

# Health Care Reform May Take Grassroots Effort

BY DOUG BRUNK  
San Diego Bureau

The way Dr. John A. Kitzhaber sees it, Americans can't afford to sit back and wait for the future of health care to unfold before them; they should assume an active role in shaping its future.

"If people are unable or unwilling to agree among themselves on a vision for the future, the political process cannot and will not do it for them—and we will be destined to continue to be shackled to the failed policies of the past," he warned at the annual meeting of the Society of Clinical Surgery in Portland, Ore. "By default, we will be allowing our future to become a matter of chance rather than a matter of choice. I think we are better than that."

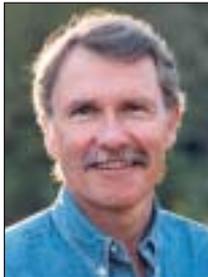
In January 2006, Dr. Kitzhaber, the former governor of Oregon, founded the Archimedes Movement, a grassroots organization that takes a "we can do better" approach to the governance and delivery of health care. The movement is "committed to providing a safe forum in which citizens and stakeholders alike can be brought together to create a shared vision of a new health care system, a space in which we can ask, 'If anything were possible, what would a better system look like?'" he said.

The name refers to Archimedes, the Greek mathematician who invented the lever and is reputed to have said, "Give me a lever and a place to stand, and I can move the Earth."

A key strategy of the effort is to agree

on what a new health care system should look like, and to expose the contradictions and inequities of the current system and create a "tension" between the status quo and a vision for a new system.

Dr. Kitzhaber, an emergency physician who governed Oregon from 1995 to 2003, said he believes there should be a different standard for the part of health care that is financed by public resources and the portion that is financed by private resources. "We must demand that we get an actual health benefit for



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DR. KITZHABER

the public dollars we allocate for health care, a positive return on investment, [and] the effective and efficient use of public tax dollars. And since these are public resources—resources held in common—we must demand that their allocation benefits all of our citizens, not just some of them, that it does not leave 47 million people behind."

As an example, he said that people who wish to buy an expensive brand-name drug when a much cheaper generic is just as effective clinically, and just as safe, should be able to do so with their own personal resources. Public resources should not be used to subsidize the difference in cost. Similarly, he said that expectant parents who want an ultrasound to determine the sex of their unborn child when the procedure is not indicated clinically for a normal term pregnancy should be able to

get that—but again, the cost should not be subsidized with public resources.

To date, the Archimedes Movement has conducted public forums and vision-sharing meetings with more than 3,000 Oregonians in 30 chapters, 13 hospital CEOs, 11 insurer and health plan executives, dozens of physicians and nurses, leaders of

national state and labor organizations, and representatives of more than 50 non-health-related businesses in the state.

The resulting consensus led to the Oregon Better Health Act, which

was introduced in the 2007 Oregon legislature as Senate Bill 27. It proposes that Oregonians have access to a "core benefit" of essential health services, and seeks to realign financial incentives to ensure fair and reasonable payment to providers, value-based cost sharing for consumers, and a transition to a more efficient delivery system.

Although SB 27 did not pass in the 2007 session, the enthusiasm it generated from citizens and stakeholders propelled the Archimedes Movement into the limelight. It also produced three documents that offer a conceptual framework for a new system in the state and that may serve as a foundation for bringing about national reform. The documents—a Statement of Intent, Principles, and a Framework—are available at [www.wecandobetter.org](http://www.wecandobetter.org).

Nowadays, Dr. Kitzhaber and his asso-

ciates are working to expand the movement to other states, especially Washington and Montana. This strategy stems from the fact that the committee that has jurisdiction over health care in the U.S. Senate is the Senate Finance Committee. Both of Oregon's senators (Democrat Ron Wyden and Republican Gordon Smith) are members of this committee, as is Sen. Maria Cantwell (D-Wash.). The committee is chaired by Sen. Max Baucus (D-Mont.).

Dr. Kitzhaber pointed out that the discourse on health care reform he has heard from the 2008 presidential candidates convinces him that the Archimedes Movement is peaking at the right time. He said that although each of the 2008 presidential candidates has proposals for health care reform, they are all defining the challenge narrowly as just a financing problem related to insurance.

"No candidate of either party has stepped up to honestly acknowledge the reality of fiscal limits, to address the long-term financial stability of the Medicare program, to challenge our current definition of a health care 'benefit,' or to discuss the difficult changes that will have to be made in our delivery system," he said.

