Reforming the U.S. Health Care System: Improving Coverage, Quality, and Efficiency

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The U.S. health system underperforms compared with other countries on multiple dimensions—access, quality, and efficiency (Davis et al. 2007, Schoen et al. 2006, Schoen et al. 2005). The United States spends on health care twice per capita what the average industrialized nation spends, yet fares the same or worse on major indicators of health outcomes and quality of care (Hussey et al. 2004; Schoen et al. 2006). High U.S. health care spending without commensurate gains in health outcomes has led some experts to conclude that the U.S. health system is on the flat part of the production curve for health services, or perhaps beyond the point of diminishing returns.

Yet, a different conclusion could be drawn—namely, that the United States is not even on the efficient production curve. When the unit of care is defined as treatment over a given condition, the cost of providing any given level of care is highly variable (Fisher et al. 2003a; Fisher et al. 2003b). Even within a given geographic area, the cost of care for say, a heart attack, depends on the hospital to which the ambulance takes you. It will affect how many days you are in the intensive care unit, how many doctors are involved in your care, and whether or not you are readmitted to the hospital after discharge. In fact, it will probably determine whether or not you are alive a year from now. Fisher and colleagues at Dartmouth Medical School conclude that the Medicare program could save $900 million a year and 8,400 lives if all hospitals had the same costs and outcomes as the best quartile of hospitals on both cost and quality (Davis 2007).

Dartmouth itself excels at controlling the total cost of caring for patients with back pain by informing patients about surgical and non-

surgical treatment options. The Dartmouth-Hitchcock department of orthopedic surgery requires patients to view a shared decision-making video informing them about the risks and benefits of different treatment options before undergoing surgery. As a result, the area has one of the lowest orthopedic back surgery rates in the United States. The Spine Center at the hospital supports patients with pain management, physical therapy, instruction, and exercise. Ironically, insurers save money on the reduced surgery and hospitalization costs, but don't pay for shared decision-making videos, and don't cover the time the nurse educators spend with that patient.

These examples illustrate that current provider payment methods reward providing more services, not getting good or better outcomes efficiently.

This contrasts with the experience of the budgeted system that faces the Veterans Health Administration (VHA). The VHA has had flat real spending per capita for 10 years. When Ken Kaiser was head of the VHA health system, he made a deal with Office of Management and Budget. If he saved money, they would let him reinvest it in the health care system. He reduced the rate of inpatient care and used the savings to build 300 primary care clinics. As the VHA rate of pneumococcal vaccinations increased, the rate of hospitalizations for pneumonia fell (Perlin 2005). Efforts like this helped make the VHA system the top-performing system in the country at the time in terms of quality, while having no increases in real cost-per-person-served over a decade.

Reforming Fee-for-Service Payment to Reward Excellence and Efficiency

Most U.S. hospitals and health systems are led by extremely capable people. Why aren't they efficient in the way that I have defined it? First of all, there's little information on the quality or cost of care for patients with different conditions. In particular, neither a health care provider nor a patient knows in advance the total cost of care to expect over an episode of illness—the patient's hospital care, his or her physician care, and other services.

Second, with few exceptions, no single firm or entity produces all of the care that a patient receives over the course of a year. Different ser-

vices are provided independently, including those provided by surgeons, anesthesiologists, radiologists, hospitals, physical therapists, and a host of other health care personnel involved in the total care of a patient with a given health condition over a period of time. The same may be true of building a house, but a general contractor typically bids on the job, retains subcontractors to do different tasks, and delivers a finished product—with luck on budget and with anticipated results.

Finally, we pay for those health care inputs separately. We don't pay a single price for total care for a condition. This means that there is no incentive to use lower-cost substitutes, whether that means a diabetes educator or shared decision-making. We don't reward higher quality. Even in integrated health care systems like Partners HealthCare in Boston, we rarely reward greater efficiency, and we have made no systematic effort to identify and spread best practices.

Improving Quality of Care for Low-Income Individuals

Turning to the issue of access to care, The Commonwealth Fund supported a study of seven public hospitals that got together to improve the quality of diabetes care—taking care of the poorest and most uninsured, many of whom are minority patients (Regenstein et al. 2005). These seven hospitals have raised their quality indicators to the national average—not as good a performance as achieved by the VHA—but up to the national average.

But even though these hospitals take people regardless of ability to pay, the uninsured receive substandard care because they just don't come in as often. They don't have their chronic conditions controlled or detected at an early stage. So safety-net providers can deliver high-quality care; but without insurance coverage, delays occur and outcomes are not as good (Institute of Medicine Committee on the Consequences of Uninsurance 2004). To reduce disparities between outcomes of high-income and low-income people, the United States may need to spend more, not less.

