

Thinking clearly about health care reform
Time for a change

Elliott S. Fisher, MD, MPH

Professor of Medicine and Community & Family Medicine

Testimony, VT State Legislature
March 8, 2005

Overview

What's wrong? The underlying causes of poor quality and high costs -- and some principles to guide reform

Where should we go? Community-based integrated delivery systems accountable for quality and costs.

How can we get there from here? Focus on establishing an ongoing process of health care reform.

What's wrong?

Important to distinguish three categories of care.

- Effective care/ patient safety -- services all patients should receive
- Preference-sensitive care -- treatment choices with tradeoffs
- Supply-sensitive care -- physician visits, specialist consultations, use of hospital as a site of care

Underlying causes of failure -- and remedies -- differ according to category

Effective care / Patient Safety

Causes of unwarranted variations in effective care

- Systems incapable of monitoring care, linking processes to outcomes, and learning from practice.

Key elements of high performing teams and organizations

- **Information systems** that support clinical decision-making, care management, process improvement and outcome assessment
- **Leadership commitment** to improving quality
- **Performance measurement and accountability**

Implications for Vermont:

- Reform should foster development of organizations with these capabilities
- Coverage expansion *alone* won't be sufficient.

Preference-sensitive care

Causes of unwarranted variations in preference sensitive care

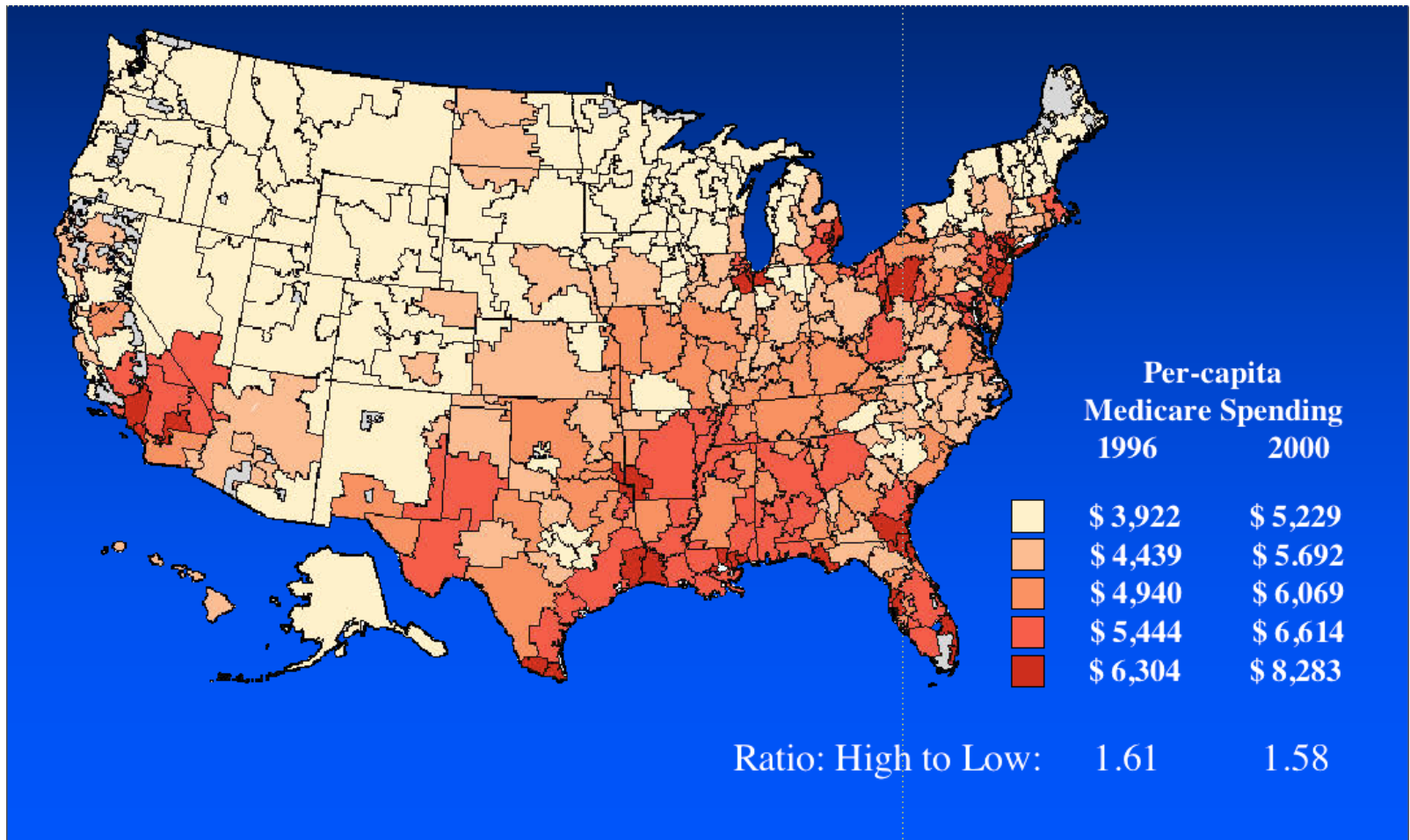
- Inadequate information on risks, benefits
- Failure to provide balanced information to patients
- Incentives that promote more care, not better decisions

Reform will require:

- Ensuring that all VT residents have **access to high quality information**
 - On when and how to use the care system
 - On risks and benefits of major treatment choices
- **Benefit design** that fosters wise use
- **Payment system that rewards shared decision-making**

