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Keynote address

Who Will Pay For Quality Health Care: *Can The State of Maine Set An Example?*

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The Importance of Maine as a Laboratory of Quality Improvement

In 1975 the Maine Medical Journal published an article written by Jack Wennberg, a physician not widely known at the time, on the unexplained wide variation in surgical procedures.

Dr. Dan Hanley created the Maine Medical Assessment Foundation and working together the two physicians forced the U.S. medical establishment to recognize that we as a nation were not getting the quality of health care services we thought we were. Although there is a greater appreciation of Dr Hanley's insight and understanding, we still lack real life examples of how a community can fundamentally improve the quality of its health care. The state of Maine can provide such an example and timing is critical.

It is very difficult to change the Health Care delivery system in times of economic stress.

The health care system has seen an unparalleled level of economic prosperity over the last five years, more troubled times are ahead and we need to make changes NOW!

We spend an estimated 15% of our Gross Domestic Product (GDP) on health care. That is 35% more than the Germany and almost

twice as much as the United Kingdom. What is driving the expense? We hear talk about too many hospital beds and the need to shorten hospital stays. Here are some interesting comparisons: ¹

	United States	United Kingdom	Germany
Hospital related costs:			
Acute care beds	2.9/1000	3.7/1000	6.6/1000
Hospital discharge	11,712/100 K	23,215/100 K	20,164/100 K
Avg. length of stay	5.7 days	6.9 days	9.2 days
Practicing physicians	2.3/1000	2.1/1000	3.3/1000
Doctor consultations	8.9/capita	5.6/capita	NA/capita
Procedural related costs:			
MRI	8.6/1MM	5.2/1MM	6.0/1MM
Cardiac cauterization procedures	148.9/1000	33.4/1000	69.0/1000
Liver transplant	1.8/100K	1.2/100K	0.9/100K
Prescription drugs	\$562/capita	NA	\$367/capita

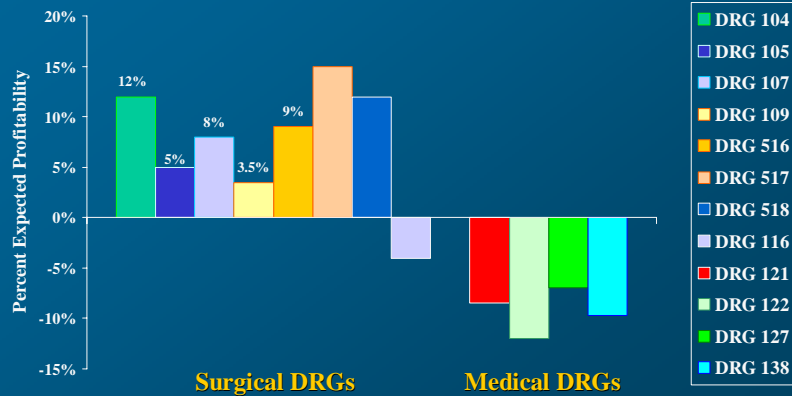
Does More Spending For Health Care Help US Citizens Live Longer?

Life Expectancy at 65	18 years	17.75 years	17.90 years
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¹ The full charts are included in Dr. Altman's PowerPoint presentation in the appendix.

Relative Profitability Across DRGs

Cardiac DRGs



SOURCE: MedPAC

Technology is a major driver in health care expenditure growth, the question is, is it worth it?

“When costs and benefits are weighed together, technological advances have proved to be worth far more than their costs.”²

The Wennberg Analysis Group concluded that increased spending for high cost patients in higher spending regions is associated with lower quality, worse access to care, and no gain in satisfaction. Higher spending is associated with a small increase in the risk of death and that the US is wasting about 30% of Medicare spending.

We need to change health care services reimbursement to pay for improved quality because:

- Quality of care in the U.S. is not as good as it should be and not improving quickly enough
- Estimates are that 50% of patients do not receive appropriate care

² David M. Cutler and Mark McClellan, “Is Technological Change In Medicine Worth It?” *Health Affairs*, September/ October 2001. Can be found at: http://www.laskerfoundation.org/reports/pdf/cutler_mcclellan_2001.pdf.

- Paying for services regardless of the quality of the inputs and outputs does not provide the right incentives
- Must consider both the quality of the care provided to an individual patient and to the community.

Is pay-for-performance the answer, or will it only lead to more spending; and how is it to be measured?