We need a multi-pronged strategy of covering the uninsured and improving the quality of care given by safety-net providers. And we simply cannot improve what we do not know. So, not only do we need data on quality and efficiency, but we also need these data by race and

ethnicity, and for different population groups as well. We need to pay much more attention to the Medicaid program, to rewarding performance and quality, and to spreading best practices, particularly for providing care.

Extending Health Insurance Coverage to All

I have published ideas about how we might go about expanding health insurance coverage (Figure 8.1) (Davis and Schoen 2003). Given our mixed public-private system of health care financing, building on group coverage has many advantages—whether it is through Medicare for older adults and elimination of the two-year waiting period for the disabled; by expanding the children's health insurance program to cover low-income adults as well as children; whether it is creating something called a Congressional Health Plan (CHP), modeled on the federal employees health benefit for small business and individuals to buy into; or whether it is by expanding group coverage through employers. Doing this would cost new federal dollars—about $70 billion a year—and would increase total health spending by about $50 billion (Davis and Schoen 2003). Over the long run, people could have a choice among these sources of group coverage with competition among public programs like Medicare, the CHP, and private coverage.

What are some other examples? States could also be a basis for expansion of coverage. Maine has the most interesting experiment going on right now, called Dirigo (Figure 8.2). It involves a sliding-scale deductible and a sliding-scale premium. The state government contracted with Anthem to create some insurance products, one of which has a $1,250 deductible, and another a $1,750 deductible. A small business can buy coverage for workers through Dirigo. The employer pays 60 percent of the worker's premium and the employee pays the rest. But if the employee's income is below the poverty line, the employee pays nothing. If the employee's income is above 300 percent of the poverty line, there is a $1,250 deductible and effectively a $124 monthly premium. Dirigo started in January 2005, and as of December 2006, it covered about 13,290 people. It is very important to watch how this plays out.

A Framework for More Comprehensive Reform

- Establish a new group option for uninsured individuals and small businesses ("Congressional Health Plan"); includes federal reinsurance
- Tax credits for standard plan premium in excess of 5% of income (10% in higher tax brackets)
- Default enrollment through income tax system
- Public expansions:
  - Medicaid/CHIP/Family Health for everyone below 150% of poverty
  - Medicare buy-in 60–64 years old; elimination of disabled waiting period
- Employer COBRA expansions; young adults; "pay or play"

Figure 8.1
Toward Consensus
Source: Davis and Schoen (2003).

Health System Transformation to Improve Quality and Efficiency

There are other initiatives like the Rhode Island Care (RIte Care) program. This program gives targets to managed care plans to improve quality with respect to prenatal care, immunizations, and lead paint screening, and it awards bonuses to managed care plans that improve quality on those dimensions. They decided they would cover pregnant women two years' post-birth. Through their efforts, they slowed down second births and improved the health of the mother and the children. The women had so many fewer pregnancies that the net cost to cover these women for an additional two years' post-pregnancy was negative. In the last four or five years, costs have risen by about 80 percent with their RIte Care managed care providers (Silow-Carroll 2003). To put this in perspective, costs have risen by about 210 percent in commercial business over this period.

While health care costs are of concern to Americans, that doesn't mean they will accept cheap and inferior care. Instead, we should aim for approaches that improve quality at the same cost—maybe eliminating some overuse and reducing cost—and maybe also increasing the use of services that are currently underutilized.

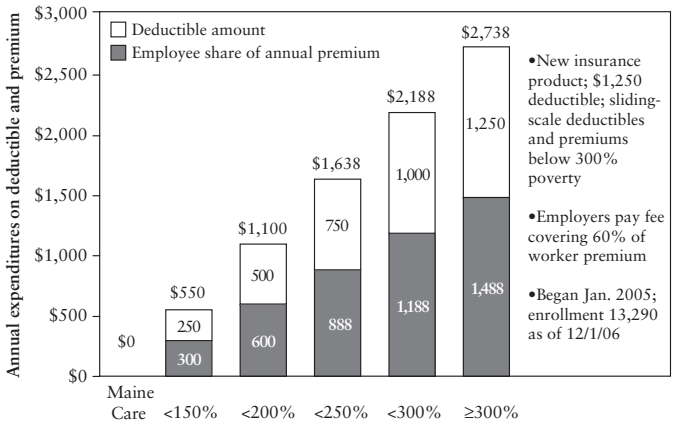

Figure 8.2
Retaining and Expanding Employer Participation: Maine's Dirigo Health
Source: Based on Dirigo Choice Health Plan 1 deductibles and Commonwealth Fund estimates of premium amounts. Employer contribution to premium not shown.

How could we improve quality? We have heard the information technology strategy. I would stress transparency. Let's make information on quality and cost public, and let's hold providers accountable and reward high-quality performance.