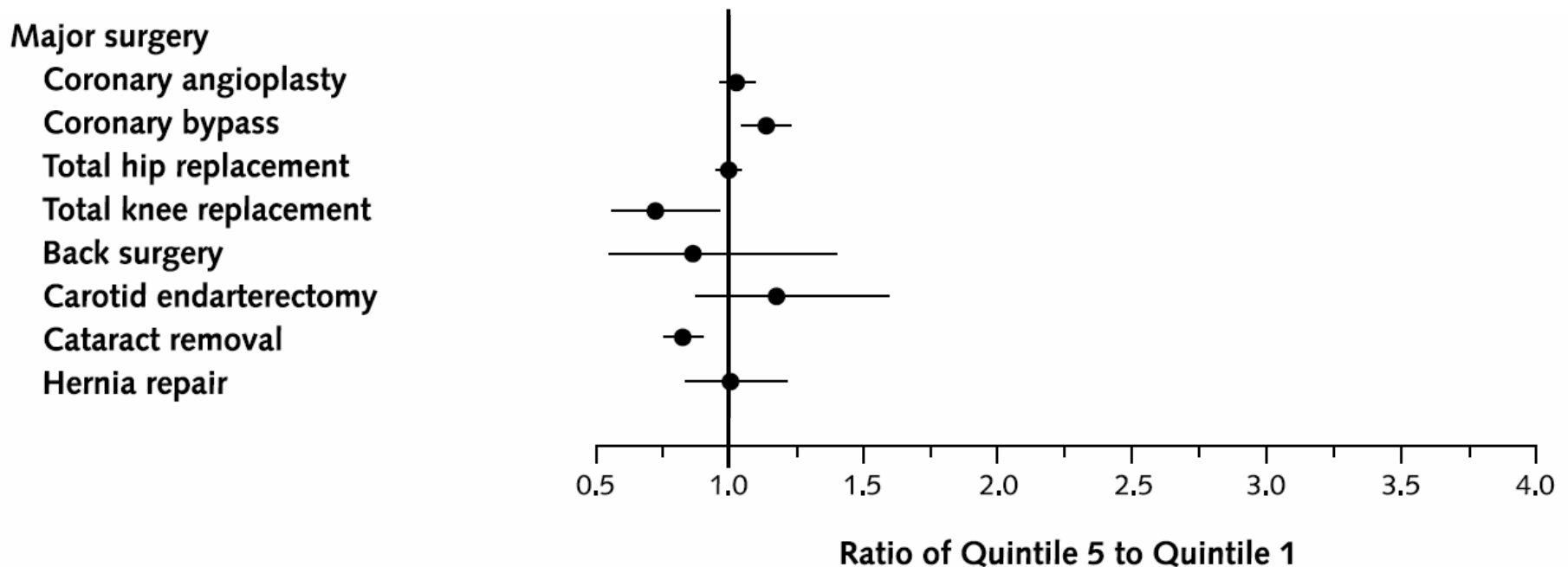
Supply sensitive services / Spending

U.S. Regions differ by two-fold in per-capita spending.

