Fixing Healthcare Episode 5 Transcript:

Interview with Dr. Donald Berwick

Jeremy Corr: Hello, and welcome to Fixing Healthcare with Dr. Robert Pearl and Jeremy Corr. I am one of your hosts, Jeremy Corr, and I am also the host of the popular New Books in Medicine podcast. I have with me my co-host, Dr. Robert Pearl. Robert is the former CEO of the Permanente Group, the largest physician group in the United States, responsible for caring for Kaiser Permanente members on both the east and west coasts. He's a Forbes contributor, a professor at both the Stanford University School of Medicine and Business and author of the bestselling Mistreated: Why We Think We're Getting Good Healthcare and Why We're Usually Wrong.

Robert Pearl: Hello everyone and welcome to our monthly podcast aimed at addressing the failures that occur in the American healthcare system and finding solutions to make it once again the best in the world. We are very excited you have chosen to join us in this quest.

Jeremy Corr: For 40 years our nation's political and medical leaders have talked about fixing the American healthcare system. No one has succeeded yet. We need a hero. Our guests are the top leaders and thinkers in healthcare.

Robert Pearl: The show's format is simple. Our guest will have 10 minutes to present a road map for fixing American healthcare is the biggest problems and I will probe deeply, based on my experience as a physician and healthcare CEO. I'll scrutinize the plan, post questions that challenge our guests, and help our listeners separate real solutions from hype. Then Jeremy will dive in from the patient's perspective ensuring their concerns are addressed, making certain the concepts are clear for listeners, and help translate any medical jargon we may have used into normal conversational language. Unlike many other healthcare shows we're not interested in hearing about a pilot project that worked in one location or a new device that a company simply wants to promote. We're searching for truly disruptive change, not just a few minor tweaks.

Jeremy Corr: Our guest today is Dr. Donald Berwick. He is the president emeritus and senior fellow at the Institute for Healthcare Improvement or IHI, which he co-founded and led for 18 years. From July 2010 to December 2011 he served as President Obama's appointee as administrator for the Centers for Medicare & Medicaid Services (CMS). He has served on the faculties of Harvard Medical School and Harvard School of Public Health. He's an elected member of the National Academy of Medicine. His numerous awards include the 2007 William B Grant Prize for health services research and the 2007 Heinz Award for public policy.

Jeremy Corr: In 2005, he was appointed honorary knight commander of the British Empire by Queen Elizabeth the second. He has coauthored over 160 scientific articles and six books including "Curing Healthcare" and "Escape Fire: Designs For the Future

of Health Care." Dr. Berwick is considered a revolutionary in American healthcare. Dr. Berwick, welcome to the show.

Donald Berwick: Thanks very much, Jeremy and Robert. It's a pleasure to join you.

Robert Pearl: Don, consider yourself an applicant for the job of the leader of American healthcare. You're being hired due to your experience and expertise and your reputation as a visionary and innovator. You're being hired because after decades of talking about the unaffordability of healthcare coverage and nearly 20 years lamenting lagging quality and over 100,000 deaths nationally each year to preventable medical error, our country is ready to make a major change. As I told the audience we're not interested in small incremental fixes or simply trade-offs among cost, quality, and service, but instead believe disruption as possible. And you, Don, are the right person to make it happen.

Robert Pearl: So deliverables are significant in size and scope, but unless we can achieve this level of improvement we don't believe over the next 5 to 10 years the American people will be willing to move forward. We'd like you to provide a plan to achieve the following: One, increased life expectancy in the U.S. From last among the 11 most industrialized nations to at least the middle of the pack. Increase quality outcomes as publicly reported by organizations like National Committee of Quality Assurance by at least 20%. Decrease cost of care by 20% of federally reported data. Improve service and convenience by 20% in patient reported satisfaction. And improve professional satisfaction for clinicians by 20%.

Robert Pearl: Dr. Berwick, you'll have 10 minutes or so to outline the system of healthcare you believe is capable of accomplishing all of these outcomes and the steps you will take in this role to get there. Please let us know your thoughts, Don. I can't wait to hear your ideas.

Donald Berwick: Yeah. Well, thanks for asking. Your question, Robbie, appeals to narcissism, but I have to start by saying I don't have the answers. I'll do my best at laying out what I think the frameworks are that'll help us get to what you laid out. But the most important part of this hour together is going to be conversation and exploration. The first part of the plan that you're asking you for is that although you're appointing me czar of fixing healthcare, I decline. This can only be done together. And the most important component of action is that action begin to be consolidated among stakeholders. We have a highly fragmented system in which people are trying to solve problems separately. That is just not going to work.

Donald Berwick: And so the first step I take is to form a table of healthcare leaders and stakeholders who we share a common intent. We're going to have to fix healthcare together. There's no top-down single-minded answer. Okay. So that said, at the table that I would set, I think the most important starting point is aim. As you said in your introduction we have not just a pretty broken system, a terribly broken system. Our costs, the quality of our care, and the health status

we achieve is nothing like what's technically possible. We're not even close. And that has to be recognized. And I think the kind of self justification or denial, which is too prevalent in healthcare, has to go away. We need leaders at all levels to say the system is not working, it cannot work.