We also need to make a greater investment in information on comparative effectiveness. The United Kingdom's National Institute of Clinical Evidence reviews the cost-effectiveness of new drugs and procedures. In the United States, the Institute of Clinical Standards in Minnesota does the same. There is a tendency to equate greater efficiency with lower cost, but if you're not on the curve, you're not efficient—more patients could be cared for at the same cost. What's needed is to examine variations in cost and quality and spread best practices. Baicker and Chandra, for example, find that there is wide variation across states in the average quality of care and the amount of Medicare spending (Baicker and Chandra 2004). The more Medicare spends, the lower the quality. Most of us are used to curves that go the other way, so this is counterintuitive.

States like Iowa use a lot of primary care, so they have low costs and high quality (Figure 8.3). On the other hand, states like Texas and Florida use lots of specialty care, so they have high costs and low quality. If you take 30 percent of the money away from Florida, they will just slide down their curve; they won't go up to where Iowa is. To get the kind of results that Iowa has, you need to change the style of practice and shift the production function outward.

What can be done about efficiency? One strategy is direct contracting with accountable health care systems. There is a lot that can be done to reduce re-hospitalization by paying advance-practice nurses to follow patients home from the hospital. The Commonwealth Fund is funding an intervention that Aetna is doing in Pennsylvania with Mary Naylor, Mark

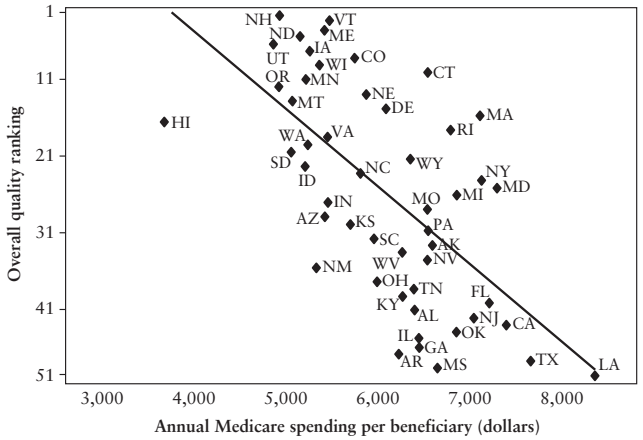

Figure 8.3
Variation in Quality and Medicare Spending Across the States of the U.S., 2000–2001
Quality expressed by percent of beneficiaries with atrial fibrillation who had Warfarin prescribed. For quality ranking, smaller values equal higher quality.
Sources: K. Baicker and A. Chandra, Medicare spending, the physician workforce, and beneficiaries' quality of care, *Health Affairs* Web Exclusive, April 7, 2004, using Medicare claims data; and S. F. Jencks, E. D. Huff, and T. Cuerdon, Change in the quality of care delivered to Medicare beneficiaries, 1998–1999 to 2000–2001, *Journal of the American Medical Association* 289, no. 3 (2003): 305–312.

Pauly, and colleagues that shows promise (Leatherman and McCarthy 2005). Efficiency can also be increased by using Medicare to foster high-performance health care through the use of primary care.

In general, there certainly *is* a way to have it all, in terms of better access, higher quality, and greater efficiency, if we move ourselves from clearly inferior points below the production function, up to the curve, and then have a societal debate about where we want to be on the curve. I think we should recognize that as new technology comes along, it probably is going to take higher spending to get the same, or better, quality care with that new technology. As the population ages, it probably is going to take higher spending to achieve care of the same quality.

It is important that savings be redeployed to improving health care. We cut $1 trillion out of health care with the Balanced Budget Act of 1997 and used the surplus generated to cut taxes in 2001 (Figure 8.4). We cannot continue to cut Medicare and Medicaid and use the savings to extend tax cuts. Funds are needed to help expand health insurance coverage, invest in information technology, and spread best practices.

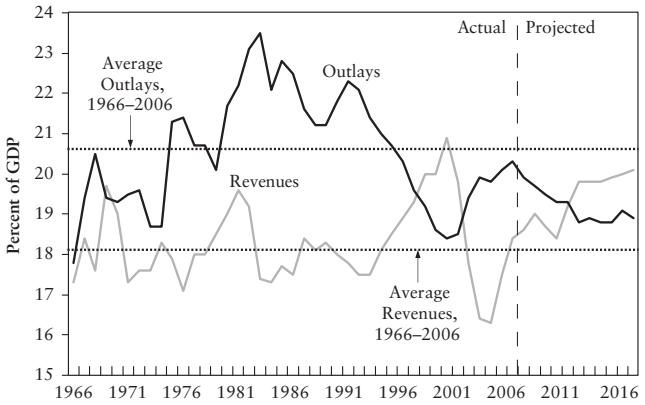

Figure 8.4
Tax Revenues: Currently at the Low End of the Historical Range
Actual 1962–2006; Projected 2007–2015.
Source: Congressional Budget Office, *The Budget and Economic Outlook: Fiscal Years 2008 to 2017*, January 2007.

