

Toward a National Conversation on Health: Disruptive Intervention and the Transformation from Health Care to Health

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ABSTRACT Over a century ago, Abraham Flexner's landmark report on medical education resulted in the most extensive reforms of medical training in history. They led to major advances in the diagnosis and treatment of disease and the relief of suffering. His prediction that "the physician's function is fast becoming social and preventive, rather than individual and curative," however, was never realized. Instead, with the rise of biomedical science, the scientific method and the American Medical Association, the health care system became increasingly distanced from a holistic approach to life that recognizes the critical role social determinants play in people's health. These developments created the beginning of the regulatory controls that have come to define and shape American health care – and our unhealthy obsession with illness, disease and curative medicine that has resulted in a system that has little to do with health. To realize Flexner's prediction, and to transform health care into a holistic system whose primary goals are focused on health outcomes, six disruptive interventions are proposed. First, health needs to be placed in the context of community. Second, the model of primary care needs to be revised. Third, big data need to be harnessed to provide personalized, consumable, and actionable health knowledge. Fourth, there needs to be greater patient engagement, but with fewer face-to-face encounters. Fifth, we need revitalized, collaborative medical training for physicians. And finally, true transformation will require market-driven, not regulatory-constrained, innovation. The evolution from health care to health demands consumer-driven choices that only a deregulated, free market can provide.

INTRODUCTION

More than a century ago, Abraham Flexner's landmark report resulted in the most extensive reforms of formal medical training in history. But Flexner's prediction that "the physician's function is fast becoming social and preventive, rather than individual and curative,"¹ was never realized. Instead, physicians and other health care providers became increasingly distanced from a humanistic, holistic approach to life and health that recognizes the critical social and cultural requirements necessary for the preservation of health. These reforms, along with the formation of the American Medical Association in the late nineteenth century, created the elite, often unchallenged status of biomedical science and the beginning of the regulatory controls that have come to define and shape American health care.²

With the rise of biomedical science and the concomitant introduction of the scientific method in modern medicine, people

have seen remarkable advancements in the diagnosis and treatment of disease and the relief of suffering. Unfortunately, such advancements have also eliminated the majority of alternative healing practices and the schools dedicated to those disciplines, ultimately reducing the number of practitioners and establishing restrictive limits on the number of physicians trained at the remaining accredited medical schools.

Medical education at these schools has been increasingly ensconced within a rigid framework focused on illness and disease, and with scant attention focused on what Flexner had envisioned as the "social and preventive." There has also been little evolution in that overall framework, and limited emphasis on the social determinants of health and even the role of the physician in preserving health and improving life. As a result, physicians, and our health care system in general, are ill-equipped to address and act upon the root cause of the majority of health and medical problems plaguing our nation – problems that are largely preventable. Our unhealthy obsession with curative medicine, based on the belief that biomedical science will provide all of the answers, has created a health care system that has little to do with "health."

So, when it comes to health care in America, one point is abundantly clear: the systems we currently have in place are not working well. But when citizens, politicians and the media demand fixes, what exactly are they seeking to improve? Is it general improvement, centered on our health care system having greater safety and reliability? Is it the integration of services and elimination of waste in order to reduce costs? A reduction in the incidence and prevalence of chronic illness?

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Is it seeking to focus on promoting preventive measures to ensure the vitality, well-being, and resilience of each person and our population? Facilitating trans-disciplinary professional care team cooperation and coordination to maximize care-delivery effectiveness? Increasing information digitization to facilitate seamless data sharing and use? Training a new breed of clinician to make Flexner's prediction a reality? Delivering a person-centered approach to care, where quality of life is the ultimate goal of our efforts? Reducing and minimizing government intrusion, allowing free-market forces to empower the consumer?

Or are they seeking all of these, and dare we strive for *the simultaneous achievement of all these goals*?