Donald Berwick: The language that the Institute for Healthcare Improvement, the organization that I used to lead, introduced in the mid 2000s thanks to my colleagues Tom Nolan and John Whittington is the "Triple Aim," which is now widely used globally. What Nolan and Whittington set out is that we need a system of three goals of better care for people when they're in the care system, better health for populations, and lower per capita cost through improvement, not through rationing or withholding. That was the mission I brought to the Centers for Medicare & Medicaid Services when I took over in the Obama administration. The Triple Aim became tattooed on every single person there: better care, better health, and lower costs. Unless we agree to those goals with metrics, we don't mean it. And so far we don't mean it.

Donald Berwick: Concomitant with the Triple Aim is another goal I think, which is healthcare as a human right. For some reason that I do not understand this country has been ambivalent about declaring as an intention what every other civilized democracy in the world has said, which is healthcare is a human right. It's the same as the right to clean air, to primary education, or to food security. We don't always deliver but unless we intend to do it, we're not going to get there. And I would end once and for all the equivocation in this nation if you're in the United States you have a right to healthcare.

Donald Berwick: With respect to the Triple Aim there's one other goal that I would set out and that has to do with a component of the Triple Aim. That's lower per capita costs. I'm worried about 18% of GDP (being spent on healthcare). I would set an unequivocal goal to be at 15% within the next five to six years. There's no reason we can't do it at 15. Every other nation is below 13 or 12. That would be a tremendous solution to the cost problems we've got.

Donald Berwick: So one of the key initial steps is to change payment. I simply do not believe the Triple Aim is accessible in a fee-for-service system. I wish it were. Maybe it is. There are countries which are doing better than we are in fee-for-service payment, but I no longer believe that that's compatible with the redesigns. And so I would move us as fast as I possibly could to global budgeting, budgeting for the care of populations. That responsibility probably belongs at the community or regional level, not at national level. And so entities such as the one you led for so long, Robbie, the Permanente Medical Group and its partner Kaiser Foundation Health Plan. The Kaiser Permanente model of population based finance I think is the model. I don't see a better one.

Donald Berwick: I work a lot in the United Kingdom and especially in England right now. England's been having some troubles with the National Health Service (NHS), but finally they're moving to population-based budgeting at the community level. They call it the health economy level through integrated health systems.

What that does is give leaders a chance to allocate resources where they're needed instead of staying in a gerbil cage of production. The common vocabulary for this is moving from volume to value payment. I don't think that's correct. We need to get out of volume-based payment, fee-for-service. But I think payment needs to be seen as a support system for redesign. We need to lower cost and improve outcomes at the same time. And I would much prefer a payment system which supports leaders at the community level to redesign the pursuit of health and well-being at the community level.

Donald Berwick: One of the vocabularies the United States has not adopted that I would adopt forthwith is the World Health Organization's framework of "health in all policies." This sounds a little vague, but it's really not, and the WHO documents, as well as many other scholarly documents, lay out how you need to see health through all lenses at once: transportation, housing, environment, recreational budgets, criminal justice reform. And I would set out a national and regional designs that include from the start health in all policies. And I'll come back to that.

Donald Berwick: Everything I just said, setting aims, changing the payment system, establishing global resources from the community level, health in all policies is of course leadership dependent, and so it's almost boring to say it but we need leaders who support this, which means the goals of the leaders have to be the Triple Aim. Right now the leadership system in healthcare is largely oriented toward maintaining volume. I hope if any test is ever named for me, the Berwick test, it would be this: we're en route to the healthcare system we need when hospitals seek to be empty. And I actually would use that as an index that we need boards of trustees and leaders at the facility level to be trying to keep people from needing to use the facilities as a primary goal.

Donald Berwick: Now, how is all that achieved? The general approach now is either exhortatory, do better, try harder, I'm a hero; or contingency based, we'll pay you differently if you do better. It's carrots and sticks. I don't believe in either of those. I think there's a thorough commitment to redesign of care at the community level. At IHI, where I'm now senior fellow, I lead the IHI leadership alliance, which is a club sort of. It's a membership group of about 40 organizations, and I'll do a commercial here on the podcast saying if there are any organizations out there that want to get involved in pursuit of the Triple Aim join the IHI leadership alliance. It's a very dynamic group of organizations that are trying to change the game through redesign of care, and they've articulated a set of redesign principles which are real. There are 10 of them. And they lay out the frameworks for changing the flow of care.

Donald Berwick: I'll say, not to flatter you Robbie, but I've seen an awful lot of this in place at Kaiser Permanente, a lot of movement going on there at an organization I deeply respect. But some of them, for example, would be move knowledge, not people. That's one of the redesign principles. It's really moving us into the much more mature versions of telehealth, telemedicine, remote care, non-visit-based care that is now accessible. We know how to do it. There are examples all over

the world. This needs to become a mainstay of the healthcare delivery system: the virtual delivery of care, not through encounters.

Donald Berwick: Another one would be customizing care to each individual, largely through patients' self care, and equipping people in homes to do health-promoting activities, and healthcare activities directly at home, all the way from high-tech at home to the usual list of maneuvers which prevent the onset of illness. Another is to assume abundance. That's another design principle. We need to get out of the notion that only doctors could do the things that doctors do today. And a widening of the scopes of practice and of the nature of the workforce is really key.

