

# Lessons from Oregon: Changing the Way Health Care Works

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**A**NOTHER PRESIDENTIAL ELECTION IS IN THE PAST. Another Oregon legislative session is over. It is that time in the cycle of our country's policy and political life to take stock. Is this really the best that we can do – the best that we can expect? For those of us fortunate enough to have been involved in trying to change health care, it is both a frustrating and exciting time; frustrating because we can see how far short our previous efforts have come and exciting because of the potential that previous efforts have shown.

Health care has come full circle. After some exhausting attempts to reform health care, the system remains a dysfunctional combination of cottage industries surrounded by large, special interest industry sectors. A paradoxical combination of records are being set – most profitable years for many specialty physicians, hospitals, insurers and pharmaceutical companies alongside records for most uninsured people, largest malpractice awards, highest malpractice premiums, most medical errors. No one would blame patients and taxpayers for developing a view of health care similar to Woody Allen's world view, "More than any other time in history, mankind faces a crossroads. One path leads to despair and utter hopelessness. The other, to total extinction. Let us pray we have the wisdom to choose correctly."

While we have certainly had our share of setbacks in Oregon, a lot of us are not at this crossroads yet. What knowledgeable Oregonians may be able to contribute to this next debate is some optimism and a rationale for that optimism. While that optimism has been challenged, there are institutional, political and social reminders all around us of Oregon's ability to make difficult choices.

## The Oregon Health Plan: A Different Vision

**M**EDICAID, A FEDERAL ENTITLEMENT PROGRAM, was designed in the 60s to assist specific less fortunate U.S. citizens (disabled, blind, some children, pregnant women etc). However, Medicaid did not provide assistance to many poor Americans because income alone was not felt to be a sufficient indicator of need. It seemed obvious to many Oregonians that the federal Medicaid program did not fill the gap in health care, and indeed, the OHP took a new direction. Medicaid had become a system that rationed people because it was the easiest thing to do.

Many of us think of the Oregon Health Plan (OHP) as a Medicaid reform program with a prioritized list of benefits. But in fact, the OHP was much more. It was an ambitious set of reforms designed to reshape the entire health care system. The approach was comprehensive with specific parts of the plan focused on the three major reasons for poor health and lack of insurance: 1) the inability of the public sector to pay for all of those without sufficient resources, 2) the unwillingness of the private sector to insure all workers and their families who could not do it themselves and 3) the reality that some people without access to employer insurance but with substantial resources would be deemed too "risky" to be sold insurance at any price.

In OHP, employers were accountable for coverage. A high risk pool was made available to those with adequate incomes who remained uninsured. Mandating benefits through legislation was replaced by a focus on expanding coverage made possible by explicit rationing of benefits rather than people. New tools created by legislation enabled the OHP to address these problems through processes to engage communities in public, a process to prioritize benefits, a process to evaluate evidence related to health services, and processes to assist the private sector in making insurance as available as possible.

What excited people then and what excites them now is not what OHP produced but what it stood for – a plan with a goal, delivered in a framework that made health care sense and was consistent with what health care should be about.

As we evaluate proposals to reform or improve our current system it will be valuable to consider the OHP approach, not so much for its specific ideas, but rather for the framework it used in arriving at those ideas. Subsequent work has shown that the OHP framework retains its relevance beyond the borders of Oregon. Across the country people want their health provided in a different way than it is being provided today. When it comes to health, people want to address the real problems with realistic options to solve them.

What becomes important in this approach is not just the goal but a sense that we know how to get to the goal. Leaders need a set of guiding and interacting principles – a framework – in order to achieve a goal effectively. The public needs to be able to understand the framework to ensure that their leaders are genuinely pursuing the goal and doing so in the best way possible. A framework that only emphasizes profit or competition provides neither inspiration nor boundaries. We deserve more than that.