Most American presidents over the past 80 years have proposed comprehensive changes to improve the standards of health. Many benchmarks have been set, but few of those milestones have been achieved. The politicization of health care, extensive legislation, and the creation of numerous government agencies have resulted in a government-controlled regulatory quagmire with perverse incentives and unintended consequences that continue to drive up costs without improving quality, while at the same time limiting competition, innovation, and consumer options. What we do next will either further accelerate the financial collapse of the unsustainable trajectory we are on or allow market forces to help transform our failing health care system and its misguided focus.

The authors propose that the national dialog on health care has been seeking answers to the wrong questions. The present debate is focused on costs, payments, reimbursements, insurance, and coverage. Instead, *our primary goals should be refocused on health outcomes* – on people living longer, healthier, lives, and with greater choice as to when, where and how they obtain health care services.

Our current health care systems drive available products and services based on acuity, with an emphasis on specialty care. Testing and prescribing have become ends in themselves. Lost in the labyrinth of tests and pills are the people the system is supposed to serve – and the most fundamental aspects of health and well-being that are the true drivers of the demand for health care services.

The results of our product-and-procedure focus on the health of individuals are startling. Nearly 68% of Americans are overweight or obese.³ A full 30% of potential military candidates ages 17–24 do not qualify for military service because they are overweight.⁴ And we reimburse treatments but refuse to pay to improve and sustain health and well-being.

This fee-for-service model reimburses easily quantifiable procedures instead of the less-quantifiable, messy work of thoughtfully reflecting on people's wellness. We reward intervention over prevention. We pay an extraordinary amount of money, both as individuals and as a nation, for the privilege of a health care system that does not prioritize actual health outcomes.

As a result, despite years of temporary tourniquets created to address these problems, America is at an impasse. The

proposed solutions that have failed in the past are not likely to be successful in the future. We need something more disruptive and transformative.

We are long overdue for a new model – a health care system that is driven by a person-centered, consumer focus; that has as its primary goal improved patient health outcomes for all Americans; and that recognizes that individuals and care providers are enmeshed in systems that must be realigned to focus on health rather than on adding still more high-cost services.

We cannot continue to rely on the new rules, regulations, mandates, and billing codes that have gotten us into this mess in the first place. In fact, we need to abandon the fee-for-service model and its accompanying bureaucratic fantasies altogether. In its place, we need to allow the free market to thrive in order to produce the disruption necessary to truly transform health care in America.

How will this new model be realized?

Restructuring the health care system to achieve such wide-ranging transformation is a complex problem that will require an equally complex set of interventions aimed at the optimization of multiple factors. To that end, the authors propose the following six areas of focus that embody elements of this new model:

HEALTH IN THE CONTEXT OF COMMUNITY

In the new model, community plays the primary role in creating a culture of health; health care plays a secondary role. Using the tools of public health and medicine, community and health care partnerships collaborate to identify and define local needs and to build a shared vision of health and better living for the individuals in those communities. There is even a role to be played by online, virtual communities of individuals with shared interests. Public health focuses on social determinants and populations. Medical care systems focus almost exclusively on individual patient behaviors and treatments.

The environment for the provision of health services will need to expand beyond the traditional clinical spaces that clinicians are accustomed to calling home. We will need to enable healthy activities in the communities where patients live, work, and play. Taking advantage of the determinants of health,⁵ we can evaluate physical environments and decide whether and how they enhance or detract from health goals. Food deserts, isolated neighborhoods, failing infrastructure, and lack of access to transportation combine to create unhealthy habits. Federal, regional and local governments; non-government organizations; and cultural, political, educational and spiritual leaders will all work together to leverage social and family networks in a cultural transformation that jointly achieves common community health goals.

A consumer-oriented free market system will allow for health-oriented neighborhood development projects that help

tackle these issues, encouraging people to become more active and to eat better through the support of community-based programs. Care will not be centralized in hospitals, clinics, and doctors' offices. If it is true that health is realized at home, health promotion must be promoted and sustained in the same place.

A REVISED MODEL OF PRIMARY CARE

One key element to realigning our focus on health outcomes is a revision of the primary care model. In the future, primary care should support communities and individuals to better achieve results. New iterations of the Patient-Centered Medical Home (PCMH) model carry great promise; results from initial investigations into PCMH implementation have been promising.⁶⁻¹⁰ The model provides the clinical framework needed to meet the strategic objectives of quality care, population health and lower costs with better outcomes and safety.