Donald Berwick: Jeff Sachs just published a very fine paper on community health workers and how revolutionary for real investment in community health workers would be. That would apply to this country as much as in any other. Another idea is simplification. We need to get out of the enormous complexity that patients find themselves in -- in the care and payment system. And the same for the clinicians, people who give care. We have made so many stupid rules and those stupid rules have to be stopped. They have to be taken down. Many of the are rules are about metrics which make no sense, metrics that don't help people at all. We need to put ourselves on a metric diet, a measurement diet. I've called for a reduction in the amount of measurement that's going on in American healthcare by 75% over a four or five year period.

Donald Berwick: One of the most important components of simplification goes back to the payment system, which is if we get out of fee-for-service payment, if we move toward global population-based budgets, the payment system should get far easier to manage and far lower cost. There's probably 10% of the total American healthcare bill right there, right in the simplification of payment systems. I publicly supported some version of Medicare for all. I think a single-payer system in the country would be the most logical place to go. Politically, it's very difficult. I don't think that people need to fall on their swords about that right now, but if we just think about simplification of payment as a goal, it'll free up resources and spirit for work on what matters.

Donald Berwick: I will [inaudible] those redesigned principles and more I know that could be added, but one that I want to close with is simply moving upstream, promoting well-being. Go back to the health and all policies idea. If you get serious about understanding why we get sick, what causes the heart attacks and the broken arms and the strokes and the depression and the substance abuse, if you ask what the causal system looks like, you move out of healthcare toward what is called somewhat vaguely social determinants of health. The term is vague, but the ideas are not.

Donald Berwick: I've recently read a book that I think everyone listening to this podcast should read tomorrow. It's called "The Health Gap." It's by Sir Michael Marmot, the British epidemiologist. And Marmot takes the very complex literature on determinants of illness and parses it. He's got six basic categories of causes, and

his point, like mine, is we can't get to the health without going through the causes. Those causes lie in the structures of society, early childhood experiences, education, workplace conditions, attitudes toward the elderly, community resilience, and most of all perhaps fairness and equity. At the root of illness in America is inequality, inequity. It's residue of racism. The consequences of poverty are inabilities to nations to decide to end poverty, which we couldn't do. And unless we move our attention towards the causes, the repair shops that are very expensive compared to moving upstream. And so a key element of my plan would be to reallocate resources toward working on social determinants.

Donald Berwick: Now, in a global budget environment that becomes, if not easy, at least feasible. Questions then can be asked about whether we're doing enough to move upstream to deal with adverse childhood experiences, with loneliness and isolation among the elderly, with inadequate housing, with a broken criminal justice system. And I personally think the healthcare system today is to become a leader in the reform and improvement of communities, so they're more resilient and support the pursuit of health. I am quite confident that through redesign, a consolidated payment, claritive aims, focus on health in all policies, working hard at the redesign components, principles like expanding telehealth and telemedicine, and moving towards social determinants of health, we can meet and beat every single goal that you just laid out in your introduction, Robbie. I know there's a lot there to explore. Let me stop and welcome your challenges and push-back and further questions. Thank you.

Robert Pearl: Well, first, thanks, Don. That was quite inspiring and well focused. Unlike your opening comment about narcissism I think you're an overly humble man. Your 100,000 Lives campaign was a tremendous success. Certainly the IHI continues to be at the cutting edge of change and the Triple Aim, as you say, is now fully embedded in all that we do. Let me just briefly ask you about the 100,000 Lives campaign. It was a total success I know back then. What do you think has happened since that time?

Donald Berwick: A loss of focus. I think that the distractions of healthcare today mainly around business imperatives and the economic pressures of a continually rising healthcare cost have taken conversations in the boardroom, in the C-suite very much toward issues of revenue and margin and cost reduction through blunt tools. Boardrooms and C-suites need to see safety as a strategic imperative as well as a moral imperative. And unfortunately that's not very much the case today. The need remains enormous and the potential remains enormous because we have a lot of knowledge about how to improve safety and a lot of good examples. And we have a workforce that wants to do safe care. So we have the science, we have the knowledge, we know the problems there. We need to refocus on strategy and we're seeing a bit of a downturn now.

Donald Berwick: I must say I just had the privilege of co-chairing a new National Academy of Medicine Committee on the global quality chasm. You remember I was on the group in 2001 that published "Crossing The Quality Chasm" for the U.S. Now

there's a global report on quality and its consequences, problems and quality globally, especially in low and middle income countries. What this group has documented, and it's published, the report is now out from the National Academy of Medicine, the number of lives lost globally due to problems in quality, led by problems in safety and reliability, exceeds the death rates from malaria, TB, and AIDS combined. We're looking at something around 8 million deaths a year globally. It's hard to think of a more urgent crisis except maybe a climate change and global warming.

Robert Pearl: So, Don, let me now focus in on what I believe is at the heart of your proposal, and I support it greatly, which is this moving from fee-for-service to capitation, because like you I don't believe that fee-for-service can solve the problems. And let me parse it out through a series of questions. Let me first try to figure out when you talk about this capitated type of approach, and I want to emphasize what you said at the delivery system level, do you see this as being a I'll say government overseen approach, because I'm not quite sure who else would organize it? Or do you see it relative to Alain Enthoven as being a competition amongst several entities in the same marketplace each of which is capitated in the same way?

