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The Insurmountable Opportunity: The Debate After Healthcare Reform

Thank you. I am delighted to be here. I also salute you for your service to our country.

I want to start with my favorite story. My wife is Navajo and we were married in a traditional ceremony in Blue Canyon, Arizona. As many of you might know, the ceremony itself is elegant. At one point: Yellow corn meal and white corn meal are made into a mush. When you eat the mush, you're married. Later on, people from the community come together to give you advice about the future. It was November, cold and snowy, and we were crowded into a small Hogan. Folks were eager to finish up because there was a wonderful feast prepared for us next door. Sitting near the front was a friend of mine, Jeff Begay, and as people talked I could see him clearing his throat, ready to say something.

But just at that exact moment, out of the blue, came a knee in his back from his wife who was sitting behind him. So he said nothing.

A few more minutes of talking. Then, once again, Jeff was ready. And again, at that very instant, there came a knee in his back. So he said nothing.

Like I said the hogan was very crowded. Folks were ready to eat. People were winding down. Not Jeff. He cleared his throat again. This time loudly. And in the precise moment – this time with a great deal of force – came that knee in the back. His last chance – and he said nothing.

As they were leaving the hogan, Ella turns to her husband. “Jefferson! Why didn't you say anything. I kept kneeing you in the back to say something.” Jeff told me this story then adding – with some embarrassment – that he would have told me about the importance of communication in a marriage.

I like this story as a journalist because I think it's about the essence of storytelling. What stories are we trying to tell? Are we getting to the essence – the communication essential in a democratic society? Or are we just putting a knee in someone's back.

Of course there have been more than a few knees in the back when it comes to the healthcare reform debate. This is exactly why we need to talk about storytelling.

I am honored to be here this morning because I am such an unlikely person to be here. I am not a health care expert. I am journalist – and even then I had not spent much time on health care policy until this past year.

So how did this all happen? My last newspaper job was editorial page editor of the Seattle Post-Intelligencer. One of my jobs was hosting editorial boards where we'd spend an hour with

candidates or experts on public policy issues, including health care. Every time we had a session on health care reform, I would ask, “well, what about the Indian Health Service? How does that fit into the system you are talking about?” I’d get blank stares. No answer. The folks who were designing a shift in health care had not thought about the impact of the IHS on the system.

I had a head start with this notion: I grew up with the Indian Health Service in Fort Hall, Idaho. It seemed to me that a natural story to tell in the coming health care reform debate was to look at the government’s ability to deliver.

I found this disconnect fascinating – so when the P-I newspaper died, I applied to the Kaiser Family Foundation and said I’d like to explore the topic in some depth. They were gracious enough to allow me to do so and that’s what brought me here today.

My first thought – one that excited me – was to somehow inject the Indian Health Service into the larger debate. I wrote several pieces along those lines, but they would pretty much fly past people. I have to admit that the country wasn’t ready for to even hear about the government’s own delivery system. And why not? They had been told a story, over and over, about how ineffective government is when it comes to health care.

I call it the Indian Health Service Paradox. The IHS is the largest direct provider of health care in the U.S. Public Health System. Yet it’s an agency either unfairly maligned as a “disaster” or absent from the discourse about health care reform. That’s too bad because the agency, even with its problems, is a sustainable model for universal care.

If you look at this as a storytelling exercise, there are two master narratives about the Indian Health Service.

First, everyone knows the Indian health system needs more money. Everyone, it seems, except the collective members of Congress who, when they write budgets, can’t seem to appropriate at least as much money as they do for the U.S. Bureau of Prisons.

And, second, critics say the Indian Health Service represents the failure of government-run care with complaints ranging from rationing to mismanagement of government funds. In the current reform debate, Sen. Tom Coburn, R-Oklahoma, repeated this narrative again and again, calling the IHS “a failure.” Just last month the senator said: “Nationwide, Indian health care is the worst. The joke is if you’re in Indian health care don’t get sick after June, because that’s when it runs out of money.”

Three words are chilling: Government-run care.

The two narratives of resources and failure fit into those three words and they stick because the truth is far more complicated. It’s hard to communicate a “yes, but” message in a political context.

Yes, the IHS does ration care – but that’s because it has only so much money in its one of its budget lines. In fact some doctors tell me they make better decisions because of rationing ... A

“if I spend the money here, I won’t have it there” type of thinking.

Yes, the IHS isn’t perfect with its spending (or insurance billing operations), but is that also a reflection of its limited budget? We really won’t know the answers unless the agency gets adequate funding.

There is another story that deserves at least the same attention as the first two themes: The really remarkable efforts underway to improve quality for American Indian and Alaskan Native patients.