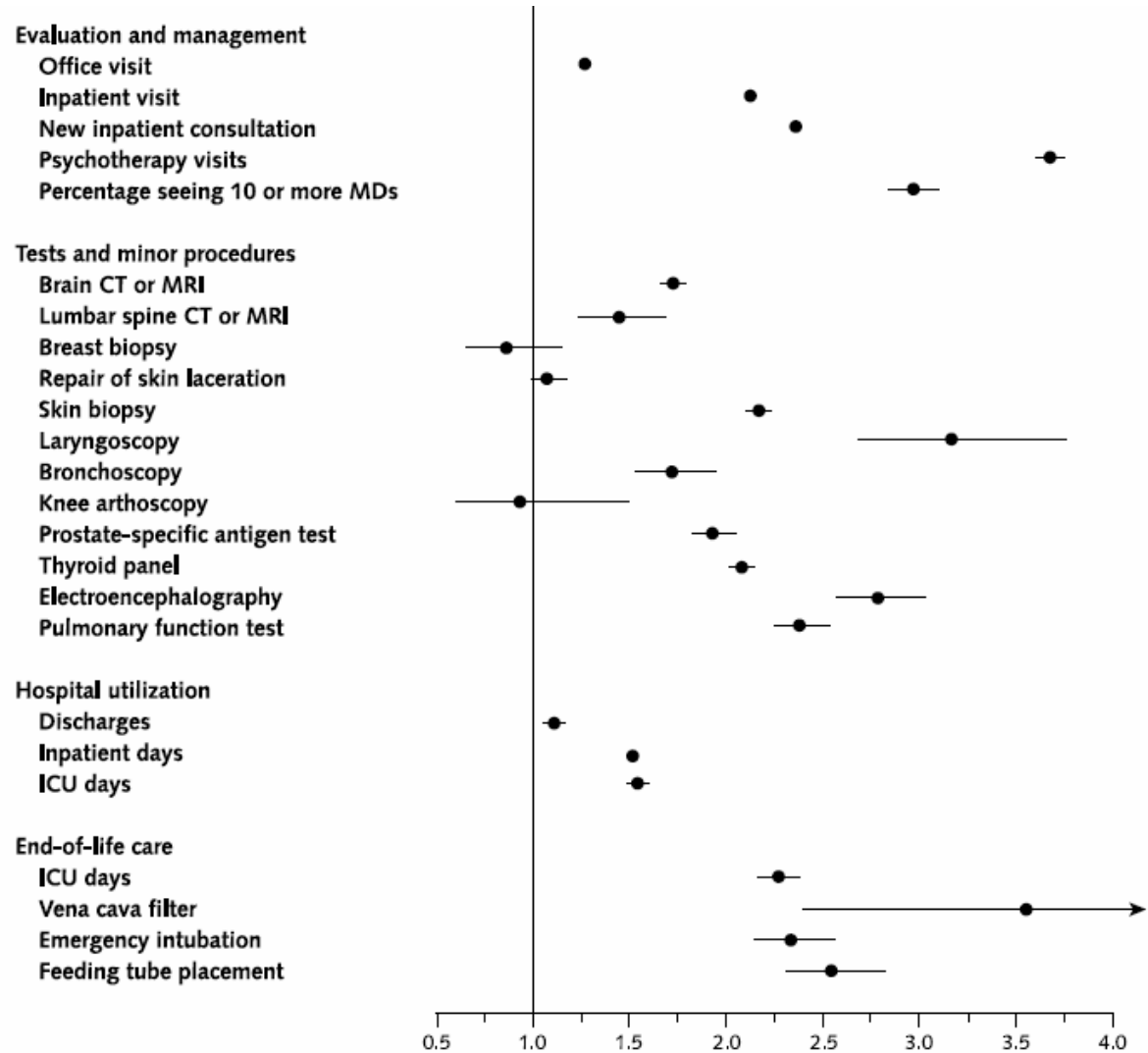


Supply sensitive services / Spending

High spending regions don't provide more elective major surgery.

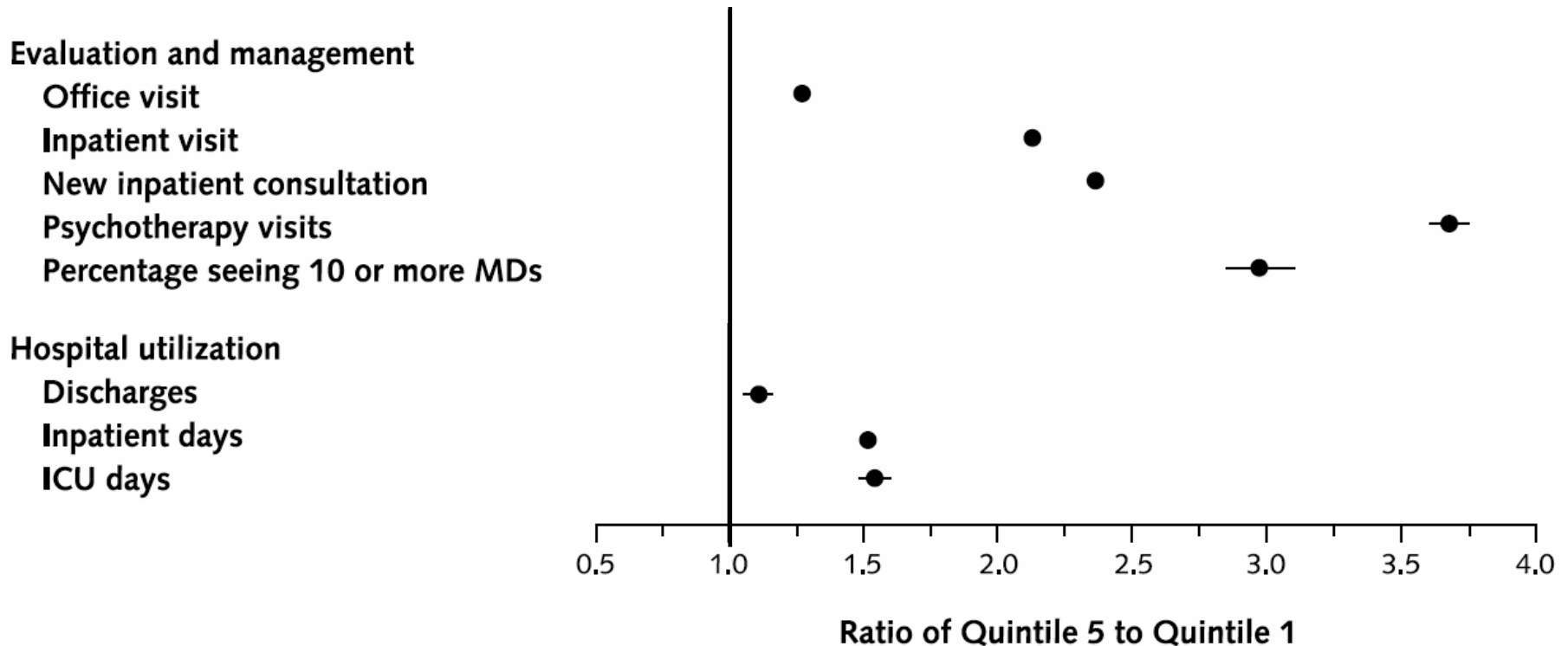


Higher spending is due almost entirely to greater use of supply-sensitive services: hospital stays, MD visits, use of specialists, minor tests, more aggressive care at the end of life