Indeed, future primary care centers should embrace this collaborative model of health that leverages community resources and is grounded in behavior change and sustaining healthy lifestyles. And with the reduction of regulatory barriers and a transition to free-market enterprise, it will be possible for primary care to innovate well beyond what has been possible in a fee-for-service environment.

We are starting to see a glimpse of this as the direct care market is beginning to take hold, although the market continues to be limited due to government intrusion.¹¹ While some have expressed concerns about the impact of direct primary care on access to care, reduced benefits and disparity,¹² such concerns provide further evidence of the need for free-market solutions that will eliminate these problems, which are largely, if not entirely, the product of government intrusion in the health care industry.

PERSONALIZED, CONSUMABLE, AND ACTIONABLE HEALTH KNOWLEDGE

Health Information Technology (HIT) can also play a significant role in improving health outcomes. Through effective HIT tools, we can deploy population analytics that enables clinicians to quickly and easily assess and monitor the health of not only individuals but also populations. Population health needs can then be identified, and appropriate resources applied efficiently, in a continuous feedback loop to help monitor and improve safety and mitigate the risk inherent in health care.

It is clear that the future of health is a connected one. However, the cacophony of new data, from activity monitors to a growing number of biometric devices, needs to be coalesced into actionable, personalized and consumable health knowledge in the context of traditional health care data. HIT can present data in more meaningful ways, but we must also train clinicians to build connections among patient data in order to provide appropriately targeted health support.

Technology and innovation have led to remarkable advancements in every other industry, and consumers have shown willingness to share personal and financial data in order to reap the benefits offered by services and applications. However, health care itself as an industry has had limited success, and despite tremendous pressure and financial incentives from the government, there has been little improvement in our ability to use, share, and learn from the ever-growing body of health care data. Consumers have once again been left out of the conversation.

Legislation that should serve to empower individuals has instead served to empower the vastly complex HIT industry – and to create remarkable barriers for free-market solutions that would indeed revolutionize the availability and provision of new choices for consumers.

GREATER PATIENT ENGAGEMENT BUT WITH FEWER FACE-TO-FACE ENCOUNTERS

Each person must also be prepared to engage in this new model. People, especially those with chronic conditions, can and should be monitored closely. However, the size and scope of our unhealthy populations demand fewer face-to-face encounters with caregivers. Instead, monitoring will need to be realized through other modalities – phone, email, and World Wide Web- or text-based visits with coaches, nurses, dietitians, psychologists and, yes, even physicians and others who can help people address the underlying causes of their poor and deteriorating health.

Such dramatic changes will create a significant adjustment for those accustomed to seeing clinicians regularly. But, the reality of our health care crisis is that people's clinical encounters have not improved, and are not equipped to improve, their health behaviors and efforts to help them embrace lifestyle changes. Much care can and should be virtualized. The current marketplace has simply not emerged as a profitable endeavor, with legislation reinforcing and creating a monopoly on our current episodic sick-care system rather than focusing on improving life.

REVITALIZED, COLLABORATIVE MEDICAL TRAINING FOR PHYSICIANS

Among the greatest challenges to embracing a new health model is revitalizing medical training and the scope of that training. We need to revisit curricula in order to expand the scope of health care professional education beyond sick-care models. We also need to train physicians and other health care providers to work in care teams where each individual works at the maximum of his or her skill level; in addition, we need to recognize and embrace the talent of other types of care providers to help achieve desired outcomes.

Currently, we train physicians to treat illness, and then put them at the front and center of health care policy and delivery. Physicians will need to work more collaboratively with other health team members such as behavioral

specialists, exercise physiologists, coaches, monitoring technicians, and even avatars and others who will be active practitioners of healthy life promotion, motivation, and encouragement.

Physicians must also understand that often doing *less* (fewer labs, fewer procedures, etc.) can actually be *more* beneficial to the health of their patients. Physicians will remain essential, but their position within the health and health care system will change. They should not be the “first and last resort.” Physicians should participate in patient care only when their particular skills and technical expertise are required.

