

PMO 526

**Assessing and Improving the United States Health Care
System**

4 November 2002

THE EXECUTIVES

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The United States Health Care System Past and Present

Health care in the United States has come a long way. Two hundred years ago, our first physicians had little equipment and made house calls on most of their patients. Their ability to treat effectively was limited by contemporary medical knowledge and classical treatments such as bloodletting and mercury that frequently did more harm than good. Hospitals came into being in the 1850s and health care became centralized around them. The Flexner Report in 1910 led to medical education being based on a more scientific foundation. With time medical practices became more scientific and hospitals replaced homes as the loci of care. By mid-20th Century, the quality and sophistication of American health care had increased by leaps and bounds. Today, the United States is the world's leader in medical discovery, technology and innovation.

Despite its awesome technological capacity, American health care developed into a fragmented apparatus with differing levels of access. The World Health Organization (WHO) considers these outcomes serious defects in a medical system. In a recent survey of its nation members, the WHO ranked the U.S. 24th in “the provision of good health care” and 54th in “fairness of an individual's financial contribution toward his/her health care”. However, the U.S. was ranked 1st in “responsiveness to the expectations of the population”. That is why, despite the faults in our system, people from all over the planet travel to the United States for health care. While Colombia was ranked first on “financial fairness”, there are not many people in the developed world who consider going to Colombia for their health care. All financial fairness means is that everyone has access to some kind of health care; it says nothing about the quality or level of that health care.

When it comes to health care, there are many things that the United States does well. For example, Americans don't have to wait long for open-heart surgery. However, there is room for improvement in the system.

In this paper, we will discuss some of the faults of our health care system. We will also suggest approaches to improve risk management and effectiveness within our entire system of health care.

The Need for Change

When engaging our health care system, we Americans assume we will get the best medical care available. Unfortunately, even in our modern, technologically advanced system mistakes like wrong-side amputations are known to occur. However, far more serious are the more frequent but less shocking medical errors made that often injure patients and create a need for additional care. These errors lead to patient's distrust, malpractice suits, and consequently, defensive medicine. In turn, defensive medicine, which definitely increases the cost of health care, can lead to more errors.

Many health care professionals have no incentive to point out flaws in the system. During their professional training they are taught that mistakes are not acceptable and that nothing can be overlooked even when the job involves long hours of caring for

numerous people. Over the years, the traditional theme of risk management in health care has been “by working harder and being more conscientious errors would be prevented”. Fortunately, this theme is starting to change. Health care workers are recognizing the flaws in the system and realizing that working harder is not enough to prevent the errors that are occurring. Improving the system’s alarming error rate will require unprecedented levels of cooperation between the various factions and interest groups involved in the delivery of health care.

Our group thinks that a paradigm shift is required before any significant improvement can occur. All too often, top managers/administrators dictate changes without first seeking input from those responsible for implementing new programs. These health care leaders, disconnected from the idiosyncrasies of clinical practice, frequently implement programs that have the exact opposite of the intended effect. For example, a health care manager may order an increase in a clinic’s daily appointments in hopes of improving access. The manager does this without first seeking the clinic’s input. More appointments are added to clinic’s schedule, but the access problem is unchanged. Had the administrator asked the clinic staff he/she would have found out that a shortage of appointments was not the problem. The real problem was the untrained appointment clerks filing appointments on a first come first served basis rather than patients being triaged to appropriate appointment slots by trained health care workers.

Besides incorporating them in the organization’s decision-making, health care professionals must be encouraged to take the risk of sticking out their necks and offering solutions to problems in the system. Many professionals are afraid to voice their ideas and experiences because it may result in being labeled troublemakers or may open them up to lawsuits when they expose systems that encourage errors.

How do we fix the system?

Our group suggests a system-wide update to health information systems. Despite the increased labor and cost associated with developing and effecting a universal health care information network, we believe it is a good idea. The health care industry should take advantage of computer technology to improve the continuity of care afforded to its patients as they go from one sector of the system to another.