Donald Berwick: I think either could work, Robbie, but as much as I respect Alain Enthoven and I respect him deeply as you said it's hard to think of a way to do that other than with government in the lead. I of course had the experience of running Medicare and Medicaid, a single payer system for elders and vulnerable populations in the country, and I think it's got tremendous achievement and a lot of possibility. So I'm not jaded about the role of government as a payer. In fact, I'm enthusiastic about it if we could get behind us and do it. I think the delivery systems that do that should be regionalized or as local as possible, and what I'm seeing happen in England right now with these, they call them IHS's, integrated health systems, is quite thrilling. We're looking at entities that say, "Okay. I've got a budget, 300,000 or a million," and those entities have tremendous flexibility to move the money around, can move the resources around and make plans for population health. That's what we need.

Donald Berwick: If you could think of a lead other than government I'd be open minded about it. Some things we do through authority structures like a federal administration or there may be quasi-governmental forms, but I think government needs to be in the lead. I think the concept of competition at that level does not appeal to me. I think a competition in healthcare is in large measure a failed experiment.

Donald Berwick: Some places it may help. It may work and we probably could get more deeply into that. But I think overall competition tends to produce a number of effects that are not helpful to the public. We don't consolidate resources for urgent matters like housing and transport and the social determinants. The movement of knowledge about improvement decreases as people treat improvement knowledge as proprietary. Competition inevitably leads to some kind of gaming about who's in and who's out of my system, and a competitive environment with incomplete risk adjustment. The game is make sure that well people use

your services and sick people go elsewhere, which is exactly the opposite of what we need. So I do prefer a kind of a government sponsored or quasi-government, regionalized, single-payer format of some type.

Jeremy Corr: So you talked about healthcare as a right and moving towards a single payer. I think a lot of the public that has concerns about that are worried about if we do move to a single payer a lack of choice, lack of freedom with their health options and increased wait times and things like that. What would you say to those people?

Donald Berwick: Do you like it now? I mean, can you read your bill? Do you get a straight answer from your insurance company? How good is it right now, actually? And remember a single payer is not a single provider. That's a different idea and not the one I'm talking about. We have pluralism in American healthcare. There are several hospitals in your community. There are many doctors. You have choices now, and there's nothing about a system of consolidated payment that needs to take away that kind of choice on the delivery system side. My point is you need a payer system that stands up for you, that's protecting your interests. And that's what I was able to help run it at Medicare and Medicaid, and I think we need public accountability in a payment system and simplification. And I think patients who are worried I'd ask them to take a look at how it is now.

Donald Berwick: And then I would also point out that, correctly designed, a consolidated payment system, a Medicare for all kinds of system, should have built in accountabilities. This is government. If the government is the actor, governments are supposed to be accountable. So I'd say you probably have more responsiveness in such systems, especially if you have regional forums. I want to say again, Jeremy, I am not a person that believes, as I said earlier, that we need to fall on our sword on a single payer platform. I don't think that's right. I think this is something that should be shaped in a way that takes into account people's concerns.

Donald Berwick: And maybe there's a middle road, maybe there's some other way to do this as long as we have simplification, accountability to patients and families, local controls, embracing the Triple Aim, getting the healthcare workforce off the gerbil cage of volume in fee-for-service environments. As long as it allows us to put resources where health lies, then I think it should be on the table. And that's a mature dialogue this country needs.

Jeremy Corr: So if we were to move to a single payer, a government payer, I think that one of the questions a lot of people have is what would happen to the major commercial payers out there, your Blue Cross Blue Shield, Aetna, things like that, and would they even allow something like that to happen with the amount of power they have?

Donald Berwick: Well, to the second question, no. I mean, they do what I would do if I were they, which is say, "No, we want to have this ball. We'll make it our job and we'll do it," because they want to stay in business. Why wouldn't they? If we went to a

government payer, to a Medicare for all kind of system then, yes, those companies their job has changed fundamentally and is a much smaller, different job. They might become the transactors. You could use some of the existing insurance architecture to essentially be the administrators, train the public system. In fact, that's exactly how Medicare works. Medicare work through contractors, some of whom are Blue Cross Blue Shield plans.

Donald Berwick: But instead of being entrepreneurial organizations trying to sell insurance they're the administrators for the government insurance program. And that would be a way to do it. But not to mince words, there would be a change in that industry. It would be smaller and it would be more administrative and less in control of the payment systems.

Robert Pearl: Maybe be cut back if I could for a second to a comment just made Don that popped into my mind, which is that as I looked at the system in England, one of the problems that I've seen is the vagary of politics. Depending upon which party is elected they might choose to put more money or less money into healthcare and trying to design facilities, create staffing, all the things that we do is a multi, multi-year process. How do you see leveling out the funding that's going to be provided so that it's predictable at each of these community levels that you're espousing?

Donald Berwick: That's a really, really good question, Robbie. Yes. Probably the most important to me, the most significant criticism of a publicly funded single-payer system is that. Well, that kind of means that political vicissitudes, changes in party control, changes in doctrine, would be reflected in the funding and management of the healthcare system. And that is indeed what you see in countries that have government healthcare systems. My view of that would be part of the design has to be a very specific conversation to mitigate the toxicity of that kind of variability. Perhaps done through term structures, term structures for the administrative system itself bridging across elections and making sure that there's some more stability in the leadership of the system. I'm somewhat intrigued by something like perhaps an authority or utility structure which would have quasi independence, still be accountable in the end to government but be made somewhat immune from the kind of vicissitudes you're talking about.

