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MAYOR BLOOMBERG PROPOSES SWEEPING CHANGES IN HEALTH CARE
FINANCING THROUGH NEW USE OF INFORMATION TECHNOLOGY AND NEW
FOCUS ON PREVENTION

Mayor Highlights Failure of Current System to Sufficiently Improve Health in Speech to Academy
Health National Health Policy Conference

Mayor Michael R. Bloomberg today called for a restructuring of how the United States pays
for health care services in an address at the Academy Health National Health Policy Conference in
Washington, D.C. In his remarks, the Mayor argued that the deepest failing of the current health
care system is its emphasis on expensive treatments over preventive care that can be cheaper and
often more effective. The Mayor focused on the need for more widespread use of health information
technology to support preventive care and reform health care financing.

“We’ve got a health care system that’s not only breaking the bank, and not only leaving one
out of six Americans uninsured, but which also provides decidedly ineffective care,” said Mayor
Bloomberg. “We have the most expensive and most advanced health care system in the world, yet
we lag on such basic measures as life expectancy, and we fail to prevent death and disability for
millions of Americans with common conditions such as high blood pressure and diabetes.”

The Mayor told conference participants that universal health insurance alone won’t
automatically lead to the health improvements unless we start paying for prevention as well as
treatment, saying that, “We’re paying for a disease care system, not a health care system. We must
fundamentally reorder our priorities – and start rewarding the primary and preventive care that
keeps people out of hospitals in the first place.”

The Mayor spoke about the importance of information technology in health care and the role
it can play in preventive care, detailing the successes that the New York City Health and Hospitals
Corporation and the United States Department of Veterans Affairs have had implementing
Electronic Health Records systems. To speed the pace of change, the Mayor called for a new
national goal: five years from today, every doctor’s office, clinic, and hospital in America that
accepts Medicaid and Medicare must be using prevention-oriented Electronic Health Records.
Electronic Health Records, the Mayor noted, will allow private insurers and Medicare and Medicaid
to make meaningful measurements of physicians’ performance, help them improve it, and recognize
and reward them when they do.

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“Today, most businesses, down to the smallest corner grocery store, have better information about their sales and inventories than even affluent medical practices have about their patients,” the Mayor said.

As Mayor, Michael Bloomberg has implemented a comprehensive citywide public health policy known as Take Care New York, a program of 10 preventive health steps that every person can follow to significantly improve his or her health. Since being introduced in 2003, Take Care New York has successfully increased New Yorkers’ access to health care, reduced smoking rates, increased HIV testing and colon cancer screening, and further reduced childhood lead poisoning and infant mortality rates to historic lows. For the first time since World War II, life expectancy for the average New Yorker is longer than the U.S. average.

The full text of the Mayor’s remarks as prepared for delivery follow. Please check against delivery.

NATIONAL HEALTH POLICY CONFERENCE
“YOU GET WHAT YOU PAY FOR: LET’S PAY FOR PREVENTION”

[Introduction by Dr. Thomas Frieden]

“Thank you, Tom, for those kind words. And thank you all for that warm reception on this cold winter day. There’s no question about it, Tom Frieden is a great doctor. He may not be as famous as the TV heart-throb “McDreamy” doctor on Grey’s Anatomy—but he ought to be. Because I think he’s simply the best in the business.

“The proof is in the national example New York City has set by making restaurants and bars smoke-free, and in beginning to phase out the use in our restaurants of artificial trans-fats that increase heart disease and stroke. The proof is also in the numbers—the record numbers of New Yorkers who have stopped smoking, who are being screened for colon cancer, who are getting free and fast tests to learn their HIV status, and who are taking other steps essential to living longer and healthier lives.

“It’s all part of a public health policy we introduced that we call Take Care New York – a simple program of ten steps, like the ones I’ve just described, that every New Yorker, and indeed every American, can follow to significantly improve his or her health.

“And in New York, it’s working. For the first time since World War Two, the average New Yorker has a greater life expectancy than the average American. That means that if you want to live longer, come to the Big Apple! We’d love to have you be one of the more than 44 million visitors we host each year, or the record number of people from around the world moving to our growing city.

“Take Care New York is just one part of a true sea change in health care in our city—one where we’re re-directing our resources to bring about a shift. It’s a shift from simply responding to and treating illnesses to actually preventing them.

