contribute to the well-being of all, so, likewise, society has an obligation to distribute its benefits and burdens in a manner that is fair and just. Health care, because it is a social good, must be distributed equitably to all members of society. It must be available to all in a manner that is fair.
- *Care for poor, sick, and vulnerable persons* Because of the social nature of persons and the requirements of justice, society and its individual members have a special obligation to care for those who are disadvantaged and not able to fully participate in society. In a particular way, this applies to meeting basic human needs and to enabling participation in social life. This suggests a social responsibility to provide access to appropriate quality health care for the uninsured and underinsured. Those with greater needs should receive services that address their needs.

Furthermore, because Jesus had a special affection for poor and vulnerable persons, Catholic health care "distinguish[es] itself by service to and advocacy for those people whose social condition puts them at the margins of our society and makes them particularly vulnerable to discrimination" (Directive 3).[4] Catholic health care is characterized by its efforts to alleviate the conditions that perpetuate the structures of poverty and vulnerability in society.

- *Prudent and responsible use of resources* Because creation is a gift of God intended for the benefit of all, the goods of the earth must be used responsibly with the recognition that they are for the benefit of all and not the possessions of a few. A just health care system should be characterized by equity, efficiency, effectiveness, good stewardship, and a keen recognition of the

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Health care cannot be considered a mere commodity, dependent on one's ability to pay.

REFLECTIONS

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limits on societal resources, on health care resources, on human desires and aspirations, and on human existence itself. In the light of limits, it is necessary to set appropriate priorities with regard to societal needs and within the health care system itself.

• *Respect for the religious and ethical values of both individuals and institutions* The role and values of religiously affiliated health care institutions and plans should be protected.

If one were to put these principles alongside our current experience and ask what direction they invite us to take, one would see, I suggest, that they compel us in the same general direction outlined in the IOM reports: systemic reform. The gap between how things ought to be and how they are cannot be overcome by patchwork efforts. Instead, there must be a real transformation of how persons maintain access to health care and how health care is delivered in our country.

Over the last two years, your board has become convinced of the need for such transformation and of the obligation we in the ministry have to take a leading role in bringing it about. In a future column, I will reflect on what it will mean for us as ministry gathered and engaged if we take on the task of mobilizing ourselves and others to bring about systemic change in these two areas. □

NOTES

1. Quoted in Institute of Medicine, *Insuring America's Health,* National Academies Press, Washington DC, 2004, p. iii. The IOM report can be found at www.nap.edu/books/0309091055/html/.
2. Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the 21st Century,* National Academies Press, Washington, DC, 2001, which can be found at www.nap.edu/books/0309072808/html/.
3. "Gaudium et Spes," in Austin Flannery, ed., *Vatican Council II: The Conciliar and Post Conciliar Documents,* vol. 1, St. Paul's Editions, Boston, p. 981.
4. U.S. Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services,* 4th ed., Washington, DC, 2001, pp. 9-10.