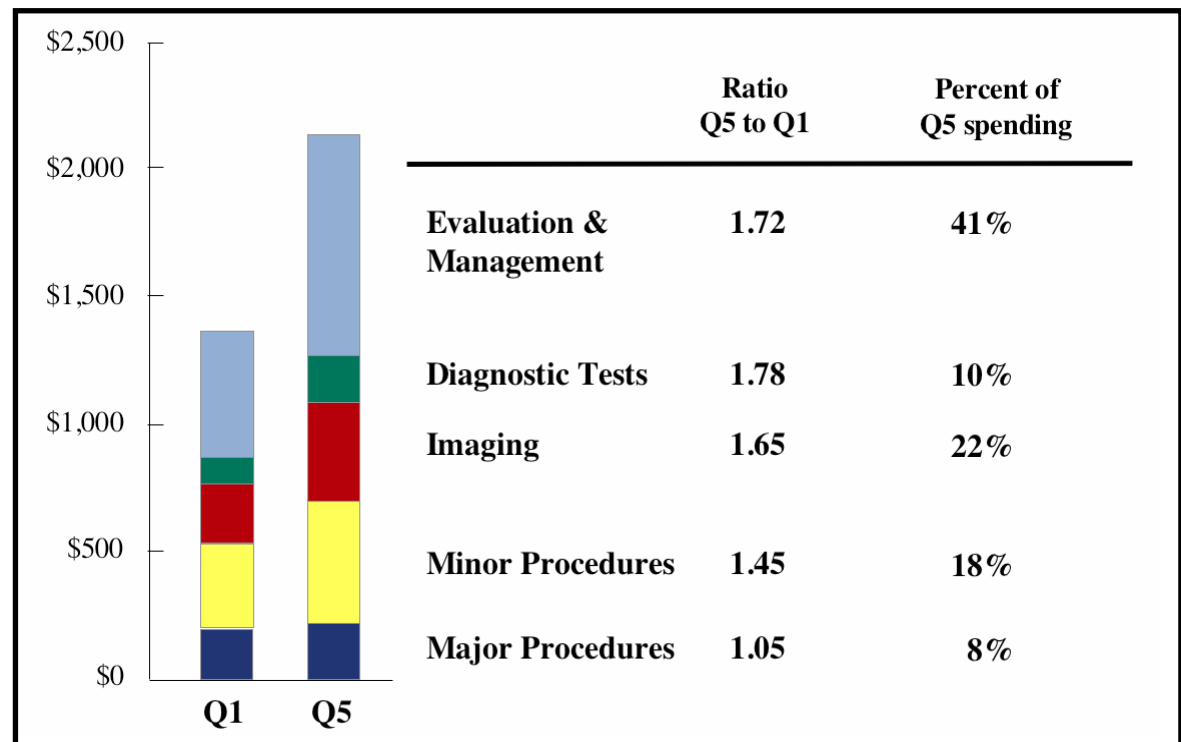
Supply sensitive services / Spending

Higher spending is due almost entirely to greater use of supply-sensitive services: hospital stays, MD visits, use of specialists, minor tests, more aggressive care at the end of life



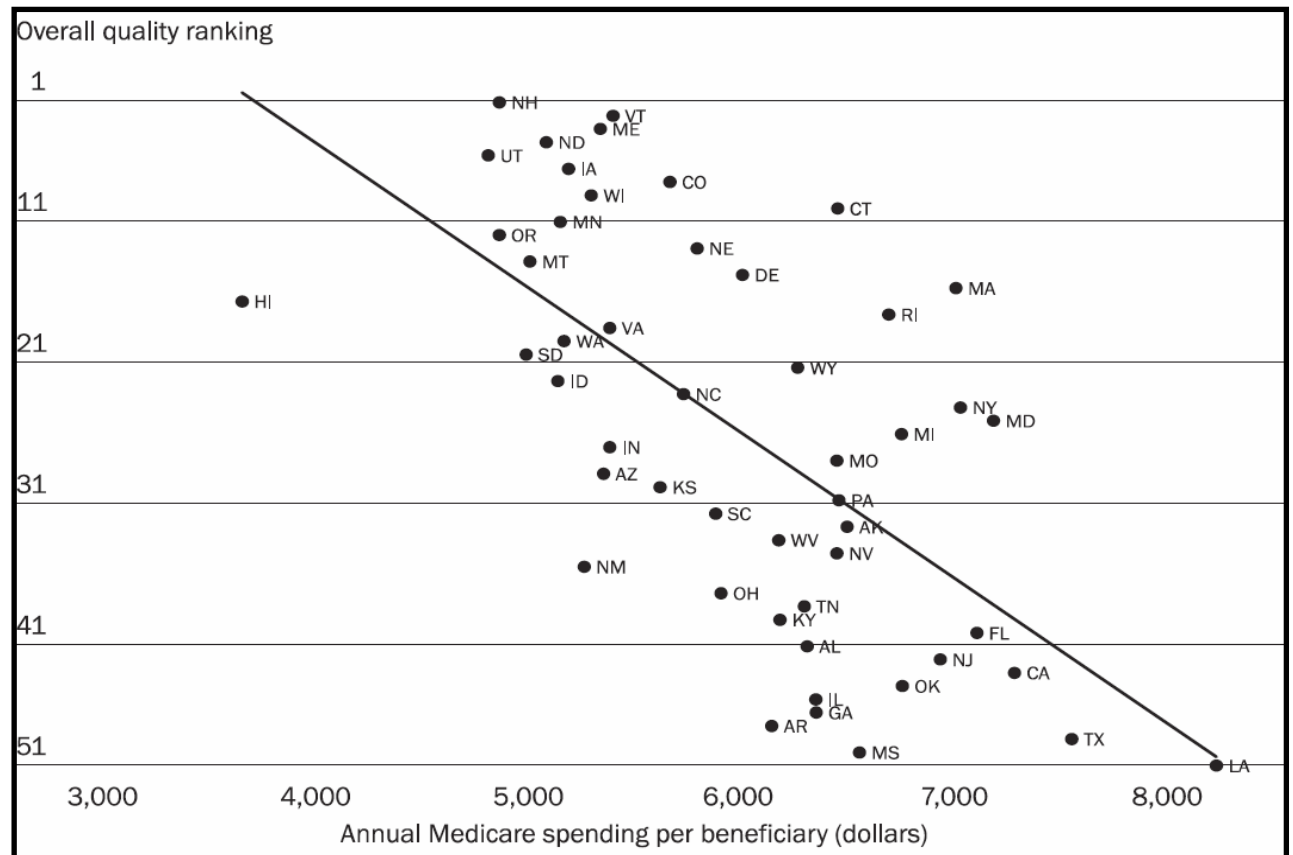
Supply sensitive services / Spending

Supply sensitive services not only explain the *difference* between high and low spending regions, they also make up a large fraction -- probably more than 50% of all spending.