“That’s a transformation that our whole nation needs to make, too. And that’s the message that I want to focus on today: American health care, like New York City’s health care, needs a big dose of preventive medicine.

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Now, we all agree that our health care system is on life support. Health care reform has become Topic A – here in Washington, in state capitals from coast to coast, and in all the news stories about high taxes and unnecessary suffering.

But this national conversation on health care is, I think, missing the biggest point. It’s focusing on two facts with one common feature: The number 16. (And it’s not “Sweet 16,” either. Far from it.)

We spend 16% of our Gross Domestic Product – almost $2 trillion a year – on health care. And that even with all that spending, 16% of our people – 47 million Americans – have no health insurance at all.

Now certainly, both of these problems merit a lot of attention. But there’s a third issue that’s even more fundamental: not only do we have a health care system that’s breaking the bank, and one that is leaving one out of six Americans uninsured, it is also providing decidedly ineffective care.

It’s time to face facts. Even though we have the most expensive and most advanced health care institutions in the world, we have to face the fact that we trail 45 nations in life expectancy – nations that don’t spend anything close to what we do on health care, or nations with health care systems that we’ve traditionally disparaged.

We also have to face the fact that the health care institutions that we are so proud of are not only costly, but do an inexcusably poor job of controlling silent killers like heart disease and diabetes. And, finally, we have to face the fact that, by itself, insuring the uninsured won’t automatically produce the health improvements we have a right to expect from additional investment in health care.

Health coverage for all is a worthy goal—but it grossly over-simplifies the problems we face. Politicians love to propose magic bullet answers to our biggest challenges. But in the real world, simple solutions to complex problems just don’t exist. And as with many other societal problems we face, money isn’t everything. If it was, we would now, after all the grand governmental announcements of solutions, and initiatives – with their attendant voter-pleasing press conferences – we’d all be living to 125!

Just look at the number one killer in America: heart disease. What are some of its principal medical causes? Out-of-control hypertension, diabetes, and cholesterol levels. But amazingly, today, nearly nine out of 10 Americans who have any of those three conditions already have public or private health insurance coverage.

So there must be something else wrong, another essential problem, one that we’ve not yet tackled, but which is a real killer. And that is, that we’re not buying health care that produces the kind of results that really matter.

In health care, as with everything else, you get what you pay for. And right now, it’s not stretching the truth very much to say that we’re paying for a disease care system, not a health care system. We’re managing how we die, not postponing it.
“That means that if we want a healthier, greater-life-expectancy nation, we’ve got to change, and start paying for prevention, as well as for treatment. Currently, this is precisely what we are not doing. Instead, we’ve developed a system that rewards costly procedures at the expense of preventive care that can be cheaper and is often more effective.

“Want an example? Aspirin and blood pressure pills that cost pennies can prevent heart disease and many of the nearly one million heart attacks Americans suffer every year, and also avoid $84,000 bypass operations.

“Yet while I see plenty of acute care facilities built with the help of generous donors across our country, I don’t recall seeing new dispensaries that give away free or low-cost preventive medicines being dedicated. Perhaps that’s because “grateful patients” are more generous than those who are lucky enough never to become one. The fact is that 95% of medical expenditures in the United States are for curative care, and only 5% are for prevention.

“Want another example? It’s estimated that more than 100,000 Americans die every year from medical errors. That’s an unspeakable tragedy. But what’s more inexcusable than the toll taken by these sins of commission is the even larger number of people victimized by medical sins of omission – who die from the failure to take basic preventive health steps. And the fault lies not with individual doctors, and generally not with their patients, but with the skewed priorities and politics of our entire health care system.

“Just last month, Dr. Lynne Kirk, the president of the American College of Physicians, correctly diagnosed our problem. We are, she told Congressional Quarterly, facing ‘the collapse of primary care medicine in America.’ And the reason is as plain as dollars and cents – not a lack of funds, but a drastic misdirection of where we spend them. Doctors shun primary care and instead pursue other branches of medicine – because that’s where they can earn more money. Fewer and fewer medical students, most of whom come out of school saddled with huge debt burdens, are going into primary care. They just can’t afford it.