Donald Berwick: But look, no system of finance is going to be perfect. Right now in a multi-payer, privately funded system, for-profit or nonprofit, you have a different kind of problem which is opacity. Change the CEO of an insurance company and you will see the insurance company behaviors change. So I'm not saying that a Medicare for all kind of system would be ideal. It would not be ideal. It couldn't be ideal. But the problem it brings I think maybe less onerous than the ones with this currently opaque, impossible to understand system.

Robert Pearl: There clearly will be winners and losers. If you're correct that the goal of hospitals will be to decrease the size of their inpatient volume, certainly hospitals will need to close and we want to improve efficiency and maintain

quality. How will that decision be reached and how will those communities that lose a hospital or those facilities themselves that close respond? And how would you address that?

Donald Berwick: People will have to change or the hospitals in the current model of top-line-driven, keep-the-beds-full are going to be in a different game. And there will be resistance of course. The pharmaceutical pricing problem needs to be addressed and there'll be pushback on that. So we can't be wimps about this. There has to be some political courage. But when you look at the winners and losers there's a short-run and a long-run version. And in a country with 18% of our GDP going to healthcare where no other country is above 12 or so, in a country which is 49th in life expectancy at age 15, in a country which has inequities in health status that few others rival, I can't say we're winning right now. We're not winning.

Donald Berwick: The public isn't winning. The corporations aren't winning if the money is coming out of their pockets. Families and individuals aren't winning. Professionals aren't winning. We want to produce health. So yes, there'll be some local stakeholders that are going to have to change their business model. Welcome to business. But the amount of gain here from the societal point of view is absolutely massive. We're talking not just about the ability to invest in [inaudible] and public goods, our ability to lead the lives we want. We're talking about corporate success here, about the health of the American economy. That's why leadership and aim are going to be so key here, which is to kind of gird our loins to go ahead and go through the transition to get to the better place.

Donald Berwick: But your question is right, Robbie. There's a political side to this and there's no way around it. If clinicians, physicians, nurses, pharmacists, therapists, if the clinicians care about well-being and the public they're going to have to be willing to become political advocates for these changes.

Jeremy Corr: You talk about hospitals striving to be as empty as possible. How would you communicate that effect on the local economy to people or in a local economy where one of these hospitals is a major employer?

Donald Berwick: The issue here in the long run, an economy is not a solid one that requires you to waste effort in order to make money. That isn't good in the long run for anybody. I'd take it as a matter of abundance. That hospital costs that went away, that job that is no longer needed is a person [inaudible] something else very important for society. And we have to have plans. We can't just say "too bad, you lose." We have to have plans for helping with those transitions in both the insurance industry and the delivery industry. And this, by the way, will happen over a time frame long enough that some of the normal dynamics of attrition and turnover can be exploited to make the discomfort for the healthcare workforce buy the changes we're talking about, including the insurance industry. We need respectful plans for helping with retraining in new opportunities. But we have to treat this as a matter of generating abundance, not loss, so that the hospital resources, the people that get freed up because

we're no longer investing in wasteful activities that resource [inaudible] using should be.

Robert Pearl: There's a lot of evidence that the biggest difference between the United States and other countries, as you mentioned earlier, is around pricing. Not just drug pricing. Will physicians get paid, would nurses get paid, would hospital administrators get paid? Getting people to lower what they charge the government is going to be able to do it through Medicare as you know because it can apply the prices without having to negotiate them. As soon as you move to these broader systems how do you think, I'll call them the legacy players of today, are going to respond? What do you expect they're going to do? And how would you address it?

Donald Berwick: Well, that's why a global budget is so key. You'd need to change the conversation. Unless the common pool resource to use Elinor Ostrom's phrase ... She was the Nobel prize economist who asked questions about how society solves problems when there's a commons at stake. But unless you have an unlimited common pool, you don't get the discipline and thinking about where those resources should be expended that we have in a system with no limits at the moment. By limits I don't mean rationing by the way. There's so much money on the table and waste that we don't have to ration, in my opinion, anything in order to get to the goals that you and I are talking about.

Donald Berwick: You need discipline, and we don't have a system that's disciplined that way right now. It is price so far as you understand 70% of the differences [inaudible] for other differences, but that's going to be part of the problem of transition, getting prices back on the table and saying we can't have these differentials and achieve the Triple Aim. It just is not going to work.

Robert Pearl: You and I completely agree about how badly broken the American healthcare system is. But 76% of patients report that they get great care. How do you explain this divergence? And, as you said earlier, how are we going to overcome this denial?

Donald Berwick: I think 76% of patients and more are grateful to their clinicians for goodhearted efforts they see. It's a good part of someone's life to know that there's someone out there who cares about you and will care for you. So we're seeing gratitude and its effects. We're also seeing consequences of opacity. The defects that you and I are so aware of, Robbie, because we know the science. That knowledge is not really even made digestible to the American public. Even people in my family. And I've studied defects in healthcare for 40 years now. Even people in my family gets surprised when I show them an article that shows the rate of problems. So we have a communication challenge here. That's why my number one step in the plan you're asking me to lay out after declaring healthcare is a human right my step is face the problems directly, really make well known how far we are from what's theoretically possible.

