

**Statement of**

**Harvey V. Fineberg, M.D., Ph.D.  
President  
Institute of Medicine**

**Before the**

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Committee on Government Reform  
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Good afternoon, Madame Chair and members of the Subcommittee. I am Harvey Fineberg, president of the Institute of the Medicine of the National Academies. As an independent, scientific adviser to the nation for improving health, the Institute of Medicine seeks to provide advice that is unbiased, based on evidence, and grounded in science. We produce about 50 reports each year on health care and biomedical research policy, the majority of which are commissioned by federal agencies, sometimes under a mandate from the United States Congress. Our work ranges across the spectrum of our nation's health concerns, embracing, for example, the public health infrastructure, the conduct of biomedical research, the emergence of microbial threats, and disparities in health care and health outcomes among different races and between the rich and the poor. One major series of studies examines how to improve the safety and quality of health care received by Americans, and this work, I believe, is especially pertinent to decisions about the future of the Federal Employees Health Benefits (FEHB) program. I would like to share with you some reflections on the state of health and health care in our country, presenting a few ideas that bear on the FEHB program.

### **Advances in U.S. Health**

The past century witnessed an unprecedented pace of progress in the health and well-being of the American population at every stage of life. The life expectancy of the average U.S. citizen—which only a century ago stood at a mere 47 years—has grown by almost two-thirds, while infant mortality has declined by more than 75 percent in the past 50 years alone.<sup>1</sup> These dramatic improvements in the scope of life have been accompanied by substantial progress in combating some of the most deadly and pervasive threats to the public's health. Death rates for cardiovascular disease, which rose through the first half of the 20th century, have been cut in half in the last 40 years, and even larger reductions have been seen over that period in deaths from stroke.<sup>2</sup> These two conditions account for nearly 40% of all deaths in the United States. Every year, three-quarters of a million persons survive who would have succumbed to these conditions if their previous high rates of mortality had prevailed.

While the mortality rate from cancer has proved more resistant to change, we have made significant strides in improving diagnostic practices, therapies, and survivorship rates for many major cancers, including breast cancer, prostate cancer, colon cancer, and leukemia. Public health campaigns to reduce tobacco consumption have driven down deaths from lung cancer in this country over the past 15 years. HIV/AIDS remains a serious public health threat, but preventive efforts can work, and advances in antiretroviral therapy have converted a diagnosis that was a nearly uniform death sentence into a frequently manageable chronic disease.

The U.S. continues to be a world leader in biomedical research and education. Many advances in understanding and combating heart disease, cancer, HIV, and other serious diseases are the fruit of decades of public investment in basic and clinical research, mainly

through the National Institutes of Health. The Centers for Disease Control and Prevention (CDC) leads in protecting the public's health within our borders, and CDC experts are called upon to confront diseases around the globe, such as last year's SARS outbreak. Meanwhile, U.S. academic health centers set world-class standards in biomedical education and research.

All of these substantial accomplishments and strengths, however, leave our nation's health care system with much room for improvement.

### **Causes for Concern**

*High costs and rising expenses.* Americans spend on health care roughly one in every seven dollars they spend on everything. After remaining relatively flat as a fraction of GDP during much of the 1990's, U.S. health expenditures rose by 8.5 percent in 2001 and 9.3 percent in 2002 (the most recent years for which figures are available).<sup>3</sup> Between 2002 and 2003, the average cost of premiums for employer-based health insurance programs shot up by 13.9 percent.<sup>4</sup> Such costs are leading some employers either to cut health benefits or to pass on substantial portions of these costs to their employees, and they are also becoming a matter of concern for the affordability of federal health care programs.

*Failure to insure all Americans for basic health care needs.* The Census Bureau estimates that 43.6 million people, or more than 15% of the U.S. population, lacked health insurance for the entire year during 2002.<sup>5</sup> Other surveys suggest that over 15 million additional Americans typically have no health insurance for at least part of each year.<sup>6</sup> Beyond this high prevalence of uninsurance within the population, even many Americans who do have insurance are covered by plans that are principally designed to protect against catastrophic health emergencies. Such plans do not cover basic health care that may prevent far more dangerous and expensive conditions later on.