“Now, I’m not a psychiatrist, but I think I know the clinical term that describes this: it’s nuts. What we’re doing is encouraging expensive forms of treatment and discouraging less-costly disease prevention. We’re breaking the bank, and certainly not getting our money’s worth.

“The bad news is that, left unattended, it’s going to get worse. This collapse of primary care comes at a time when we need to provide more, not less, preventive care to the baby-boomers who are America’s growing middle-aged bulge.

“We give older Americans Medicare. We’ve made progress, although not enough, in covering children. But frankly, your health begins to need extra preventive attention when you reach your 40s, and we do nothing special for this expanding group. What they need is preventive care that will help them avoid heart disease, cancer, stroke, and other debilitating conditions that, because they’re now middle-aged, they are at increased risk of developing. If we wait to treat them until they reach advanced stages of these diseases, we’re cheating them—and ourselves, too. And that’s why we must begin to “pay for prevention”—to fundamentally re-order our priorities, and reward primary and preventive care that keeps people out of hospitals in the first place.
“Now, the good news is that the essential pre-requisite for creating a ‘pay for prevention’ system is within our reach, if we redirect our efforts toward what works, and away from what’s always been done! A heavy political lift, but a necessary one if we want results.

“And this may actually be possible because of a striking development: Electronic health records—the software programs that can store and analyze patient information far more efficiently than written records do. We already know that “EHRs” greatly reduce the medical errors that can result from misplaced or illegible written records. But their potential goes far beyond that. Getting preventive health value from EHRs is by no means automatic. But if we program and implement them with disease prevention as our goal, they can be crucial to rebuilding primary care in our nation.

“So we need to make EHRs as standard as stethoscopes in doctors’ offices across the country. That’s because the essence of preventive care is information – information that patients, doctors, and other health care workers need so they can make the right decisions, at the right times.

“Information technology is an area in which I have some experience – although let me make it clear that neither I nor the company I founded directly invests in, or markets, personal medical information or electronic health records.

“Twenty-five years ago, my company began to sell computers that analyze financial information, and put those computers on the desks of investors. They gave people who need to make critical decisions the information they want when they need it. Virtually every other industry has undergone a similar information revolution. But it’s a revolution in which health care still lags.

“Today, most businesses – down to the smallest corner grocery store – have better information about their sales and inventories than even affluent medical practices have about their patients. The truth is that the U.S., which is the leader in so many other areas in medical technology, is woefully behind other industrialized nations in implementing electronic health records.

“But we now have it in our power to change that. And in the process, we can both improve health outcomes and re-engineer our health financing system. There are two key reasons why.

“First, electronic health records are interactive technology. They help doctors deliver better preventive care. Take high blood pressure, for example. Nearly 50 million people in this country have uncontrolled high blood pressure—a condition that puts them at risk of heart disease, stroke, and early death. Let’s say that a patient with high blood pressure comes in to see her doctor. The doctor calls up her electronic chart on a desktop computer. And it will remind the doctor to monitor the patient’s blood pressure, review her progress with her, and to adjust the patient’s medication as needed.

“In short, EHRs can bring information directly to the point of care, at the moment it’s needed, where and when it can do the most good. They can also prompt the doctor to reach out when the patient ought to come in, but doesn’t.

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“Think about it: you get notices for preventive maintenance from your dentist, your veterinarian, even your auto mechanic. Why not your doctor, too? EHRs can generate those notices—automatically.

“There’s a second reason that EHRs are key to rebuilding preventive care. It’s because they can also tell us how well doctors do in keeping people healthy. And that in turn allows us to build in financial incentives for preventing illness.

“Take the example of high blood pressure again. With EHRs, doctors can know exactly how many of their patients have high blood pressure. They can see for what percentage of their patients they’re doing a good job of helping to keep it under control. And they can know what treatments are working best, and improve the care they provide.

“Without EHRs, there is simply no way to accurately evaluate doctors’ performance. But if – and only if – we implement prevention-oriented EHRs, then private insurers and Medicare and Medicaid will be able to make meaningful measurements of physicians’ performance, help them improve it, and recognize and reward them when they do.