Many of you are involved with the Improving Patient Care, or IPC, project – and it is designed to show measurable improvements in preventive care, experience of care, managing chronic conditions, while maintaining financial viability. In plain language the goal of IPC is to make it easier for patients to see a doctor or nurse and then to spend less time in the waiting room (without spending too much money in the process). This is the ultimate initiative for doing more with less.

Dr. Ty Reidhead, a Corps officer, said IPC is important because if you pick any one health condition, whether it’s cardiovascular or depression, a single focus might not be enough. “We were worried that we wouldn’t change the system enough, we’d get better diabetes or depression care,” said Reidhead. “Instead what we tried to do to look at patient care to meet their needs, no matter what they came in with.”

One innovation to improve care was a standard bundle of patient tests, flagging early warning for alcohol misuse, depression, domestic violence, tobacco use, blood pressure and obesity.

Nearly 40 units in the Indian health system are part of the IPC pilot. A key element of the initiative is transparency. Results are measured and become learning tools that are shared across units in the program.

One of the reasons why the Indian health system deserves broader discourse is that one word, “system.” If nothing else, this is what needs to be part of the larger national debate about health care. When a patient is discharged from a hospital, the real savings begins with after care. That’s especially true for health providers run by the IHS, tribes or urban organizations. They provide care for a “population.” The patient remains in the “system” even after being released from a hospital.

Why does a systemic approach matter? Because treating chronic diseases represents three-out-of-four health care dollars. The goal of a low cost, high quality system is the only sustainable model going forward. And that is a story that must be told.

Let me be clear here: There are problems at the Indian Health Service, too few resources, considerable work force issues, and, even some execution and cultural climate issues. But that, too, ought to be a part of the national dialogue (instead of out right ignorance or a dismissal as a “failure.”)

But consider this as a storytelling problem. One issue that we, as a country, have to deal with is that most of our stories – our master narratives – are about “more.” We want more land, as in Manifest Destiny, we want the best health care possible (or at least the most expensive); and we want a better future for our children.

But what stories do we have that talk about “less?” How can we as a society be more effective with what we have already? Again, this is where government-run care offers a few lessons.

At the Alaska Native Medical Center and SouthCentral Foundation, Dr. Doug Eby, told me that they realized a long time ago that revenue was going to be a problem in the future. They could not continue to grow; they had to find ways of cutting costs. And that very idea meant rethinking the relationship with patients.

Let’s look at the data from SouthCentral Foundation after a decade of changes.

Hospital days are down 40 percent. ER and urgent care (are) down more than 40 percent. Specialty care is down 60 percent. Primary care visits, down 20 percent.

In 75 percent of the HEDIS measures, we’re at the 75th percentile or better. Many, we’re at 95. And that’s in a hard to reach population. We’ve had a massive reduction of total costs. Our health outcomes are better. So is the happiness – both the patients and staff, satisfaction is 90 to 93 percent. Our staff turnover is one-fourth of the level it was five years earlier.

If the Indian Health Service is stuck in the national debate as a “failure,” then the Public Health Service Commissioned Officers Corps is largely non-existent.

This is terribly ironic. In politics, many of those who honor the men and women who wear the nation’s uniform in military service would also dismiss government-run health care with a blanket statement. It’s as if somehow the uniforms that you wear deserve less attention or praise.

That’s too bad. You have a great story to tell.

Later this year, Seattle’s Amazon.com – the world’s largest online retailer – will move into its new headquarters near Lake Union. Then Amazon will leave an old Art Deco building, once known as the U.S. Marine Hospital.

What if we took this empty building and turned it into a hospital? What if we staffed it with federal employees? What kind of health care would that look like?

Of course you know that history. It’s back to the future for many of you.

Congress passed a law in 1789 that provided for health care for sick and injured merchant seamen. But the thinking, even then, was broader. Philadelphia faced an extraordinary Yellow Fever outbreak in 1783 that killed more than 4,000 people (out of a population of 37,000). And therefore the primary mission of the new health service was to intercept diseases brought home by sailors returning from sea.

The Public Health Service and the marine hospital network eventually expanded across the country. This was the original “public option” because this government-plan was funded by a monthly deduction from the seaman’s wages. The scope of medical activities grew as well, ranging from the treatment of epidemic diseases to industrial hygiene.

PHS could have become the basis for a national, federal health care delivery system. By the 1970s marine hospitals and clinics served American Indians, the urban poor, as well the agency’s traditional clients of merchant marines and some federal retirees.

“These hospitals have a record of service to this nation, and especially to its merchant seamen, which is long and distinguished,” President Richard Nixon wrote in a veto message to Congress over the funding of public health. “Nevertheless, it is clear that their inpatient facilities have now outlived their usefulness to the federal government. The number of individuals they serve is declining and many of the facilities have become old and outmoded.”