Supply sensitive services / Spending

High spending regions have worse quality,

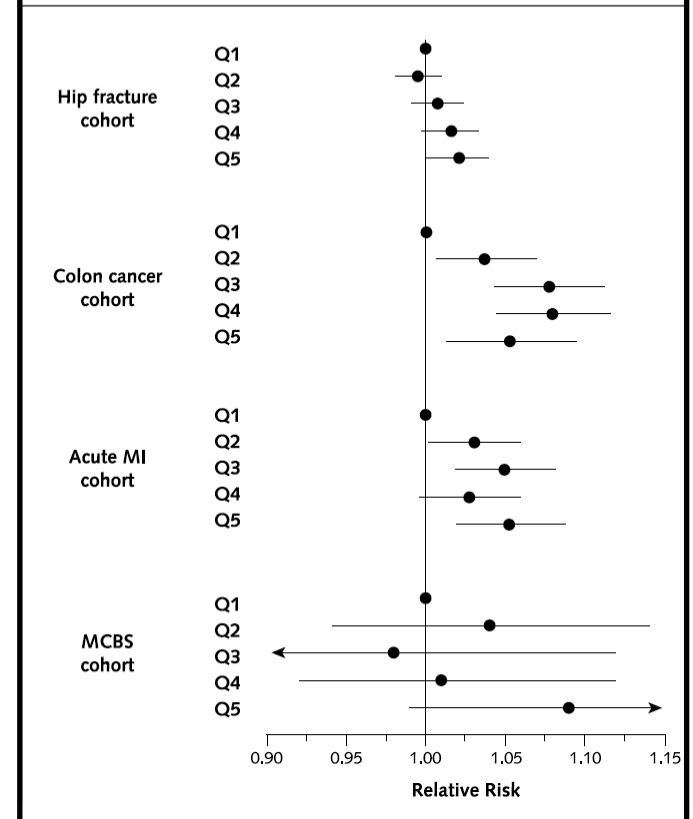


Supply sensitive services / Spending

Health outcomes are no better -- and possibly worse.

Risk adjusted mortality rates were *higher* in each of the four study populations -- and in *each* patient subgroup examined.

Figure 1. Adjusted relative risk for death during follow-up across quintiles of Medicare spending.

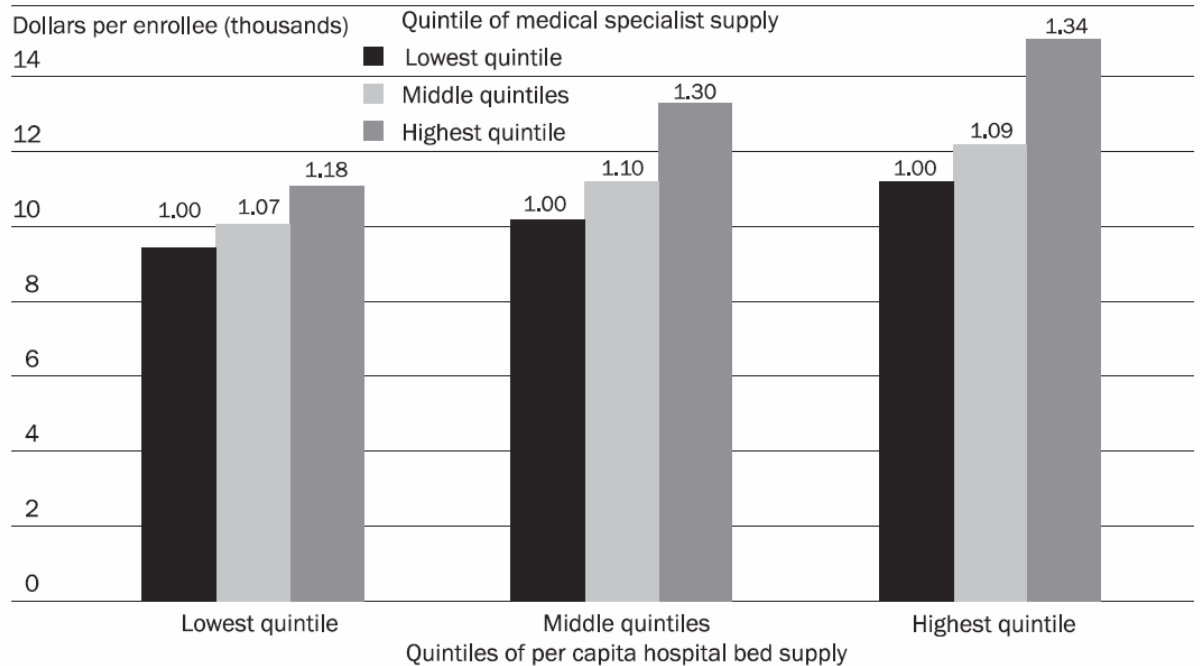


Supply sensitive services / Spending

Differences in health system supply are a major determinant of regional differences in utilization and spending