Changing the roles of clinicians, however, will require that we train other health care providers as an integral part of this new team. The culture of health care teams will need to be modified to align with the paradigm of health. Programs like the health catalyst post-graduate program at the University of California, Irvine School of Medicine also have great potential to support this new health model.¹³ A health catalyst is a health professional who engages people as a coach and educator to assist them in developing healthy and sustainable lifestyles. While simple in concept, enabling health care providers to act as health catalysts will require changes across all health profession education structures. We need to train our care providers to work in PCMH environments and to act as health catalysts.

The Disruptive Interventions Required for Health Care Transformation

Health in the context of community A revised model of primary care Personalized, consumable, and actionable health knowledge Greater patient engagement but with fewer face-to-face encounters Revitalized, collaborative training for physicians Market-driven innovation

MARKET-DRIVEN INNOVATION

The transformation from health care to health will require sustained intervention in all of these critical areas. Each requires such significant systemic change, however – and the health care-industrial complex is so entrenched – that to be successful we need more than just the sum of all these interventions. What America really needs is something even more disruptive that will address not only each of these interrelated issues but also all of the questions and goals outlined at the outset of this discussion, simultaneously. A true transformation of health care, from a system focused on illness and disease to one focused on health and outcomes, will require market-driven, not regulatory-constrained, innovation. The evolution from health care to health demands consumer-driven choices that only a deregulated, free market can provide.

But how do we know that changing from a fee-for-service model to a consumer-oriented, free-market model will meet the goals outlined at the beginning of this paper? We need only to examine the evolution of government-controlled health care and compare it with the impact of deregulation on other industries to find overwhelming evidence for getting the federal government out of health care.

Since the early 1900s, medical special interests have been lobbying government officials to reduce competition. By the 1980s, policies and laws were in place to restrict the supply of physicians, hospitals, insurance, and pharmaceuticals and to subsidize demand.¹⁴ Ever since, the federal government has been trying to control high costs through policies and regulations. The impact of government influence was best described by the House Budget Committee: “In too many areas of the economy – especially energy, housing, finance and health care – free enterprise has given way to government control in “partnership” with a few large or politically well-connected companies” (Ryan, 2012).

The American government has spent billions of dollars on studies, analyses, systems, and processes to fix what is wrong with health care without really asking whether it can or should be fixed, and without considering the root cause that got us here in the first place. It is time to honestly acknowledge the disheartening impact of regulatory constraints on the health care system we have today – and in doing so, abandon the legislation and regulations that have consistently failed to produce meaningful results.

Arguments against consumerism in health care are based on the necessary pre-conditions that patients must have choices in the type of care they are offered and how; access to available, complete and comprehensive health information; a willingness to evaluate that information; and, ultimately, an ability to make good decisions regarding their health care needs.¹⁵

These arguments are both antithetical to the very nature of consumerism and to pre-conditions that can exist only if free-market forces are allowed to create these conditions. Others have argued that the very nature of health care spending related to preventable chronic conditions is incompatible with consumer-directed health care. Essentially, such arguments assume that individuals are simply incapable of making rational decisions, and that government interventions have failed simply because they have been misdirected; the proposed solution to this problem is simply to increase spending on prevention and public health.¹⁶

We must instead consider market-driven innovation and the art of the possible.

No nation can be happy, at peace with itself and fully productive when it is not in good health. Poor health outcomes are rapidly curtailing our ability to compete in a global marketplace and are putting our strategic and economic advantages at risk. But,

by changing the focus of our health care efforts toward better health and better lives, we can finally begin to put into practice what Flexner envisioned more than 100 years ago.

Flexner recognized the importance of public health and the need to apply scientific rigor to medical education, while at the same time remaining flexible and able to change to meet the needs of society from one generation to the next. Just as Flexner's recommendations created a revolution in medical education over a century ago, so too his vision of the future can serve as the spark to launch a new revolution today. There is little doubt he would find the need for such a revolution long overdue.

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