The rest of the country took a different approach – goals were not clearly identified, little change occurred in the framework related to those goals, most of the attention was paid to content – what do I get right now. The Clinton Health Plan never got off the ground because it could not articulate an understandable framework for change. The alternative to the Clinton plan, market based reform, failed to reduce costs, failed to cover more people and did not create a blueprint for change that was understandable or predictable. Market based reform became profit oriented reform leading to the system we have today – the most expensive, profitable, mediocre health system in the world.

Oregon succeeded in forcing health system and public leaders to focus on a much more challenging goal and do so in a framework that forced meaningful change. The Oregon Health Plan was really not about Medicaid, not about rationing, not even really about the uninsured. It was about looking at the health care world differently and acting on an alternative vision.

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## The Goal

**I**DENTIFYING A GOAL that genuinely represents the desired outcome is not as easy as it may seem, especially in health care. How many health care initiatives genuinely focus on health – rather than health services? Most focus on the process and payment for care, not the actual product. Oregon's goal was health – not just for each individual but for every individual as a member of an Oregon community. Oregon's goal recognized the reality of the connection we all have to each of us being as healthy as reasonably possible. Reducing the number of uninsured was not the goal. It was just the most obvious way to improve health in the entire community.

Focusing on health though is not what made Oregon unique. Changing the framework is where the OHP approach departed from any other efforts. OHP created a framework that ensured decision makers would have to face the reality of the goal. The framework made the goal possible.

## Framework

**T**HE FRAMEWORK that OHP created for leaders was consistent throughout the process. The principles that make up this framework are as relevant today as they were when the plan was being developed. The OHP framework emphasized a commitment to:

### Equity

We need to acknowledge that our current health care system falls far short of even reasonable equity. Many people have nothing, some people have everything and many of us receive our care in one of several tiers in between. These inequities have become intolerable and unbearable. Taxpayers would support improved equity especially if the resources to do so came from more careful spending. Improving equity by transferring resources better spent becomes a motivator, a reason to reallocate resources. How do we rationalize providing ineffective, futile or dangerous care in any circumstance when children with all their potential before them have no access to care? Yet the current system actually provides incentives for such care for some people. We are willing to pay much more for the insured to take the latest brand medicine without any evidence of better effectiveness while thousands of our neighbors are uninsured. It is hard to argue that giving more health care to people who already have it, or more health care to people who do not need it, improves health more than giving some health care to people who have none.

### Value

There should be an explicit value determination for all important services. Value is derived from the relationship of cost to benefit. Benefits include effectiveness, risk and importance. Reducing costs came into the process not as a goal but as part of the value determination. No community has limitless resources. Shared resources (public dollars) are always limited. Cost becomes the major enemy of improvement in health especially for the vulnerable. Benefits are determined by evidence and the importance communities attach to benefits. If services or products have similar effectiveness and risk, competition can increase value by decreasing costs. The health industry should be rewarded with profits by increasing value, not the reverse.

### Transparency

Health cannot be defined and administered behind closed doors if equity and value are true driving forces. The challenge is to engage individuals and communities. Individuals and communities deserve to know how the value determination weighs costs, benefits and risks. The evidence about benefits and risks needs to be available for all – buyers, sellers, consumers, practitioners. Consumers deserve to know and agree when the forces of competition should shape their health care and when they should not. Consumers need to be responsible for their decisions in a transparent process but they also deserve to know about conflicts of interest, evidence and what the particulars are of their situation. More decisions need to be made with all involved confident that the information playing field is a level one.

### Explicit Decision Making

Incentives and disincentives encouraging or discouraging care need to be explicit for patients, practitioners and administrators. Key to explicit decision making is using evidence. Taxpayers and patients deserve to know whether there is evidence of effectiveness and risks and how the evidence for one option compares to another. Once the evidence is available it should be possible to "follow the money" in order to assure maximal value is obtained and sustained. Patients often have no idea of the system incentives encouraging or discouraging care. We should stop drowning patients in glossy superficial information while we hide the most important information from them. When we make a decision about a medication we should remember how it could improve our health and at what risk...not how beautiful that former gold medal winner looked skating effortlessly across a frozen lake.