We at The Commonwealth Fund have created a Commission on a High-Performance Health System. The basic charge to the Commission is to find policies that will simultaneously improve access, quality, and efficiency—whether that means ensuring the affordability of care for those with low incomes through expanded group coverage, high-cost care management, selection of a medical home, and/or more emphasis on primary care, better information, rewarding providers for performance, and/or developing networks of high-performing providers (The Commonwealth Fund Commission on a High Performance Health System 2006).

References

Baicker, K. and A. Chandra. 2004. Medicare spending, the physician workforce, and beneficiaries' quality of care. *Health Affairs*, Web Exclusive. http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.184v1.pdf. Accessed April 18, 2007.

The Commonwealth Fund Commission on a High Performance Health System. 2006. *Framework for a High Performance Health System for the United States*. New York: The Commonwealth Fund.

Congressional Budget Office. 2007. *The Budget and Economic Outlook, Fiscal Years 2008 to 2017*. Washington, DC: U.S. Congressional Budget Office.

Davis, K. 2007. *The Best Health System in the World* (President's Message, 2006 Annual Report). New York: The Commonwealth Fund.

Davis, K., A. L. Holmgren, C. Schoen, S. C. Schoenbaum, M. M. Doty, and J. L. Kriss. 2007. *Mirror, Mirror on the Wall: An Update on the Quality of American Health Care*. New York: The Commonwealth Fund.

Davis, K. and C. Schoen. 2003. Creating consensus on coverage choices. *Health Affairs*, Web Exclusive. http://content.healthaffairs.org/cgi/reprint/hlthaff.w3.199v1.pdf. Accessed April 18, 2007.

Fisher, E. S., D. E. Wennberg, T. A. Stukel, D. J. Gottlieb, F. L. Lucas, and É. L. Pinder. 2003a. The implications of regional variations in Medicare spending. Part 1: The content, quality and accessibility of care. *Annals of Internal Medicine* 138 (4): 273–287.

Fisher, E. S., D. E. Wennberg, T. A. Stukel, D. J. Gottlieb, F. L. Lucas, and É. L. Pinder. 2003b. The implications of regional variations in Medicare spending. Part 2: Health outcomes and satisfaction with care. *Annals of Internal Medicine* 138 (4): 288–298.

Hussey, P. S., G. F. Anderson, R. Osborn, C. Feek, V. McLaughlin, J. Millar, and A. Epstein. 2004. How does the quality of care compare in five countries? *Health Affairs* 23 (3): 89–99.

Institute of Medicine Committee on the Consequences of Uninsurance. 2004. *Insuring America's Health: Principles and Recommendations*. Washington, DC: National Academies Press.

Jencks, S. F., E. D. Huff, and T. Cuerdon. 2003. Change in the quality of care delivered to Medicare beneficiaries, 1996–1999 to 2000–2001. *Journal of the American Medical Association* 289 (3): 305–312.

Leatherman, S. and D. McCarthy. 2005. *Quality of Health Care for Medicare Beneficiaries: A Chartbook*. New York: The Commonwealth Fund.

Perlin, J. B. 2005. Information, measurement, and mission: Challenges and strategies for achieving excellence for veterans. Presentation to the Health Management Academy, West Palm Beach, Florida. April 23, 2005.

Regenstein, M., J. Huang, L. Cummings, D. Lessler, B. Reilly, and D. Schillinger. 2005. *Caring for Patients with Diabetes in Safety Net Hospitals and Health Systems*. New York: The Commonwealth Fund.

Schoen, C., K. Davis, S. K. H. How, and S. C. Schoenbaum. 2006. U.S. health system performance: A national scorecard. *Health Affairs*, Web Exclusive. http://content.healthaffairs.org/cgi/content/abstract/25/6/w457. Accessed April 18, 2007.

Schoen, C., R. Osborn, P. T. Huynh, M. M. Doty, K. Zapert, J. Peugh, and K. Davis. 2005. Taking the pulse of health care systems: Experiences of patients with health problems in six countries. *Health Affairs*, Web Exclusive. http://content.healthaffairs.org/cgi/reprint/hlthaff.w5.509v3.pdf. Accessed April 18, 2007.

Silow-Carroll, S. 2003. *Building Quality into RIte Care: How Rhode Island Is Improving Health Care for Its Low-Income Populations*. New York: The Commonwealth Fund.