Donald Berwick: I do think that the number you quoted it probably doesn't show the real facts, because my experience is when I go into a group of patients or just people who are inpatients now, if I ask them whether the care system seems coordinated on their behalf so that the left hand knows what the right hand is doing, or if I ask them whether they think the costs are justified at that level, people absolutely experience the defects. I don't think you can find many people who can't report an error in their care, the care of a loved one. So tapping that energy is going to be part of the plan.

Robert Pearl: You and I both are very concerned about medical error. In my book "Mistreated," I took my dad's death from a medical error. You've talked about some of your own family's experiences, but I want to look at a parallel process and problem, which is that of failures in prevention. And I look at the number of people who get heart attacks and strokes because our nation controls blood pressure only 55% of the time or die from colon cancer. Maybe 100,000 people a year would not have to die if they had the proper screening, which can be easily done in the comfort of the bathroom once a year. How are we going to get both patients and physicians to value prevention as much as they do intervention?

Donald Berwick: Changing the flow of resources is one way. I mean right now the economics of prevention are nowhere near as favorable as the economics of doing an MRI. Again, reverting back to the concept of global budgets or single-payer systems, which have global budgets, and population responsibility would get us much more interested in prevention. I think we need better technologies in the preventive space. I mean, people know that it's not a good idea to be obese or to smoke. That's not the problem, I don't think. They know it but behavior change is very hard and that investment in health in a sense that we're all moving toward wellness and as a collective, as a group with solidarity, words you don't always hear in the United States would help.

Donald Berwick: We can talk all we want about the importance of physical exercise. That doesn't create the bike paths or the work schedules or the facilities that allow us to be vigorous in what we do. We can talk all we want about proper nutrition but it doesn't solve the problem of food deserts or proper management of the causes of obesity. So yeah, this is another case of working together as opposed to separately to create the conditions in society which make our communities resilient. It can work.

Donald Berwick: An example I've seen in England and Scotland talked about recently a lot here in the U.S. Is the daily mile. This was started by a school in Scotland, the Saint Ninian's school in Stirling, Scotland. They just measured obesity in their kids, They found 45% of the kids in this elementary school to be obese or overweight. After a year they were able to introduce somebody they call the daily mile. Every kid and every teacher runs a mile a day. Within less than three years they've eliminated obesity in the lower primary grades. That has become policy in Scotland, policy in England. It's policy in Netherlands. A society wakes up and

introduces a kind of way of helping each other be healthy. And I think that's far more effective than the next exhortatory poster that says don't eat too much.

Robert Pearl: Very impressive. I don't know anyone, Don, who has seen in great detail the healthcare systems around the globe than you. Is there one that you would hold up as a model that we could learn the most from?

Donald Berwick: I haven't seen one that I think would be the model. The American solution is going to be different or just a much more complex country. I would say you could tour the world and find examples country by country of pretty impressive change. In Scotland, for example, they have a program called the early years collaborative in which the National Health Service is working with communities, all the municipalities in Scotland, on the well-being of children under five with respect to infant bonding and safe birthing and school readiness. And that's the health system working with communities on improving the conditions of children who then can become healthier.

Donald Berwick: I think the emergency medical services system and the integration with primary care in Denmark I find, at least the last time I looked, very impressive. Singapore is doing some early but promising stuff on elder care and aging in society. They're not yet there, but you're going to see some pretty interesting stuff go on there. I spent a lot of time in developing countries and low- and middle-income countries, I must say one of the other things I've noticed is community mobilization and the use of a nontraditional workforce to produce stunning results that we can re-import them back to the United States, and learn from these global examples in societies that don't have the money to waste that we waste and so they're cleverer than us in some ways and they come up with good innovations.

Donald Berwick: But I would say no country has yet put together the system that I would aspire to in the U.S. But we're going to have to put together pieces of the quilt, and that quilt is going to be far better for our country than our current system.

Robert Pearl: I know you spent quite a bit of time in Sweden studying a particular hospital there. Do you want to tell the listeners about your experience there and your conclusions?

Donald Berwick: Yeah. The Institute for Healthcare Improvement has a set of so-called strategic partners. These are organizations or systems around the world that IHI has long term relationships with. One of them has been Kaiser Permanente as you know. But sometimes there are political entities. In this case, it's the county of Jonkoping in Sweden. Jonkoping County is, I don't know, maybe about 50 or 60 miles, little more, outside Stockholm. It's a county of about 400,000 people. Sweden funds its healthcare system as a single-payer system at the county level, basically. So Jonkoping County, now called Jonkoping Region, is responsible for assuring care to its population. And that system, that county system, its performance is stunningly good. It's the best in Sweden which is one of the best in the world.

Donald Berwick: They have a whole range of things they're doing, including things with social determinants, elder care, continuity of care, working with the well-being of children. At the hospital level, remember I said Berwick's goal is hospitals seek to be empty, they have hospitals that work very hard on not being necessary. The most interesting example I've seen in the past few years was an innovation that their teaching hospital called Ryhov Hospital were due to the inventiveness of a patient they have gone to a self-hemodialysis. They have a hemodialysis unit, but the nurses don't really run it. They're there but what happens is patients do their own hemodialysis. More than half of their patients do that.