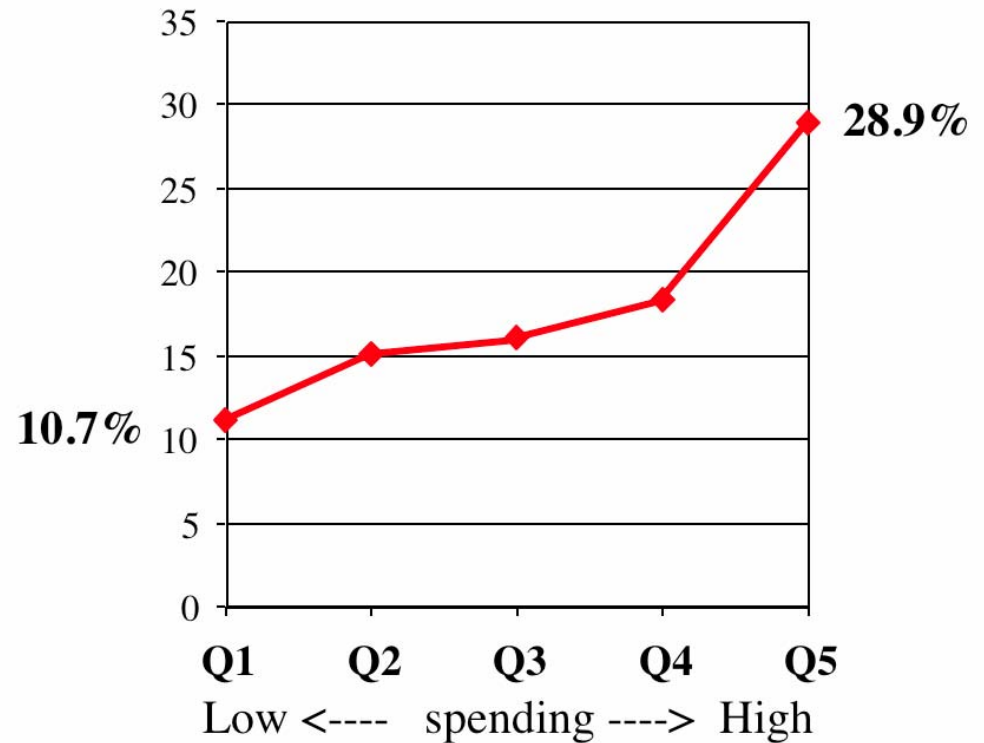
EXHIBIT 5

Association Between Medical Specialist Supply And Practice Intensity At Different Levels Of Hospital Bed Supply In The Fee-For-Service Medicare Population



Supply sensitive services / Spending

Higher capacity is associated with greater complexity (which probably explains the lower quality of care in high spending regions).



% of chronic disease patients with 10+ MDs involved in care during first year

Supply-sensitive services

Implications for reform

Implications:

- US is wasting at least 30% of health care spending
- Substantial improvements in efficiency are likely to be possible, even in moderate spending regions like Vermont.

Reform will require:

- **Controlling future growth of capacity**
- **Monitoring capacity, utilization and spending** of care systems
- **Monitoring quality**
- **Reforming incentives** to reward quality and efficiency

Overview

What's wrong? The underlying causes of poor quality and high costs -- and some principles to guide reform

Where should we go? Community-based integrated delivery systems accountable for quality and costs.

The current approach

narrow focus on individual providers and price

Current insurance models pose a structural barrier to improving quality and controlling costs

- Focus largely on individual physician and unit or episode price
- Efforts to reduce costs focus on the price -- driving up utilization
- MDs remain in small groups with multiple contracts
- Resources for improving infrastructure inadequate
- Incentives remain problematic

Control of capacity still doesn't occur

- Decreased utilization in one patient group leads to compensatory increase by other patients (if capacity remains in place and incomes depend upon throughput).

Some corollaries

Consumer driven health care won't save (much) money

Principle: *financial incentives to choose wisely*

Problems: (1) no influence on decisions of high cost patients
(2) *compensatory increase* by other patients as providers stay busy.
(3) Inadequate information for patients

Result: Savings for some individuals (healthy ones)
Costs rise for sick
No limits on overall spending or growth

Some corollaries

Chronic disease management won't save (any) money.

Principle: *manage care for high cost cases*

Problem: (1) only affects enrolled patients
(2) requires additional personnel to manage care
(3) compensatory increase in use by other patients as providers stay busy.

Result: Savings (and better care) for enrolled individuals
May *increase* overall costs

Some corollaries

If we control capacity -- universal health coverage shouldn't cost much.

Theory: (1) resources already pretty busy
(2) payment caps would ensure constraints
(3) universal coverage would allow currently uninsured to begin using system (increased use).
(4) Currently insured would have slight decrease in frequency of use

Result: improved health for uninsured
improved health for insured (perhaps)
restored sense of community

Principles to guide reform

Reform should address underlying causes of poor quality and high costs:

- Failure to invest in information systems and organizational structures necessary to deliver safe, reliable, effective care
- Failure to ensure provision of balanced information to patients.
- Failure to manage capacity and improve efficiency of care.

Key elements of reform

- ***Delivery system redesign:*** Fostering organizational accountability for quality (comprehensively defined), costs and capacity
- ***Payment system reform.*** Reforming payment system to reward quality and efficiency.
- ***Benefit redesign.*** Redesigning benefits to foster wise decisions by public and patients

Fostering Organizational Accountability

1. Foster development of population-based, integrated delivery systems that can be held accountable for capacity, costs and quality
 - *Physicians in large groups with affiliated hospital(s)*
 - Formal: prepaid group practices (Kaiser, Group Health)
large multispecialty group practices (Hitchcock Clinic)
 - Informal: hospitals and their affiliated medical staffs
In VT: community hospitals and local providers
2. “Single” provider organization can address quality and efficiency failures
 - **Invest in information technology** to support care management, communication, process improvement and outcome tracking
 - **Establish organizational structures** (teams, accountability systems) to foster enhanced patient safety, quality improvement
 - **Use benchmarks to manage capacity** (and supply sensitive services)

Fostering Organizational Accountability

3. Measure performance -- on all dimensions of care

- Public cares about quality and outcomes -- and must be reassured that lower costs are compatible with better care.