“Combine the power of information technology with this ability to accurately evaluate and reward performance. It gives you the right prescription for our ailing health care system. It will establish promoting health as our guiding principle and allow us to put our money where it’s needed: in preventing illness, in keeping people out of hospitals, and in providing financial incentives for helping patients live longer and healthier lives.

“I’m very proud to say that New York City government has long been a national leader in instituting electronic health records. And our Administration is building on that leadership. About ten years ago, the 11 public hospitals of our Health and Hospitals Corporation began instituting EHRs. They have drastically reduced the problems of faulty prescriptions and missed or repeated x-rays and lab tests. Now we’re going even further. Under the strong leadership of president Alan Aviles, who is with us today, HHC has also created a system wide ‘e-registry’ of patients. That registry gives HHC’s primary care doctors the tools to drive better care for patients with diabetes, asthma, depression, and other serious conditions. Over the past two years, for example, HHC has been able to significantly reduce pediatric asthma emergency room visits and admissions.

“It’s certainly true that no good deed goes unpunished. As its reward for this improved asthma care, HHC is now grossly underpaid for its intensive chronic disease management efforts, while losing all the revenue that would have been associated with those additional ER visits and admissions.

“It’s a sad commentary on health care financing in America that improved preventive care like that actually hurts HHC’s bottom line. But in the long-run, it’s going to produce better health for New Yorkers—and that’s the most important bottom line for us.

“On the outpatient level, our Health Department is now creating a national model for using EHRs to improve primary care in medically under-served neighborhoods. They’re bringing prevention-oriented EHRs to more than 1,000 doctors serving a million patients in community health centers, hospital outpatient clinics, and in private practices. Some of our community health clinics already have EHRs—and the benefits can be dramatic. Just look at the chart behind me. (more)
“It tells the story of what happened when one pioneering health provider – the Institute for Urban Family Health, which operates 11 community health centers in Manhattan and the Bronx – instituted EHRs in 2003. It shows that fewer than 30 elderly patients per month in these 11 community health centers were getting their pneumonia shots before electronic reminders were added to the EHRs. After an electronic reminder was added, however, that number jumped to nearly 400 patient vaccinations in one single month. And vaccination rates have steadily improved ever since. Multiply this chart citywide—or nationwide—and you can see how significantly EHRs can improve public health and preventive care.

“So why don’t more doctors have them? The answer, we think, comes in lethargy and high start-up costs. That’s where our City government came in. Starting last year, we began using $27 million in City funds to reduce the cost and increase the prevention value of computer systems bringing EHRs to the doctors we’re partnering with. Participating providers are putting up an additional $13 million for this project. And I’m pleased to say that New York also recently received $3 million in Federal funds that will help us evaluate this electronic network of community-based primary care providers which, once online, will really have no match in size or scope anywhere in the nation.

“Where they’ve been implemented, EHRs have already compiled quite a track record. Just look at our Department of Veterans Affairs—a purchaser and provider of health care for more than four million Veterans.

“The VA enjoys the unusual benefit of being free of the skewed financing priorities that plague the rest of the health care system. And more than a decade ago, it began investing heavily in prevention-oriented health care and in EHRs. The result? Today, the VA is widely recognized for the excellent quality of care it delivers, at costs substantially lower than those of the health care system as a whole.

“Such successes help explain why, for example, both Hillary Clinton and Newt Gingrich – two people who in the past, at least, have not always seen eye-to-eye about health care – are both big EHR fans. They’re both strong and respected leaders. But unfortunately, their warm feelings for EHRs haven’t yet ignited Washington into action – or funding – on anything like the scale we need. And there’s only so much that New York City, or any other locality, can do acting alone.

“Putting EHRs into effect—and making them the heart of a pay for prevention system—must become a national priority. To get us there, the federal government should be doing these three things. First, we have to pick up the current snail’s pace of implementing EHRs. In this day and age, there is no excuse for any more delay. So let’s set this national goal: Five years from today, every doctor’s office, clinic, and hospital in America that accepts Medicaid and Medicare must be using prevention-oriented electronic health records. And then let’s make that goal a reality.

“We can do that if Washington follows New York’s example. The federal government should be underwriting the costs of bringing EHRs to the primary care doctors and clinics that need them—and then demanding that these EHRs improve the measurement and delivery of preventive care. Clearly, lots of members of Congress are thinking about this issue. More than 100 bills supporting health information technology were filed in both houses of Congress last session. But
proposed legislation isn’t enacted legislation. And legislation that isn’t backed up by funding won’t make EHRs appear by magic. We need to buy the technology infrastructure now that will let us invest in health intelligently and efficiently tomorrow.