Donald Berwick: They come in, they put it in their own cannulation. They adjust their own machine. They decide when to do their hemodialysis, how long they do it. They're in charge. The patients are. That has reduced complications by 50% or more, reduced costs by 50%, much more empowerment of patients. They'll never go back. And that kind of shift of the balance of power and control so patients really can do things for themselves that's a theme in that county.

Robert Pearl: You mentioned earlier the book by Marmot on health gaps, and I've read a lot of his research from the past. And as you say a lot of it has to do with the social problems that lead to medical problems, particularly from disparities in power, but getting people to give up power, to give up income, to give up control is very difficult particularly in the American culture. How do you see changing that culture to get people to embrace the types of improvements that he's described as being possible?

Donald Berwick: Well, Michael Marmots book "The Health Gap" is worth reading because it's got 300 pages of answers to your questions, but you see, I think this needs to be approached not as a loss but as a gain because to improve educational outcomes or to work on early childhood experiences or to work on the loneliness of elders, there's a positive side to that. People are gaining as they do that. There are new jobs, new roles, a new sense of buoyancy among the beneficiaries. So yes, we can focus on the loss side, but I guess maybe I'm a bit of a romantic on this. I think when a true professional finds out that they have a way to transfer power, transfer locus of control, transfer knowledge to the people that they're trying to help, it feels good to see a child who finally is beginning to succeed at school. It feels good to have an elder person who was lonely no longer be lonely.

Donald Berwick: More recently I was in Gloucestershire in England. It was my last visit there. And I saw the health system reaching across to the city of Gloucester, which is pretty stressed, and they had a cadre of hundreds of very severely mentally ill people who were showing up in police stations and disrupting the peace in the community, and absorbing a tremendous amount of healthcare costs. Well, the healthcare system formed a partnership with community assets. One of them is called Treasure Seekers, for example. It's a nonprofit that runs a kind of drop in center in the downtown area in Gloucester, and in the room were some patients and the people from Treasure Seekers and the health system but also the police and others. And they couldn't sing enough in celebration of what was happening

as people with chronic mental illness were able to come in every single night, 365 days a year.

Donald Berwick: They can come in the evening. They can work in the coffee bar. They can play their guitars for others. They can have conversations. They can meet healthcare people. And the healthcare utilization of mental health has gone way down. The police are no longer seeing these people in their police stations. This was a loss of power. I mean, these people's ... the effectiveness was moving in a community, but you never saw so many smiles. People were really happy to see that success finally was in their hands.

Robert Pearl: You were a candidate for governor of Massachusetts. I have to admit I was personally disappointed to see that you did not win that election because it would've been fascinating to see what you could have accomplished. What do you think you might've done relative to healthcare had you been able to obtain that post?

Donald Berwick: Everything we're talking about. I mean, I think the ability especially well endowed state like Massachusetts to decide to seek help, talk about low hanging fruit. I mean, it's there for the asking. And what we need are leaders who pull people around the table and say, "What kind of place do we want to be? What kind of community you want to have? What do you want to be the fate of your children and your grandchildren and your neighbor?" And I think the ability to pull together people to get things done is one of the reasons we have government in the first place.

Robert Pearl: But let me go back to a comment you made when you talked about healthcare as a human right. Is there a limit? Is there a point beyond which where people are asking in healthcare an organization or a system simply cannot deliver?

Donald Berwick: It's a complex question. Well, yes, of course but remember the expectations the public has of healthcare we're not created by the public. They were created by the healthcare system in concert with American society. So we are living with the expectations we built. I'm for mature conversation with the public about what is possible and what's good to do. We deliver forms of end of life care that the public does not want, but we do it anyway. We see overuse of antibiotics. We are overusing antibiotics. We can't shift the blame of that to some public that's demanding it. If an MRI scan has asked for that shouldn't be done, we have to have mature dialogue.

Donald Berwick: I believe that the expectations of the public are quite reasonable once we have mature dialogue with them, and I think the public can have the Triple Aim. We can have the Triple Aim and joy in work. People call it the quadruple aim because it doesn't feel good to be working in a system that can't get the job done. That's why the change in the end will be attractive. And so I think better care, better health, and lower costs are all quite possible.

Jeremy Corr: What sort of nontraditional partnerships or technologies to help improve patient convenience and experience are you most excited about?

Donald Berwick: General collection. Telemedicine and telehealth, to be able to project help into people's homes and lives at their request instead of requiring them to come to us. Those are exciting. There's a whole bunch of entrepreneurial efforts under way, which basically are allowing people to get help without moving to any place. They just get it. Again, I somehow find myself talking about Kaiser Permanente a lot, but I was out in Northern California recently and saw their tele-derm programs. So I believe it's 24/7, maybe not, but there's a dermatologist always on call from the whole system if they combined the resources to do this. If I'm a patient in that system and I have a lesion that's worrying me on my skin or I'm in the primary care doctor's office and the doctor has discovered something that worries her, instantly they can get a tele-derm consultation in real time, I believe.

Donald Berwick: And they've knocked the socks off [inaudible] instant. The quality is fine. And if there's any concern, of course you can have an appointment. That's just one small example of a whole big idea, which as we say in the IHI leadership alliance, move knowledge, not people. I'm very excited about that. At the more cutting edge level artificial intelligence and machine learning are hyped without much delivery, yet I think will deliver. I think these are going to be extremely important disruptive technologies.