*Sub-par performance.* Although the U.S. spends more than twice as much on health care per capita as the median rate for the 30 members of the OECD, we rank in or near the bottom third in basic health indicators such as infant mortality and life expectancy.<sup>7</sup> The majority of Americans believe that there are some good things about health care in this country, but that fundamental changes are needed.<sup>8</sup>

*Persistent problems in safety and quality of care.* Several years ago, the Institute of Medicine reported that medical errors cause tens of thousands of deaths among hospitalized patients every year.<sup>9</sup> If counted as a "disease," errors would be among the top ten causes of death in our country. Most of these errors are preventable. The IOM report, *Crossing the Quality Chasm: A New Health System for the 21st Century* (2001) presented a blueprint to improve the quality and safety of health care. Lessons can be learned from other industries that have achieved more consistent quality standards. This report stresses the importance of improvements in the processes and systems of care, and it calls for performance measures, data standards, newer technologies such as electronic health records, and a culture of care

committed to quality and safety. Action is required at many levels: health providers, care delivery institutions, payers, and the other public and private organizations that make up the U.S. health care system.

Recent studies confirm persisting gaps between the care that Americans receive and care that meets the best professional standards. One study of adults in 12 metropolitan areas found that respondents received only around half of recommended care for acute and chronic conditions as well as preventive services.<sup>10</sup> Fewer than half the patients with a myocardial infarction, for example, were treated with an inexpensive, life-saving drug that is indicated for nearly all of them. Only about sixty-five percent of patients with high blood pressure were appropriately treated. Other studies indicate that up to one-third of the care delivered for acute conditions and one-fifth of the care delivered for chronic health conditions is unnecessary or even harmful.<sup>11</sup> The National Committee on Quality Assurance estimates that nearly 50,000 Americans die each year simply because their known health conditions are not adequately monitored or controlled.<sup>12</sup>

*Disparities in health care access and outcomes.* Within the United States, there remain severe disparities in the quality and availability of health care. Some of this variation occurs along geographic lines, such as the sizable local and regional differences in infant mortality, child health insurance coverage, hospital quality, and the availability of health care practitioners. Other variations reflect disparities in the quality of care that is received by different racial and ethnic groups (even when controlled for access-related factors such as income and insurance status). To give one example, black Americans over the age of 35 are roughly twice as likely to die of heart disease as their white counterparts.<sup>13</sup>

*Underinvestment in prevention.* The leading causes of death in the United States stem from modifiable behavioral risk factors such as tobacco use, alcohol consumption, and poor diet and physical inactivity.<sup>14</sup> Deaths from overweight and obesity are on the rise and threaten to overtake tobacco as the leading cause of death in this country. The national resources we invest in prevention aimed at tobacco, alcohol, overeating, and inactivity are disproportionately small compared to the magnitude of the harm these public menaces produce. The diverse insurance plans in this country are inconsistent in their coverage for preventive care services.

### **Key Attributes of a Health System for the 21st Century**

The American people deserve a better health care system, one that is built on the following principles:

*A population perspective on health.* As a population ages, chronic diseases take an ever increasing share of the burden of illness. Today 125 million Americans are estimated to have a chronic disease, and nearly half of them live with two or more such conditions.<sup>15</sup> Health interventions that target chronic conditions and meet the needs of these patients for

coordinated care are going to be increasingly important. Preventive interventions will have increased impact to the extent that they can focus on risks affecting a substantial proportion of the population (blood pressure, cholesterol levels, tobacco and alcohol consumption, diet and physical activity, exposure to toxic substances, etc.). Because a population's health is impacted by a broad range of interactions among biological, behavioral, socioeconomic, and environmental risk factors, attempts to improve health at the population level can achieve better outcomes through an ecological approach that recognizes the importance of these interactions and finds critical points at which to interrupt the causal chain leading to poor health outcomes.