4. Implement population-based payment systems with performance incentives

- If incomes depend upon throughput -- efficiency is penalized.
- Population-based payment (with incentives designed to foster access and improved quality) can reward quality and efficiency.

A possible path forward...

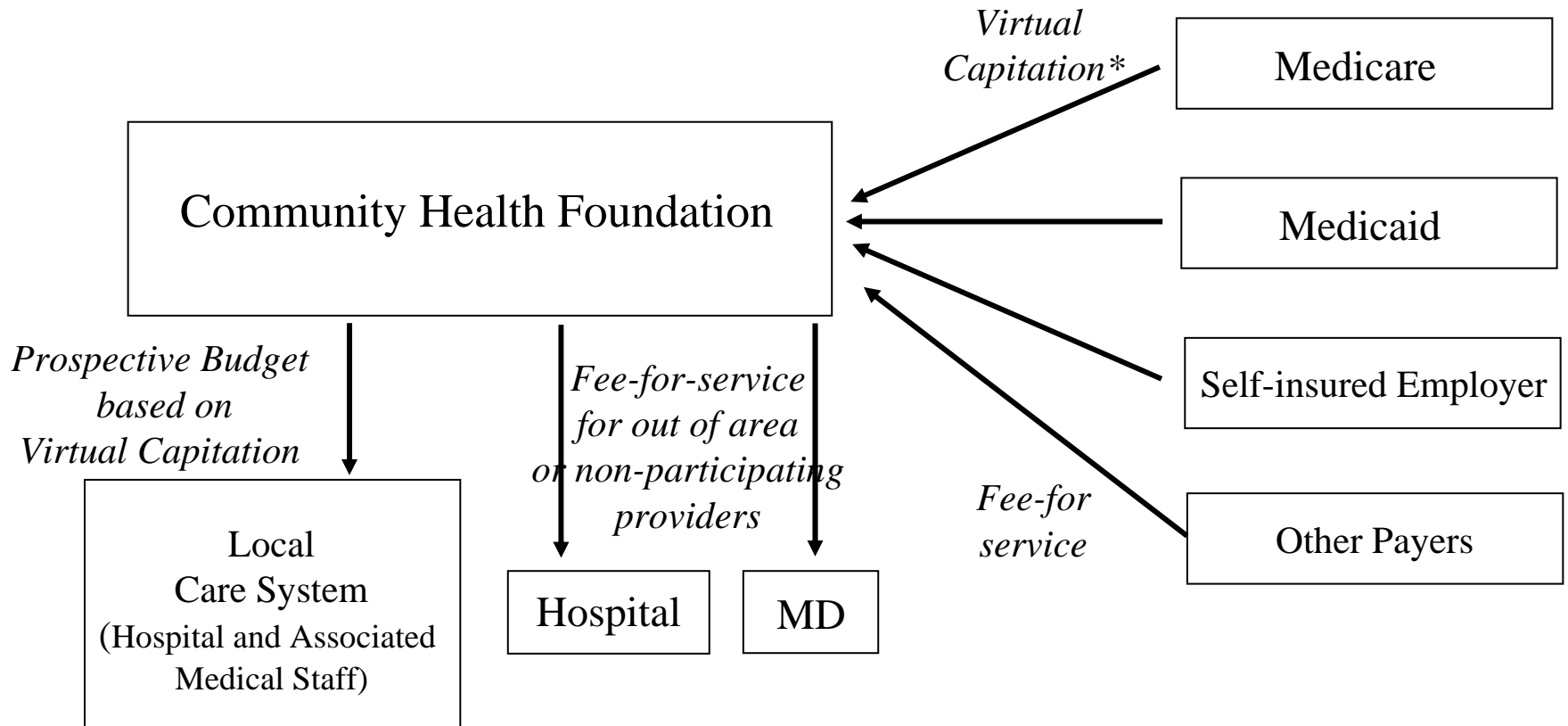
Foster development of local integrated delivery systems, building on existing community hospitals and physician practices.

Develop prospective budgets for each local health system, based upon historical trends.

Initiate reformed payment system for payers willing to participate (reward quality and efficiency).

Other payers remain in fee-for-service system, paying state-approved rates adequate to meet local budgets

A community based approach to reform



* *Virtual Capitation is defined as per-capita payment based upon projected costs for a patient population for whom provider is responsible based upon care history (e.g. chronic disease patient) or residence within the local service area of the community health plan / provider . No formal enrollment is required.*

Advantages..

Capitation gives providers the flexibility to reorganize care to improve efficiency and quality

Maintaining a parallel fee-for-service system allows flexibility to those providers or payers who don't want to participate -- and to patients who choose to seek care out of their local market (they should be free to do this).

Provides feasible phased-in approach to a statewide universal health care system, and (perhaps eventually) a single payer (multiple provider) system.

Fosters ongoing improvement by providing comparative measures of quality and costs that can provide basis for financial (or other) incentives to improve.

Unresolved issues

Out-of-state providers / bi-state markets

How to cover the uninsured

Details of performance measurement

Details of payment system and performance incentives

Benefit design

How to manage rapidly evolving landscape

Getting there from here...