“Second, and just as urgently, we’ve got to start redirecting what the federal government spends on health care toward paying for prevention. As we implement EHRs, we’ll be able to restructure Medicare and Medicaid reimbursements to do just that, based on accurate measurements of the most important clinical interventions.

“And third, the federal government has to do more to rebuild our primary care system. Restructuring Medicare and Medicaid to pay for prevention will be a great start. It will reward doctors for choosing to practice primary care.

“But other measures are needed, too. They include large-scale loan repayment plans for doctors and nurses working in primary care in low-income communities, expanded primary care medical residencies, and investments in modern primary health care centers.

“Now before closing, let me sound a note of caution, make a clarification, and state a caveat. The note of caution concerns confidentiality of medical records. EHRs are vulnerable to security breaches; electronic data can be easily copied and widely disseminated—and that can have terrible consequences. So from the outset, we’ve got to build strict security measures into EHRs. In New York, I’ve asked our State Legislature to make intentional violation of the confidentiality or integrity of EHRs a felony. The Federal government should do the same. But information technology can be made to put safeguards into the system that limit access to records, and also tell us if anyone has looked at or altered them. We’ve got to be diligent in such measures; the last thing we want is for people needing health care—and often needing it badly—to avoid it because they’re fearful of embarrassment or discrimination. But we’re talking about saving lives. So we can’t let a theoretical risk of potential problems prevent us from achieving outcomes of such great importance.

“Second, I want to clarify what pay for prevention is not. It is not what is sometimes called ‘pay for performance.’ Pay for performance is something that the Federal government, as well as private insurers, have experimented with in recent years. It involves paying bonuses to providers, especially hospitals, for meeting measures reflecting appropriate delivery of care.

“All too often, however, pay for performance focuses on what’s easy to measure rather than what’s truly important. It merely looks at process measures—what we do—not at outcomes. Pay for performance tends to ignore the fundamental task of reorienting health care financing to rebuild our primary care system and maximize the health value of our health dollars. That’s the great challenge we must take up. And that’s what ‘pay for prevention’ will permit us to do.

“Third and finally, my caveat. It’s this: Over time, paying for prevention should cut health care costs. But there are also going to be start-up expenses, in equipment, training, and transition costs, involved in re-tooling primary care in America. The cost of providing the nation’s primary care clinicians with EHRs could be as high as $20 billion over the next five years. $20 billion is a lot of money—but in the context of a $2 trillion a year health care industry, it’s a worthwhile investment. And let’s not forget that what we’re doing now costs money, too. The big difference is that paying for prevention will produce better results.

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“So we can either keep doing what we are doing now – paying for inadequate outcomes – or we can start paying for better outcomes that, in the long-run, make sense both for our health and our pocketbooks. It’s clear what our choice should be: We should start paying for health care in ways that really improve the health of our nation.

“At the outset of my remarks, I talked about the toll taken by our medical ‘sins of omission.’ And unless we change our course, those sins of omission will grow and spread throughout our society. In most cases, the effects won’t be clearly visible—but they’ll be a silent catastrophe of enormous proportions.

“Think of it as the tragedy of absence. I’m talking about the absence in our offices and factories of men and women disabled by amputations, heart attacks, and kidney failure, all because their diabetes wasn’t well-treated. Or the silence of the stroke victims left speechless, immobile, and confined to nursing homes instead of enjoying their mature years as they’d always planned and dreamed. Or the empty chairs at dinner tables in homes across our land—empty, because tests that could have detected cancer in early and treatable stages just never happened.

“Americans don’t have to accept that as our future. There’s no question that we face a crisis in health care. And on this day – Lincoln’s Birthday – let’s remember that in a time of truly unprecedented crisis, Lincoln himself challenged the nation ‘to think anew, and act anew.’

“I say let’s seize the opportunity now to think anew, act anew, and set a new course for our nation: a course that will give Americans the health care they need and deserve. And let’s start on that course now.

“Thank you, and God bless you all.”

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