Nixon articulated many of the arguments that remain a part of our current discourse on health care reform; essentially the idea that direct medical services should not be a federal responsibility. In the budgets that followed, the Nixon and Ford administrations executed an incremental implementation of that idea. It’s fascinating to go back and read the congressional testimony about what would happen without these government-run hospitals.

“If we close down the Public Health Service hospital system, we are also dismantling a valuable laboratory of a different sort,” said John Murphy, chairman of the House Committee on Merchant Marine and Fisheries. “As our population increases, and as the cost of medical services rises, it is clear that we must experiment with new methods and techniques for the delivery of health care.”

This was June 11, 1976. And even more prophetic, Murphy that the Public Health Service hospitals could serve as a “yardstick” to measure both the cost and quality of health care in private institutions.

The government’s own numbers showed that the PHS system was more cost-effective than comparable private institutions. “The study demonstrates that three people can be cared for in PHS hospitals at the cost of caring for two in the private hospitals,” Pilgrim said. “The failure of the administration to realize the potential of the Public Health hospitals is a great tragedy. Our nation is in the midst of a deepening health care crisis. Medical costs are rising at twice the rate of wages, rising beyond the average family’s ability to pay.”

The health care crisis was tiny in 1976 compared to today. It’s why we need to rethink the government programs that efficiently deliver health care.

I think, as we implement health care reform, this discussion will be back again. One of my last columns I am writing now looks at how I think one of the most profound changes for the Indian health system is under the radar – just a small piece of the bill.

Nonetheless the public perception – the story – the complex history about government-run care matters. We need to make sure that story is complete, adding a richer context to the discussion.

That brings me to your role: You need to be better storytellers and the new media landscape is ideal for that task.

Let me take you somewhere you've never been before; a place from my memory.

The Shoshone-Bannock Tribes in Idaho, like many tribes in the region, have a democratic forum called General Council. This is a once-a-year town hall with the full authority of government, where every citizen is a full member of the governing body. It was conducted at an old, round log structure, Buffalo Lodge. I was a teenager the first time I participated in General Council. I enjoyed the debate, full of a people's passion, humor, sometimes anger, and thoughtfulness. Tribal members lined up patiently waiting their turn. I used to love the ritual. Some would go to the microphone, the one that had been used many times before that day, and tap it gently a few times. Then blow. It was a signal they had something to say. The meetings were trilingual: Some talked in Bannock, others in Shoshoni, and some, like me, tried to make their points in English. The meeting lasted for hours, considerably longer than scheduled, because every member had the right to speak. It is that premise that I love: You can say something prescient or, perhaps, even bizarre, but you still have a turn at the microphone.

The tap-tap-tap of the microphone was a signal to say that the technology present didn't matter. This was a conversation about community that could be heard in this lodge at any point in history; a hundred years ago or a hundred years forward.

Yes we are in an age where technology is instant and its potential unlimited. But when I think about history I think there are other generations that must have thought that too. We now know, for example, that the ancient Pueblo villages of the Southwest had light systems for communicating village to village. Imagine the transformative power people must have felt when they talked to a village a hundred miles away – yet for all that the ancient Pueblo villages disappeared in an instant of time.

Once I attended a General Council where the outcome was all but certain. I went anyway, knowing I was in the minority. I still wanted to change people's minds and their votes. I took my turn, grabbed a microphone, made my pitch, and later watched as hands went into the air. I had swayed no one. I think the motion I opposed was approved by a margin of some three hundred and something to three. Still, I had my voice. And, at least, I presented a different course. I had respect – yet I dissented.

Our world uses Twitter as both a local and a global General Council. Every member of Social Media has a right to speak, even to set the agenda. We pick our topic when we use a hash tag:

#hcr

#patientsafety

or, I would hope, something like, #commissionedcorps

So who would we talk to in this of self-defining hash tags?

A lot people. There are some 50 million Tweets transmitted a day. And what's within those 50 million bursts of 140 characters? News, an interest in our world, is a big part of that network.

One recent traffic report shows that nearly half – 47 percent of Tweets are news-related, while celebrity and movie traffic was only about 16 percent. On Facebook, news accounts for 28 percent of the posts measured. (On MySpace, on the other hand, there was virtually no news. That space is defined for a particular audience.)

A civil society needs dissent. Ideas get better when tested and debated, when all people are given the respect of a fair hearing.

And so is Twitter (or any Social Medium) the vehicle for a fair hearing? What is the state of discourse in Social Media?