Overview

What's wrong? The underlying causes of poor quality and high costs -- and some principles to guide reform

Where should we go? Community-based integrated delivery systems accountable for quality and costs.

How can we get there from here? Focus on establishing an ongoing process of health care reform.

Getting there from here...

Now

The Future

General Diagnoses

General Approach

Theory

Focus is on substance -- the “right” answer.

Health care system is complex and poorly understood.

Reform requires federal & state action. No magic bullet or single bill will “fix” the mess.

Powerful interests have conflicting goals and can often block legislative change

Focus on establishing an effective reform process.

Development of effective reforms will require expertise.

Sustained attention will be required over many years, with federal - state collaboration.

Reduce power of single or narrow interest groups to block legislation.

What is wrong?

Action Ideas

*Real
World*

Failure to make real progress on health care reform

Establish an expert commission to guide and manage an ongoing reform process.

Charge Commission to work with federal and other stakeholders to develop annual reform proposals using “One-Text” process.

Bring proposals to legislature for up-or-down vote.

Getting serious about health care reform:

Focus on the *process* of reform -- not just the substance

Key elements of an effective reform process

- Technical expertise in those helping develop practical reform proposals.
- Sustained attention to the goals and an ongoing effort to develop practical proposals to achieve them.
- One-text approach to multiparty negotiation should be adopted to maximize opportunity for successful reform.

Getting serious about health care reform: Focus on the *process* of reform -- not just the substance

Specific approach suggested for state reform

- Establish an adequately funded Commission to oversee an ongoing reform process: (Vermont Health Care Reform Commission?)
- Goals: continually improve Vermont's health care system to achieve universal access, high quality, sustainable costs and equitable financing (achieve goals of Coalition 21).
- Charge them to employ a two-step process

Development of reform proposals and regulatory changes. Commission develops annual legislative proposals (and more modest reforms that could be implemented administratively), using “one-text” process in consultation with all Vermont stakeholders and key legislators.

Legislative action using “fast-track” vote. Each year's proposal is brought to the legislature for an up-or-down vote -- with no (or limited) possibility for amendment on that initial vote.

The "One-Text" process

One-text process was developed by Harvard Negotiation Project for use in complex multi-party disputes.

Key elements:

Neutral 3rd party (mediator) manages non-binding draft

Mediator has no authority to bind parties

Parties are asked to review and criticize single draft

“What concerns are not adequately addressed?”

“What are your underlying interests?”

Mediator refines draft -- often with support of technical experts -- until he or she believes no further improvements are possible.

Draft submitted for final “up or down” acceptance, with no modifications possible.

The "One-Text" process

Why this approach?

Efficiently identifies underlying interests of affected parties

- Understanding of interests critical to inventing policy options that meet those interests (but that wouldn't have been initially proposed by stakeholders)

Structures choices of participants to maximize likelihood of success

Currently Perceived Choice

Created by a *concession hunting mediator*

Shall I now make a concession from my stated position?

If I say YES:

- - I have to decide what to give
- - My hardliners will criticize me
- - I won't be able to take back what I've yielded
- - Whatever I give, this mediator will certainly ask for more
- - I start down a slippery slope
- **BUT:**
- + I won't be blamed for failure
- + There is a chance we'll move toward agreement

If I say NO:

- + No problem deciding what to do
- + I maintain hardline support
- + I support the reasonableness of my original position
- + I can wait and see what the other side does
- + They may make a concession
- + I can always give up something later
- **BUT:**
- - I may get blamed for the process not working

Currently Perceived Choice

Created by *the mediator using the "One-Text" Process*

Shall I criticize the draft that the mediator has offered?

If I say YES:

- + I lose nothing
- + I make no concession and no commitment
- + Future drafts will better reflect my interests
- + I keep my options open
- + I can always say no later

If I say NO:

- I look uncooperative and may antagonize the mediator
- I miss a chance to push this draft in a direction I would like
- I am likely to face a worse draft tomorrow
- I may be put under pressure to accept a later draft that I didn't influence

Currently Perceived Choice

Faced *at the end of the "One-Text"* Process

Shall I accept the mediator's final proposal?

If I say YES:

- + The commitment I am making is clear
- + The document takes most of our interests into account
- + It is a balanced, operational document prepared by a neutral
- + It is as good a proposal as we're likely to get
- + If the dispute does not end, the other side will be blamed

BUT:

- We don't get everything we want and give up a better future deal

If I say NO:

- What happens next is unclear
- The dispute goes on
- We lose the efforts of this mediator no one else may volunteer.
- We are unlikely to get a better proposal.
- We will miss an opportunity that is unlikely to recur

BUT:

- + We keep open the unlikely possibility of a better future deal.

Step Two: “fast-track” voting by Legislature

Problem: powerful stakeholders have undue influence to block or stymie progressive reform under current system.

Solution: consider bringing reform proposal for initial up or down vote

Overview

What's wrong? The underlying causes of poor quality and high costs -- and some principles to guide reform

Where should we go? Community-based integrated delivery systems accountable for quality and costs.

How can we get there from here? Focus on establishing an ongoing process of health care reform.

Single payer hospital insurance system

Gains control of -- and stabilizes access to -- most expensive component of health care

Would reduce cost of health insurance

Begins process of moving to population-based budgeting

Could provide vehicle for supporting local electronic health records

Could have perverse effects, fostering increased use of hospital as site of care -- for those without primary care insurance *or with it*

Does nothing to address underlying quality problems

Does nothing to address current payment problems faced by physicians and others (declining prices fostering increased utilization)