Donald Berwick: I work a bit with one of the organizations under the Google umbrella. This also is in England. And they've developed artificial intelligence, machine learning based methods for detecting kidney damage in hospitals, acute kidney injury, long before any clinician has realized that they can say, "Oh, look, take a look at Mrs. Jones. She's getting into trouble." They can spot it. And the computer figured out how to spot it, not a person. They've recently published on machine learning algorithms for reading chest X-rays or mammography or optical tomograms. The results are equal or better than the best experts. So we're about to disintermediate an awful lot of individual human interaction because we could use machines as our servants.

Robert Pearl: You're obviously right, Don, about the teledermatology. When I was the CEO there, we had 60% of the rashes that the primary care physician needed help on. So these are ones that are beyond just the patient needing help, the primary care physician needs help. And they were solved before the patient left the primary care physician's office 60% of the time, and I'd like to say in six minutes rather than six weeks, which was a standard in the community at 60% or less of the cost. So that is your Triple Aim being able to provide that care to an individual, to a population in a very cost effective way. And if we can do it in dermatology we can do it in a lot of different areas, particularly bringing in the best expertise from a long distance away, which is something that can't happen or doesn't happen very often in most communities today.

Donald Berwick: Yeah. And that's redesign. That's the kind of redesign we're talking about and thinking about the economic environment that allows teledermatology to thrive. Like my earlier comment about hospitals wanting to be empty, this is a case of specialists who are happy not to have a visit. And that requires an economic environment which makes that economically plausible and attractive, allowing us to focus on the needs of patients instead of the mechanics of the delivery system, next patient, next patient, next patient.

Robert Pearl: I would reframe that a little bit, Don, just for again some of the listeners, I think it's the specialist who wants to patient's problem solved before they can get to the specialist, meaning immediately rather than having to wait till the next day, a week later, a month later, or whatever it might be.

Jeremy Corr: Well, Dr. Berwick, we've taken up a lot of your time today. Can you please provide a closing statement with takeaways for both industry leaders and for the average healthcare consumer. You may also ask them to follow you on your social media channels.

Donald Berwick: Well, on the social media side, I'm a senior fellow with the Institute for Healthcare Improvement, IHI.org. And I urge your listeners to get onto IHI.org and browse around. They're going to find lots of resources that will help understand and act on healthcare. You remember for those organizations that are listening, I think you ought to consider joining. It's a stressed industry. We need optimism. At the federal level we're not getting it right now. We're getting a failure of leadership toward the healthcare we need and toward healthcare as a human right. At the community level we need to mobilize that.

Donald Berwick: I think the most important message I can give is the Triple Aim, better care for individuals, better health for populations, and lower per capita cost is achievable. It can be done. All we need to do is discover each other and work with a sense of community and solidarity that marks the best of American culture. Healthcare can change, but it can only change by us working together. And I am absolutely certain that better care, better health, and lower cost are available to us if we will commit to it and celebrate the changes that'll get us there.

Robert Pearl: Well, Don, thank you again for being on the show today. Across your entire career, you've demonstrated what is possible long before others thought that it was, in fact long before others actually saw it at all. Your 100,000 Lives campaign demonstrated the waste in terms of health deterioration and death from care that could be improved. The Triple Aim made us understand that the priorities are not competing but they need to be included together in a comprehensive type way. And IHI remains leader in quality improvement and better health and health outcomes for all Americans.

Robert Pearl: I can't promise that the approach you talked about today and the recommendations you've made will be the ones that our nation embraces. But

for any of our listeners who thought that solutions simply didn't exist, you have proven them wrong. This was a lot of fun.

Donald Berwick: Thank you very much. It was a pleasure to talk with you, both of you.

Jeremy Corr: Next month our guest will be healthcare futurist, Ian Morrison. Ian is an internationally known author, consultant and futurist, specializing in long-term forecasting and planning with particular emphasis on healthcare in the changing business environment. He has written, lectured, and consulted on a wide variety of forecasting, strategy and healthcare topics for government, industry, and a variety of nonprofit organizations around the world. He has worked with more than 100 Fortune 500 companies. He is the president emeritus of the Institute For The Future and chair of IFTF's health advisory panel. He is a founding partner in strategic health perspectives, a joint venture between Harris Interactive and the Harvard School of Public Health's department of Health Policy and Management. Ian is the author of the bestselling books "Health Care in The New Millennium: Vision, Values and Leadership," and "The Second Curve: Managing the Velocity of Change." We cannot wait to have him on the show.

Robert Pearl: Please subscribe to Fixing Healthcare on iTunes or other podcast software. If you like the show, please rate the show five stars and leave a review. Visit our website at www.fixinghealthcarepodcast.com. You can follow us on LinkedIn and Twitter @FixingHCPodcast, that's Fixing Healthcare Podcast. You can find our personal LinkedIn and Twitter accounts on the website. For additional information on other healthcare topics you can check out my website RobertPearlMD.com. Jeremy and I hope you enjoyed this podcast and will tell your friends and colleagues about it. Together we can make American healthcare the best in the world.

Jeremy Corr: Thank you for listening to Fixing Healthcare with Dr. Robert Pearl and Jeremy Corr. Have a great day.