- Should Hospitals and Physicians be rewarded only on *outcomes* or should measures include *structure*, and *process* measures as well (including staffing, complications, readmissions)
- Should programs reward only top performers (e.g., top 20% in market) or all providers reaching a fixed goal (e.g., 75% compliance with a benchmark)
- Should programs include “winners” and “losers” or can all providers WIN.

Must Recognize There Are Concerns About Focusing Too Much Attention on Pay-for-Performance and not seek flexible alternatives.

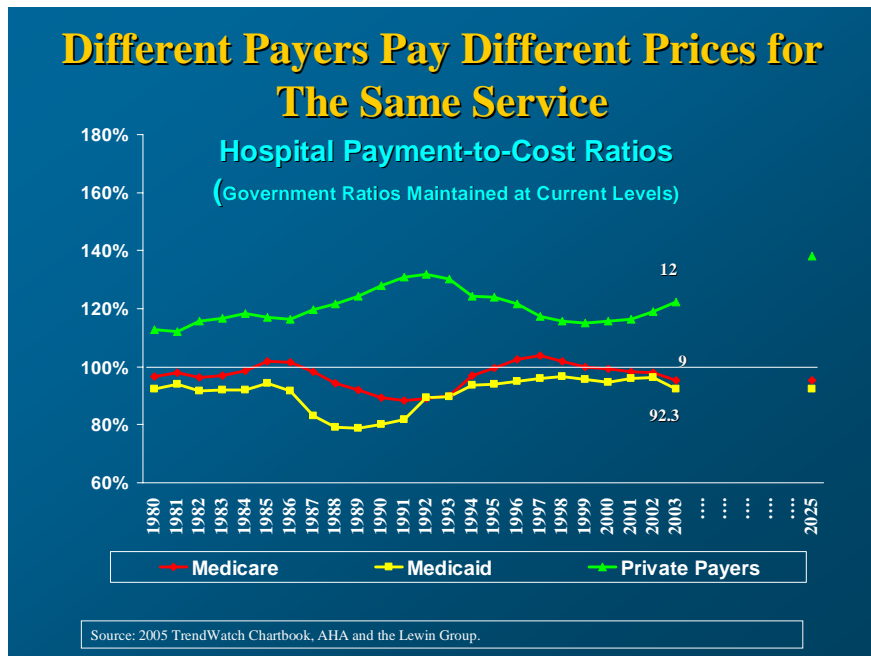
Issues presented:

- Will rewarding a finite selection of measurable guideline outcomes result in neglect in the care of conditions or outcomes not included
- Smaller hospitals or physician groups may not have the resources to participate in such programs
- Should hospitals that are hurting financially be further hurt by cutbacks in reimbursement
- How can we extend a patient centered pay-for-performance reimbursement system to include incentives to improve the quality of care of the broader community
- Participation will require extensive new data systems that will be expensive to implement
- Hospitals in networks that have sophisticated data collection systems will have a significant advantage
- Must make financial incentives strong enough
- Typical payments for best performers set to roughly 5% of revenues from the sponsoring plan or purchaser
- Incentive sponsors usually represent minority share of provider revenues

Paying-for-performance has an early record of accomplishment with promising results in California, Massachusetts and Michigan. There have been measurable improvements in quality with increased value for consumers and purchasers.

If we are to have patients play a role in improving quality and the cost effectiveness of care, we must provide them with easily available and understandable information. In addition, we must educate them on what the information means to them and their family's health. But, can we have price and quality transparency in hospital care when there are many different prices for the same provider? Third party payers know the price they pay, but the patients don't care since they don't pay the bill and the information is not available to employers who do pay the bill.

A fundamental issue is the definition of a unit of care. Is it an MRI or the total cost of treating a heart attack patient?



We must also recognize the potential losers in a “consumer responsible” price sensitive system:

- Sick patients with complex illnesses
- Patients whose treatments are more expensive than payments, e.g.
 - Burn patients
 - Psychiatric patients
 - Chronic medical conditions
- Uninsured and Medicaid patients
- Long-time workers in big (expensive) health systems
- Communities

In addition to pay-for-performance, we must concentrate on developing effective techniques to assure that the sickest and most expensive patients receive the most appropriate care.

Where is the Health Care System Going?

We need to focus our health care future on disease management. The current models don't include the physician because of a reputation of being difficult to work with. However, these systems won't work, the physician must be included. The future of healthcare is customer-centric, community based.