What Next?

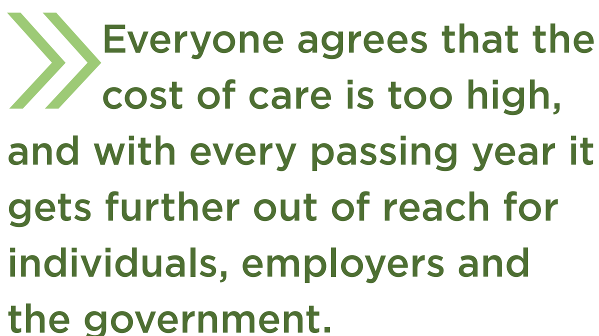
A Call for Real Reform of “Health” and “Care”

Now that the long-debated health care bill has been passed and signed into law, we must turn our attention to addressing underlying problems of health and care in America.

Except for the possibility of being overturned on legal challenges, the bill passed into law will expand coverage for the currently uninsured, at least in the short-term. While “health care” and “insurance” are not exactly synonymous, our system certainly benefits those with some type of coverage. No doubt, the debate on whether this bill was worth the cost in terms of expanding access will continue. Meanwhile, the cost and quality of our health and our care are of urgent concern.

The best and most recent example of the challenge of expanding coverage is in Massachusetts, where the bold experiment in universal coverage is now in its fourth year. According to a recent *Wall Street Journal* analysis, costs are continuing to rise unabated, with growth rates outpacing the national average.[1] The remaining four insurers may even exit the state market because of rate regulation. The cost problems in Massachusetts, as well as similar experiments in other states, demonstrate the risks associated with the act of expanding access without addressing demand for care.

The focus now must be on developing strategies for reversing the problems that currently prevent health care from being affordable and high quality. We still need reform to address the fundamental issues of cost and quality, which will further improve access in the long run.



Everyone agrees that the cost of care is too high, and with every passing year it gets further out of reach for individuals, employers and the government.

Everyone agrees that the cost of care is too high, and with every passing year it gets further out of reach for individuals, employers and the government. With health care costs growing at three to four times faster than the economy, and two to three times faster than wages, more and more people cannot afford medical care. Employers are struggling to remain competitive in global markets when health care costs make up such a huge portion of their cost of goods and services. High health care costs thus have a direct negative bearing on the overall American economy.

Likewise, the quality of medical care varies widely by provider, and these differences are not insignificant. According to a study done by HealthGrades, “Hospitals rated in the top five percent have a 29 percent lower risk-adjusted mortality rate… and also had risk-adjusted complication rates that were nine percent lower than all other hospitals.”[2]

Root Causes

Challenges Surrounding Quality

In the aggregate, health outcomes in the U.S. are worse than many other industrialized nations. But this is not for lack of spending or medical technology. The real issues driving our poor outcomes are an epidemic of lifestyle-related chronic disease and the structure of our health care system, whereby third parties — rather than end consumers — pay for services and do so based merely on the volume of services rendered.

Our nation is blessed with some of the best-trained, best-equipped and well-intended health care providers in the world. However, American health care is still largely a cottage industry. Most doctors practice in small groups and fewer than 30 percent use electronic medical records. The result of this fragmented “system” is that physicians are often handicapped by not having complete medical and medication history. Nor do they have access to tests run by their peers, and they don’t always communicate with other providers treating the

same patient. Even within hospital systems, emergency department records frequently cannot be accessed by other services and vice versa, and if the patient is treated by more than one facility, records are seldom exchanged.