### Local Control

Local communities should make decisions about health care. Communities can provide the missing link between decisions made by large organizations who finance and provide health care and decisions made in doctor's offices by individual physicians and patients sometimes determined by the self interest of each. There are limits to the effectiveness and efficiency of health decisions being made in exam rooms with one physician and one patient involved. Our communities are filled with experienced practitioners and patients who are able to understand evidence and make good decisions for their communities. Health care should not be dominated by either individual patients or large organizations. Communities are very capable of making informed, transparent decisions that work for them if they are provided the tools to do so. The most successful Oregon Medicaid HMOs are those that are part of their communities and make decisions with those communities in mind every day.

### Evidence and Prescription Drugs:

#### An Application of the OHP Framework

**I**N THE LATE 90s prescription drugs became a focus for health policy throughout the country. Costs for prescription drugs had become the second most costly component for Medicaid (the most costly if drugs used in hospitals were included). These increasing costs were a major obstacle to stabilization of Medicaid costs and further expansion of benefits to uninsured Oregonians. Access to prescription drugs was equally important especially to the thousands of Oregonians who rely on drugs to enable them to be independent. Despite a number of political obstacles, Oregon launched an approach that attracted attention throughout the world, continues today in an expanded form and relies on the same framework that the OHP established.

*Health was the goal.* How could a purchaser maximize the health of their patient population when it came to prescription drugs? *Equity and value* came into play. A careful, credible value determination should enable purchasers to find the best values – drugs which are just as effective and safe but much less expensive. Resources saved could then be transferred to people who have no resources. Rather than spend one more dollar on a drug that brings no increased value, that dollar could be spent on someone who has no coverage.

But value is often in the eye of the beholder and any consumer or taxpayer is appropriately skeptical of someone else's value determination. Oregon committed to a public, *transparent* process that involved diverse communities in a process that focused first on "evidence." Evidence would be examined in public at the Health Resources Commission (HRC), a committee of Oregon physicians, pharmacists and consumers – all volunteers. The Commission, created a decade prior at the outset of the Oregon Health Plan, was designed for the task – examine all the relevant evidence and advise the state accordingly. The Commission began by identifying the key policy approaches needed to accomplish this task including an *explicit* commitment to exposing and avoiding conflict of interest. The Commission wanted all of the relevant evidence presented in the most effective, systematic way.

Oregon was fortunate to have a world class resource available – the Evidence-based Practice Center (EPC) at Oregon Health and Science University (OHSU). The OHSU EPC was willing to take on the task of finding, evaluating and summarizing evidence about key prescription drug classes. Together the HRC and the Oregon EPC, using several subcommittees focused on specific groups of drugs, provided the most systematic, evidence-based reports available to the public. Their commitment included updating the reports so that new information could be included and any shortcomings of previous reports could be corrected.

The largest public and private health organizations in the world had not been willing to either produce or share with the public unbiased information evaluating the work of the world's largest pharmaceutical companies. That would not have been consistent with their goals and framework. In Oregon the opposite was the case. An unbiased, *transparent, explicit review* of prescription drug information was a good fit.

Oregon's approach has attracted support throughout the world. Key elements of the approach are now part of a collaboration of 14 states and two private organizations called the Drug Effectiveness Review Project. Details and drug class reports are available at [www.ohsu.edu/drugeffectiveness](http://www.ohsu.edu/drugeffectiveness). Major consumer groups use the publicly available reports to better inform their efforts to increase the value of consumer's dollars. Many pharmaceutical companies continue to vigorously oppose this evidence-based approach. Others, however, seem to understand its strategic importance and the lessons it may have for health care in general. They are interested in the goal and framework within which the project is being pursued. They should be – it may be closer to the future than the framework they are using.