Educator and scholar Robert Maynard Hutchins spent the last years of his life studying democratic institutions. During a 1962 interview, he said: “I do not think that the method of voting is a criterion for democracy, though I should certainly say that unless there were some way in which each member of the community could register his opinion on important political matters the situation was not one that could be described as democratic.”

What determines a democracy? Hutchins said every citizen must feel that he or she is taking part in important political events that affect their lives. “A democratic community is a self-governing community,” he said. “Every member of the community must have a part in his government. The real test of democracy is the extent to which everybody in society is involved in effective political discussion.”

Involved. Effective discussion. And, yes, eventually, self-governing.

Think about how those three ideas apply to Social Media, our democracy and the health care challenges we face.

We already know that Twitter is useful as a tool for “involvement.” Perhaps the best application of this is Twitter as an extension of “organize, organize, organize.” It tool for mobilizing supporters. We saw this played out with those opposed to health care reform who tweeted using the hash tag #codered, #tcot, or #killthebill using the medium to urge supporters to show up at a protest or make a telephone call.

Effective discussion. And, yes, eventually, self-governing.

What about the other two ideals? Effective discussion and self-governing.

The government of Chile is promoting Twitter to do just that. The president and the entire cabinet have accounts. As The Economist recently noted from one of the posts: “...I don't expect them to change Chile through Twitter. Instead, I hope the contrary will happen: that through

Twitter, Chile will change the ministers. Citizens that inhabit these sites don't represent the entire country, but without a doubt we help to bring more diversity to Cabinet meetings."

A worthy goal. But is it effective discussion and an avenue for a self-governing community?

No – and that's our challenge. I've spent the last year looking at health care reform and one of my disappointments has been the quality of the discourse. We neither have an effective discussion or a self-governing community.

For example: Both Democrats and Republicans have gone out of their way, it seems to me, to demonize each other instead of talking about the larger forces at work. Neither traditional media, nor social media, have created an informed forum for our discussion.

The single most important element in this discussion, it seems to me, must be our demographic imperative. We are living longer – and that changes the parameters of our health care system in huge ways. No one is to blame for that – indeed, we really ought to be celebrating this idea. This is occurring around the globe and the implication of this will impact every government.

When I first started my project I thought it was because of people my age. The baby boom is huge; 77 million people were born between 1946 and 1964. Five years from now: Those of us aged 50 or older will represent 45 percent of the U.S. population (someone turns 50 every 8 seconds).

Now that represents a challenge to any society. But it's not the scope of the problem. We need to look at the demographics of living longer for everyone. In the U.S., the U.K., France, Germany, Canada, Japan, the trend of living longer is growing. The medical journal, *The Lancet*, predicts that without any improvement in longevity three-quarters of babies will reach their 75th birthday. More than half of those babies will celebrate their 100th birthday.

Just take one disease – the most expensive disease in America – diabetes and you can see how age complicates our budgeting. Diabetes-related costs were \$174 billion in 2007. And unfortunately, the disease is increasing at near epidemic rates. About one-quarter of all Americans have pre-diabetes and if the disease fully develops, in 2002 the health care costs topped \$13,200 per diabetic patient compared to \$2,560 for people without diabetes.

One of the key risk factors: Age.

Back to the Social Media universe: How do we have a discourse about our alternatives, options, and methods of paying for our system when our health care tweets are stuck on the narrative of a rant or as an organizing tool?

What if you, as individuals, tell you story every day in 140 characters? I know this goes against the grain both because of hierarchy and tradition. Yet I believe that transparency is the new currency. The government agencies – and people – who understand this will be the most successful in this new environment. It requires a new way of thinking.

Begin by experimenting. Perhaps tweet – or Facebook – among your fellow officers at first, but always remembering that it's a public presentation.

We need to engage social media to help us solve a difficult, complex, national community discussion

When I began this project, I met with the Kaiser Family Foundation selection committee in Washington, D.C. As I outlined my project, several said that the health care reform debate might be over by the time I started writing. So I decided to write early and extend the project as long as I could. Funny how that debate lasted a lot longer than anyone expected.

Indeed – as you know – much of the debate, perhaps the most important stuff is just beginning. What we do next is far more important than the outlines we've written so far.

One of my favorite parts of the health care reform law is the increased opportunity for young people in the Public Health Service. I think this is an opportunity to retell the story about public service – one that's also a good deal for the individuals who choose the Commissioned Corps as a career option.

Health care reform, in so many ways, is you, the men and women who represent this country every day who will be a part of that next construction. What you say (or tweet) & what you do is essential to those next steps.

The old cartoon Pogo once said: We is faced with an insurmountable opportunity. One that I hope goes far beyond a knee in our backs.

Thank you for your service to our country.