"The very fact that none of these issues are a central part of the national political debate is evidence of the underlying failure in our current governance structure, of the diminishing capacity of our political system to allocate and manage public resources in a way that serves the larger public interest. It is an affirmation of the fact that we cannot solve this crisis by relying solely on our current legislative institutions."

## Database Testing Uncovers Mortality Estimate Problems

BY MARK S. LESNEY  
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Deliberate error-seeding experiments involving a large congenital heart surgery database showed that even small levels of miscoding can substantially change mortality estimates. This was especially true for miscoding of procedure type and for operations with mortality below 10%.

Such error-driven variations in mortality estimates are especially troubling in an era when registry databases are more and more expected to form the foundation of risk analysis for various operations, and might even be used to evaluate the doctors and the institutions that perform these operations. In addition, errors in databases are not uncommon. One recent study of a carefully audited California database reported at least one diagnostically relevant error in 63% of patient records, according to Dr. Steve Gallivan and his colleagues.

Computer simulation techniques were used to create realistic analysis scenarios based on data from the Toronto Cardiovascular Surgery Database for Congenital Heart Surgery, which contains information on nearly 18,000 operations. This includes outcomes for 132 operation types from which 30 marker operations were chosen, each of which had been reported at least 100 times in the database and had nonzero mortality.

Four thought experiments were performed using the data on the marker operations. In the first experiment, the only errors introduced were random miscoding of outcomes with three scenarios: error rates of 1%, 3%, and 5%. Each of these scenarios showed considerable changes in mortality rates, especially when the true mortality rate

was small (*Eur. J. Cardiothorac. Surg.* 2008;33:334-40).

In the second experiment, the only errors introduced comprised random omission of data at rates of 0%, 10%, or 20%, with the miscoding of outcomes fixed at 1%; these scenarios showed that random omission of data had no discernible effect on inaccuracies in mortality rate estimates. This was predicted by mathematical modeling.

In the third thought experiment, errors introduced comprised random outcome miscoding at different rates for deaths and survivors. A progressive increase in estimation error was seen when mortality rates fell, "and the scale of such overestimation is alarming for mortality rates below 10%," according to Dr. Gallivan of University College, London, and his international colleagues.

The final thought experiment regarded introduced errors from miscoding of the operation type with no data omission or outcome miscoding. Three operations illustrated the potential dangers of such errors: ASD/secundum repair (recorded mortality rate 0.2%), TGA repair/arterial switch (mortality rate 9.0%), and the Norwood operation (mortality rate 36.3%). The assumption was made that each operation had an equal probability of being miscoded as one of the other two. As predicted from mathematical modeling, as the miscoding rate increased, the gross mortality rate for ASD/secundum repair became increasingly overestimated, the rate for TGA repair remained relatively the same, and the rate for Norwoods became increasingly underestimated, according to the authors.

"The results reported here sound a loud note of caution and perhaps it is time for a reappraisal of the clinical database structure. ... There is often a somewhat mis-

placed belief that if one gathers a lot of data, then, if analyzed cleverly enough, they will reveal a new truth. ... This view is wrongheaded; the reality is that the more data items that are collected, the more errors occur," the authors stated. "The results we describe are alarming. Even moderate levels of error can lead to substantial inaccuracy in estimates of mortality rates and in some circumstances these inaccuracies can be gross, especially at the low mortality rates that are now prevalent in cardiothoracic surgery," they added. "Even with ... labor intensive methods, it is unlikely that errors will be completely eradicated. In view of this it is perhaps wise to adopt a more skeptical attitude to quantitative results, especially in relation to rates that are small."

"Any data collection which is not verified in a professional way is not valid and can be misused and can be used against our profession. That's why I think that verification of data at the various levels, including the local institutional level, including the automatic and computerized level, up to visiting the sites and checking 100% of the data, is of the greatest importance," said Dr. B. Maruszewski, one of the physicians responsible for the European Association for Cardio-Thoracic Surgery Congenital Database, in comments delivered at the paper's original presentation at the 2007 annual meeting of the European Association for Cardio-Thoracic Surgery.

As part of that discussion, Dr. Jaroslav Stark, one of the paper's authors, added, "You should collect as few data as possible, but even if your data set is only 20-25 items, it is still very important to check, because, as we have shown, a small error of 1% can increase your mortality estimates by five times."