Any criticism of pharmaceutical companies should really be directed at the prevailing health care model that they work within. Their mission forces them to focus first on return on shareholder investment and on the health of communities only after that goal is achieved. That might be workable since health is certainly something we would all pay for. The problem is they are boxed in by the framework they work within. The best they can do to resolve *equity* issues is to provide access to free prescription drugs for a small portion of the population. They drown us in information in order to dominate the *value* determination. Little of what goes into their information process is truly *transparent*. Purchasers and consumers have little *explicit* understanding or interaction with the pharmaceutical decision making process. Almost all of the decisions are made by very large organizations or in exam rooms where it is very difficult for confused patients to understand the options explained to them by physicians overwhelmed with information. Communities have virtually no *local control* in a process that affects them every day and allocates substantial local resources with no local engagement.

Oregon's approach to prescription drugs has deserved the attention it has received because of the content of the evidence-based reports it has produced. What policy makers need to understand is that Oregon succeeded at content by using a plan that had the right goal pursued in the correct framework.

## Final Thoughts

**W**E SHOULD APPLY the lessons learned in Oregon to other efforts hoping to improve health care or reform the health care system. For example we all struggle with the sustained reports of safety concerns in American health care despite enormous investments made in quality improvement strategies. Every serious proponent of quality improvement genuinely has a goal of improving health. Have we saddled them with a framework that makes their task impossible? Is it time to give them more to work with by making changes in the framework of their approaches through transparency and explicit information processes? Oregon's legislature recently passed legislation encouraging doctors to acknowledge mistakes and apologize for them. The legislation passed only when doctors were assured such apologies were not admissible in malpractice cases. The legislature created a Patient Safety Commission but has provided no funding for it. Commission members are committed to raise funds. While there has been some movement in the right direction is this the best we can do?

The health insurance industry's latest contribution to reform is the expansion of "consumer directed health plans." Consumers are presumed to get more involved because they have their own money at stake, but are they really directing their health plan? Equity seems forgotten as individual consumers struggle to make decisions dominated by information from large organizations. Potential opportunities abound for genuine value determinations, transparency and explicit decision making by both patients and providers. Are the designers of these plans fully mobilizing these approaches on behalf of patients? Perhaps they should consider a transparent, explicit benefit design that provides a value determination for every product and service covered. And perhaps they should insist that if practitioners are truly committed to this process, errors should be disclosed and no costs related to them incurred. And perhaps they should open their own decision making processes to the public. Let's have some shared responsibility around here.

Oregon recently considered a single payer proposal as a ballot initiative. The proposal included coverage for virtually all services including long term care. While the intention of the designers of the proposal was certainly improvement of health, many Oregonians perceived the measure more oriented to health services. The benefit package was not accompanied by an explicit plan for how such generosity would be financed. Taxpayers were appropriately skeptical that a transparent value determination would be made. What if the proposal had instead combined all current public dollars (Medicare, Medicaid), included explicit subsidies (the health benefits of employer based health insurance), made a commitment to provide a basic benefit to everyone based on evidence, used competition when the evidence supported doing so, emphasized local decision making? Perhaps starting with the several billion dollars at play in such a proposal would have been more appealing even if it meant some sacrifices for some.

Many practitioners and patients are realizing that more of the same approach is not going to lead to productive changes. We need to identify the ideas that we are prepared to take a risk on. The current approaches available always lead to more health care services, at higher costs with modest if any improvement in health outcomes. Leadership in health care is dominated by savvy policymakers who have substantial wealth at stake. They function within a failed system framework focused on money not health. Perhaps a new cadre of policy makers can break the stalemate by appreciating what the Oregon Health Plan actually means. The goal and framework created by OHP does not violate the principles of either political party. They do though create politics and policy that only the most dedicated and committed leader can manage. It is only a matter of time before the rewards of change outweigh the risks of complacency. ☞

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