*A central role for preventive care.* An efficient and effective strategy for a healthier population depends on preventing disease before it begins. For various reasons, including the fact that its success is typically invisible, prevention frequently gets shortchanged. Recent years have brought some positive trends in insurance coverage of services such as pre-natal care, immunizations, tobacco counseling, and screening for serious health conditions, but preventive care is still underfunded. For example, employer-sponsored insurance plans still often fail to cover immunizations, especially for adolescents and adults, even though these are among the most cost-effective measures in preventive medicine.<sup>16</sup>

*Coverage that is universal, accessible, and affordable.* Health care that is inaccessible or unaffordable cannot meet the needs of patients. As a recent series of reports from the Institute of Medicine demonstrated, failure to provide health insurance affects the health of the uninsured, the lives of their families and communities, and the well-being of the nation.<sup>17</sup> The lack of insurance leads to an estimated 18,000 premature deaths each year, and the value of health capital lost each year due to uninsurance is estimated to be \$65-130 billion annually.<sup>18</sup>

*Care that is person-centered rather than provider-centered.* Patients' experiences of ill-health are governed by the nature of their illnesses and the care they receive and also by their ability to obtain needed information, to participate in decision making that concerns their health, and to have different aspects of their care appropriately coordinated to match their preferences. Patients rely on the quality of information they receive from their caregivers for making health-related decisions, and the degree to which their health is appropriately managed may also depend significantly on the successful coordination of case histories, test results, and therapeutic strategies among many different providers. The flow of both information and care delivery ideally would respond in a timely manner to the circumstances of each individual.

*Care that meets the highest standards of medical evidence.* It has been estimated that there is a lag time of around 15-20 years between the discovery of more efficacious forms of medical treatment and their incorporation into routine care for patients.<sup>19</sup> Even when new discoveries are made available more rapidly, adoption of recommended practices can be very uneven. The only way simultaneously to avoid errors of overuse, underuse, and misuse is to rely on evidence from controlled studies to guide practice. The volume of new clinical

research that is published each year far exceeds the ability of individual health practitioners to keep abreast of it on their own, and better decisions for patients will depend on better systems of data analysis and management.

*A health care system that is driven primarily by quality and value rather than price.* High expense is no guarantee of quality in health care. In fact, higher quality, over time, can save money by preventing inappropriate treatment and avoiding the consequences of errors, such as prolonged hospitalization. To make decisions governed only by price rather than by performance is short sighted, and ironically, may be more expensive in the longer run.<sup>20</sup> Value here refers to the level of quality achieved at a given amount of cost. If value is to be a driver of health care decisions, we will need accurate, transparent, and functional measures of health care performance.

### **Ideas for the Federal Employee Health Benefits Program**

The Federal Employee Health Benefits Program serves a vital function and is not designed to solve all of the nation's health needs. However, the FEHB program is buffeted by the same economic and epidemiologic forces that act on the entire health system. In meeting its own clients' needs, the FEHB Program can also, I believe, serve as a model and a test bed for improving the performance of the U.S. health system as a whole. This notion of *Leadership by Example* was the subject of an IOM report, requested by the United States Congress, which examined the role of other federal health programs (Medicare, Medicaid, Department of Defense Tricare, State Children's' Health Insurance Program, the Veterans Health Administration, and the Indian Health Service) in demonstrating possible improvements in U.S. health care.<sup>21</sup>

I would like to suggest five areas where the FEHB Program may be able to enhance its service to government employees and contribute to improved performance of the health system as a whole.

