# THE HEALTH CARE SYSTEM SHOULD PRODUCE HEALTH

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Perhaps the title of this article seems obvious. Aren't health care providers and patients always working toward the goal of producing health? The answer is yes — and no.

Clearly, most individual providers and institutions have this objective, and many times they achieve it. The nature of the professional relationship mandates it, and most medical professionals work diligently and compassionately towards improving health.

However, health care expenditures are out of control, consuming more than 12 percent of our nation's wealth with the potential to approach 20 percent by the end of the decade. But there is little proof that these rapidly increasing expenditures have improved the overall health of Americans, and a growing body of evidence suggests that many medical procedures are not appropriate for certain patients.

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For some illnesses like influenza or uncomplicated pneumonia or even some types of cancer, a complete cure is the desired goal. For many chronic illnesses like diabetes, heart disease, or Alzheimer's disease, the goal is to increase or maintain the patient's quality of life.

Our society has not concentrated on these broader and more elusive goals for several reasons. Our professional socialization, financial incentives, and legal system implicitly, if not explicitly, assume that more *health services* will produce better *health.* Patients often unwittingly conspire with providers in this cultural norm that "more is better."

How would a new system that focused on health itself, rather than services, be organized? No ideal model exists. Coming closest are the HMOs — organizations based in large group practices that provide all health care for an enrolled population for a fixed monthly fee. Because they stand to profit only if they can provide care more efficiently, they take on the difficult task of deciding which services produce quality care at the lowest cost.

Imagine if a significant part of a health organization's income was tied to the improvement of their patients' health and functional status. In addition to curing illness, the organizations would be expected, for example, to decrease the number of low-birth-weight babies, to decrease the number of days of employment lost to illness, and to limit hospitalizations and expensive diagnostic procedures to those known to be health promoting. Such incentives would unleash the same capitalistic creativity towards *health* that currently exists for *health services.*

This is a complex task. We need clearer and more precise definitions of health and functional status, and we need valid and cost-effective measures that can be applied to diverse populations. We must make decisions about the boundaries of health care and other social services that contribute to quality of life — and appropriate financial incentives that will sensitively lead to this result. And finally, we need a program of universal access to such organizations for the uninsured and an integrated delivery system.

Many will say that such dramatic changes are impossible. While it will not be easy, I believe that research over the next decade, some of which is being done at the UW School of Medicine, will allow for such a paradigm shift.

I believe we must work toward this re-definition of the outcome as *health* rather than *health services.* Failure to do so will result in continuously increasing expenditures for services that will not improve health, and in draconian cost containment and rationing schemes that will likely harm patients, providers, and the existing quality of our health care system.

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