The other major factor influencing quality is that providers have been paid based on fee-for-service, with few or no consequences for poor quality. A cynical observer might even point out that medical errors and poor health outcomes actually produce additional revenue for providers. Provider accountability for quality is limited to credentialing and licensing requirements and is seldom linked to revenue, or made available for consumers to use when choosing providers. In an essay entitled "How American Health Care Killed My Father," David Goldhill describes how a preventable hospital-borne infection resulted in his father's death — along with a $636,000 bill for a five week stay in the ICU (all but $992 of it covered by Medicare, albeit at some discount). At the end of his article, Goldhill poignantly asks whether this hospital, directly responsible for his father's death, would have attempted to "collect the bill from the real customer" — his grieving mother. The story, in stark reality, illustrates the problems inherent in our system: shielding providers from answering directly to consumers for cost and quality, and paying for volume rather than value (number of days in the ICU vs. outcomes and quality measures such as preventable errors or actual outcome relative to expected outcome).

When buying cars or appliances, consumers have access to lots of data about the quality and reputation of the products they buy. But when it comes to health care, there is a dearth of information to inform consumer choice even though health care makes up more than 17 percent of our national economy. This lack of information results in very little competition based on quality because patients (consumers of health care) are so poorly informed.

The Cost Problem

The systemic issues affecting quality of care — lack of transparency, volume-based pay for providers and third party payment — also have a direct impact on the other side of the coin: the cost of care. Nevertheless, the crisis in health care is not entirely the medical delivery system's fault. Much of the responsibility for the total expenditure of health care also falls on patients. During the past century, America has changed from an agrarian, to industrial and now to a knowledge-based economy. In combination with other factors, this has had the effect of increasing obesity and sedentary lifestyles that are the meta-conditions for most of the chronic disease, which is reaching pandemic proportions in our country.

Another key factor driving health care cost is the way it is funded. Insurance is a financing mechanism, but one loaded with unintended consequences. In large part, access to health insurance coverage has contributed to the high cost of health care because normal economic principles do not apply. For many years, researchers from the Dartmouth School of Medicine have been publishing data on regional variations in treatment patterns. These treatment variations, based on a variety of factors, ranging from defensive medicine to hospital policies rather than evidence-based medical guidelines, can result in unnecessary care, higher cost and poor quality. The Dartmouth Atlas project also demonstrates a phenomenon in health care known as "supply induced demand." This means that a higher number of providers in a geographic area generally results in more procedures and higher cost. Since most expenses are paid by third parties — insurers, employers or government — greater supply does not reduce price as in other markets.

In essence, our current system shields both patient and provider from fiscal responsibility, thus cultivating unfettered demand and little true competition. The result is an unsustainable hodgepodge of medical care delivery and continued cost escalation.

Real Solutions

The ultimate solutions to our crisis in health care involve much more than temporary measures aimed at one-time cost reductions or artificial price controls. We need comprehensive changes that will affect the health and care of all Americans — fundamental realignment of incentives for both providers and consumers. The current paradigm must be changed from merely "treating the sick" at all costs to creating a culture of health.

In a culture of health, consumers would be given more tools and financial incentives to manage health risk and consider cost and quality before making health care purchases. Services such as health coaching and care coordination are also critical to support greater

empowerment of consumers. Providers must compete on the basis of cost and quality — just like every other industry, with market-based consequences for failure to demonstrate value and transparency.

Improving Quality

Three key reforms are needed:

1. Pay for quality and value, not just volume of medical care
2. Deploy electronic medical records and share them
3. Empower consumers with the incentives, tools and support they need to become more discerning consumers of health care

The highest quality of health is derived by avoiding, preventing or at least delaying the onset of chronic and acute disease. For example, the biggest enhancement to the quality of health in third-world countries comes not from treating malaria and dysentery, but from preventing it. Although America has come a long way in public health, our population has grown progressively sicker over the past several decades and the burden of disease causes our national health outcomes to be worse, in some cases, than third-world countries. Health quality will improve when we change the incentives for both providers and consumers of health care to focus more on prevention, wellness and chronic care management.