- 1. Incorporate coverage for high-value services.** Four areas that have potential for high-value services deserve special review for the availability of coverage. These are preventive services, comprehensive care for common chronic diseases, coordination of care (especially for patients with multiple conditions), and end-of-life care.
- 2. Pay for performance.** A number of private insurers and foundations as well as the Medicare program are experimenting with various forms of payment enhancement for superior quality provided by health care organizations and practitioners.<sup>22</sup> These systems all depend on the definition of quality measures and vary in the specific forms of the programs of reimbursement. Here there may be an opportunity for the FEHB Program to participate along with others in promoting effective performance measures and in testing the effects of financial incentives to increase quality. A step beyond choosing among plans according to costs and menus of coverage would be

information to employees about the comparative performance of the various providers.

- 3. Promote technology investment.** Recent reports of the IOM have stressed the importance of appropriate information technology to support programs of safety and quality.<sup>23</sup> Electronic health records can improve safety (for example in physician order entry systems that detect potential drug-drug interactions). Cost is certainly one obstacle to investing in information technology, but also deterring investment is the lack of standards for data definitions and interoperability.<sup>24</sup> Here, along with other federal and private insurers, the FEHB Program could promote data standards and appropriate deployment of information technology among providers.
- 4. Measure comparative efficacy and value.** The key to making informed choices, as an individual patient and as an insurer, is reliable information on the comparative effectiveness and cost of alternative preventives and treatments. Oftentimes in medicine, what seems promising as a therapy turns out to be less good than anticipated or even harmful, and convictions about what should work may outpace the evidence. The use of bone marrow transplant for patients with breast cancer is a case in point. The recently reported study of comparative effectiveness of different lipid lowering drugs demonstrates how life saving differences may only be revealed by carefully conducted comparative trials.<sup>25</sup> The need for this type of information applies to every public and private insurer and to every doctor and patient. The FEHB Program could seek ways to participate and encourage a systematic approach to these needed studies.
- 5. Stress health literacy.** Even well-educated adults may have difficulty interpreting and acting on the instructions from their caregivers, especially during times of acute illness and stress. A health-literate patient and family are also better able to prevent illness, to question their doctors, nurses, and pharmacists, and to obtain the health information they need from public and private sources. The FEHB Program may be well positioned to test and validate various approaches to increasing health literacy.<sup>26</sup>

Thank you for the opportunity to provide this overview and set of suggestions to the committee. If there are ways that the Institute of Medicine may be helpful as you proceed with your deliberations, we would be pleased to respond.

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<sup>1</sup> U.S. Census Bureau, *Statistical Abstract of the United States: 2003* (2003).

<sup>2</sup> Centers for Disease Control and Prevention, "Decline in Deaths from Heart Disease and Stroke – United States, 1900-1999," *Morbidity and Mortality Weekly Report* 48:30 (1999), pp. 649-656; cf. also American Heart Association, *Heart Disease and Stroke Statistics – 2004 Update* (2004).

<sup>3</sup> Katharine Levit et al., "Health Spending Rebound Continues in 2002," *Health Affairs* 23:1 (2004), pp. 147-159.