Electronic information systems could address current flaws in the dispensing of prescriptions. Illegible handwriting, highly prevalent among physicians, challenges pharmacists to decipher (instead of read) many prescriptions. Pharmacists are supposed to call physicians when prescriptions are illegible but this does not always happen. Our civilian health care system can adopt what the military has been doing for years. The military’s computerized order entry system simplifies pharmacist’s verification of prescriptions. Due to the increased legibility and feedback capacity of this electronic system, inappropriate dosages can be brought to the physician’s attention more easily.

Multiplicity of prescribing providers and use of different doctors by the same patient presents another challenge to safe drug management. Because our current system

lacks mechanisms for crosschecking medication profiles, it leads to duplication of medications and increases the risk of medication interactions. This is a big concern for elderly patients because they tend to be on multiple medications. A universal nationwide electronic system would allow pharmacists to assist prescribing providers in preventing medication duplication and interactions. This could also act as a pilot system for fully electronic medical records.

In addition to an electronic prescription system, we suggest greater use of evidence-based clinical practice guidelines. Historically, physicians have frowned on clinical guidelines equating them with 'cookbook' medicine. Our group agrees with the IOM report that evidence-based clinical guidelines should be universally adopted. These promote more standardized treatment regimens while allowing for individual patient variability and customization of treatment regimens. The core features of a treatment regimen should be evidence-based and the same across the country so the standard of care is approximately the same regardless of where treatment is provided. How do we accomplish this? It is not just a matter of keeping the clinical guidelines up to date and available. All potential users must be aware of their existence and willing to use them. Possibly the best place to start fostering the use of evidence-based clinical guidelines is in the entry-level curriculum of health care professionals with continued emphasis through continuing medical education. But most importantly, clinical guidelines must be adopted and practiced by those considered clinical experts by their field of medicine. If those setting the standard in their field refuse to follow evidence-based guidelines, those having less influence in professional standards will most likely follow suit. Consequently, positive change is less likely to happen.

Our third suggestion, one that we believe will greatly foster changes in American health care, is a change in the focus of legal proceedings involving alleged medical malpractice or negligence. The current litigious climate discourages health care providers from taking a critical look at themselves and searching for ways to improve. Acknowledging and exposing organizational or individual problems could invite lawsuits whether the problems actually resulted in harm or not. The legal industry strongly markets lawsuits through aggressive advertising from law firms willing to take cases with no payment up front. If state laws would require lawyers to charge money up front, even a nominal amount, many of these frivolous lawsuits would probably disappear. An option to deal with these issues is tort laws. A no-fault tort law could provide reasonable and appropriate compensation for those who are injured by the medical system and end the outrageously large monetary awards in many malpractice suits that are having such a negative impact on the financial health of our health care system. It would also help the problem of companies providing malpractice pressuring physicians to settle out of court, which whether they are guilty of what they are accused of or not, settling out of court makes them look guilty.

The Future

The future holds promise for many improvements in our health care system. Largely this will depend on how many of us will be brave enough to stick our necks out

and suggest changes. Doing the safe thing often means not doing anything at all and remaining with the status quo. For even when one is trying to improve a system there is the risk of failure or in rare cases implementing a system that is less effective than the one it is replacing. In order to improve the risk management and effectiveness of health care in the U.S., we need professionals willing to take the risks involved in effecting new electronic information systems, lawmakers willing to act rationally and independently of high powered lobbies, and leaders in health care pushing evidence-based medicine training and guidelines. It will take a lot of hard work, time and learning from mistakes, but if we do not try, we are stuck with the status quo. And the status quo right now involves too many errors and too many people unnecessarily getting hurt by a system that genuinely tries its best to keep them healthy. Bottom-line: The human ingenuity and technological capacity required to improve the health care system is out there, but improvement will involve growing pains and probably pretty severe ones.