The patient-centered medical home movement and the establishment of Accountable Care Organizations are steps in the right direction. These new provider communities should also foster broader adoption of electronic medical records and reduce much of the unnecessary testing and treatment common in today's fragmented and paper-intensive environment. Giving providers incentives for achieving better outcomes and sharing the savings will help establish a value-based payment system that rewards quality while refusing to pay for avoidable errors. New compensation structures should also include payment for health coaching and care coordination so that providers have a positive incentive to educate patients and achieve better health outcomes. Employers, health plans and providers must consider how to effectively deploy "physician extenders" — health care professionals that serve as care guides and patient advocates.

Consumers have a role to play in quality as well. With cost and quality data more available to consumers, patients can better choose among providers and treatment options. The U.S. Department of Health and Human Services' Centers for Medicare and Medicaid Services (CMS) already has cost and quality data, but does not make it available to quality reporting agencies. Increasing transparency, coupled with care coordination support services, will allow consumers of health care to make better choices, and providers will be forced to compete on the basis of quality.

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Better-educated patients can also improve outcomes by engaging more actively in their health. Many employers have begun to adopt value-based benefit designs to encourage better health, including such tactics as removing obstacles to medication compliance and encouraging greater use of preventive services. Employers have also added financial incentives for their employees to engage in wellness activities and health coaching programs to reduce health risk factors.

Although consumer behavior research demonstrates that individual buying decisions are influenced by many forces (both rational and irrational), the aggregate result of increased consumer forces in the market will drive improved quality. In short, while some consumers may not specifically select providers based on purely objective cost and quality data, all consumers will benefit from the increasing quality demands of those who do.

Cost Solutions

Three key reforms are needed:

1. Create incentives for all Americans to better manage their personal health
2. Increase consumerism in the purchase of medical care services
3. Increase competition among providers

The primary reason health care is so expensive is that the demand for health care services is so high. The increase in heart disease, diabetes and cancer is directly related to lifestyle choices. Numerous studies have demonstrated that when the number of health risk factors is lowered, chronic disease slows down and so

do health care costs. Of course it is important to reduce the amount of waste in health care caused by defensive medicine, fraud and abuse and frivolous malpractice suits. But, the real issues driving health care cost in America are the declining health status of our citizens, distorted payment incentives and limited competition among medical care providers.

To get a handle on our health care costs, consider an analogy. Imagine a balloon filling up with water from a faucet. Then try to slow down the expansion of the balloon by squeezing it, rather than turning down the faucet. The point for health care is that as long as health risk factors are increasing and chronic disease is becoming more and more prevalent, health care demand will continue to increase and so will cost.

For too many years, health plans have insulated people from having any significant incentive toward choosing optimal treatment, rather than taking it for granted as an entitlement provided by a third party. By contrast, a McKinsey study reports that participants in well-designed consumer-directed health plans are more likely to use their preventive care opportunities and to participate in wellness programs.[3] The field of behavioral economics is also contributing to our understanding of how people make lifestyle choices and thus how to best align incentive structures for consumers. It is becoming clear that the amount, type, frequency, timing and communication of incentives all play a significant role in engaging people to better manage their health and their health care finances.

Ultimately, consumerism must also drive greater competition among providers. In their groundbreaking book *Redefining Health Care*, Professors Michael Porter and Elizabeth Teisberg lay out in great detail how in health care, competition occurs at the wrong level. Competition among medical delivery providers does not happen to any significant degree on a cost and quality basis. For a transformation to occur, consumers must be armed with better knowledge about health care cost and quality. Timely information, along with value-based incentives and support teams of coaches and care coordinators, will create more prudent health care consumers and further drive competition, cost and quality.

Conclusion and Summary

In this post-reform era, we must regain sight of the real problems in our health care system. As long as we are an aging nation with more and more chronic disease, less price sensitivity among consumers and minimal competition among providers, health care costs will continue to increase at an unsustainable rate.

Realigning incentives for consumers and providers will reform not just health care, but the health status of our nation. Long-term sustainability can only be achieved by shifting to value-based reimbursement for providers and value-based benefits that reward outcomes and personal responsibility. Achieving better outcomes in quality and cost will occur only when we truly empower and support individuals to better manage their health and their care.

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NBH-0404 7/2010