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- <sup>4</sup> Jon Gabel et al., "Health Benefits in 2003: Premiums Reach Thirteen-Year High as Employers Adopt New Forms of Cost Sharing," *Health Affairs* 22:5 (2003), pp. 117-126.
- <sup>5</sup> U.S. Census Bureau, *Health Insurance Coverage in the United States: 2002* (2003); Kaiser Family Foundation, *Health Insurance Coverage in America: 2002 Data Update* (2003).
- <sup>6</sup> Congressional Budget Office, *How Many People Lack Health Insurance and For How Long?* (2003).
- <sup>7</sup> Data on infant mortality, life expectancy, and health care expenditures from OECD and WHO statistical tables; Gerard Anderson and Jean-Pierre Poullier, "Health Spending, Access, and Outcomes: Trends in Industrialized Countries," *Health Affairs* 18:3 (1999), pp. 178-192; Gerard Anderson et al., "It's the Prices, Stupid: Why the United States Is So Different from Other Countries," *Health Affairs* 22:3 (2003), pp. 89-105.
- <sup>8</sup> Humphrey Taylor and Robert Leitman, eds. "Attitudes toward the United States' Health Care system: Long-Term Trends," *Harris Interactive*, 2:17 (August 21, 2002).
- <sup>9</sup> Institute of Medicine, *To Err Is Human: Building a Safer Health System* (National Academies Press, 2002).
- <sup>10</sup> Elizabeth McGlynn et al., "The Quality of Health Care Delivered to Adults in the United States," *New England Journal of Medicine* 348:26 (2003), pp. 2635-2645.
- <sup>11</sup> Elizabeth McGlynn and Robert Brook, "Keeping Quality on the Policy Agenda," *Health Affairs* 20:3 (2001), pp. 82-90.
- <sup>12</sup> National Committee for Quality Assurance, *The State of Health Care Quality: 2003* (2003).
- <sup>13</sup> Centers for Disease Control and Prevention, "Disparities in Premature Deaths from Heart Disease – 50 States and the District of Columbia, 2001," *Morbidity and Mortality Weekly Report* 53:6 (2004), pp. 121-125; Institute of Medicine, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare* (National Academies Press, 2002).
- <sup>14</sup> Ali Mokdad et al., "Actual Causes of Death in the United States, 2000," *Journal of the American Medical Association* 291:10 (2004), pp. 1238-1245.
- <sup>15</sup> Partnership for Solutions, *Chronic Conditions: Making the Case for Ongoing Care* (Johns Hopkins University, 2002).
- <sup>16</sup> Institute of Medicine, *Calling the Shots: Immunization Finance Policies and Practices* (National Academies Press, 2000).
- <sup>17</sup> Institute of Medicine, *Insuring America's Health: Principles and Recommendations* (National Academies Press, 2004); *ibid*, *A Shared Destiny: Community Effects of Uninsurance* (National Academies Press, 2003); *ibid*, *Health Insurance is a Family Matter* (National Academies Press, 2002); *ibid*, *Care Without Coverage: Too Little, Too Late* (National Academies Press, 2002); *ibid*, *Coverage Matters: Insurance and Health Care* (National Academies Press, 2001).
- <sup>18</sup> Institute of Medicine, *Hidden Costs, Value Lost: Uninsurance in America* (National Academies Press, 2003).
- <sup>19</sup> Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the 21st Century* (National Academies Press, 2001), p. 155.
- <sup>20</sup> Sheila Leatherman et al., "Making the Business Case for Quality," *Health Affairs* 22:2 (2003), pp. 17-30.
- <sup>21</sup> Institute of Medicine, *Leadership by Example: Coordinating Government Roles in Improving Health Care Quality* (National Academies Press, 2003).
- <sup>22</sup> Meredith Rosenthal, "Paying for Quality: Providers' Incentives for Quality Improvement," *Health Affairs* 23:2 (2004), pp. 127-141.
- <sup>23</sup> Institute of Medicine, *Patient Safety: Achieving a New Standard for Care* (National Academies Press, 2004); *ibid*, *Key Capabilities of an Electronic Health Record System* (National Academies Press, 2003).
- <sup>24</sup> Robert Miller and Ida Sim, "Physicians' Use of Electronic Medical Records: Barriers and Solutions," *Health Affairs* 23:2 (2004), pp. 116-126; David Doolan and David Bates, "Computerized Physician Order Entry Systems in Hospitals: Mandates and Incentives," *Health Affairs* 21:4 (2002), pp. 180-188.
- <sup>25</sup> Christopher Cannon et al., "Comparison of Intensive and Moderate Lipid Lowering with Statins after Acute Coronary Syndromes," *New England Journal of Medicine* 350:15 (2004), forthcoming.
- <sup>26</sup> For more on the subject of promoting health literacy, see the Institute of Medicine's forthcoming report *Health Literacy: A Prescription to End Confusion* (National Academies Press, 2004).