Change The Expectations In Health Care

by Jonathan Shreve

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It is my premise that the primary reform that is needed within the health care system is a change in our expectations. Making it clear what we expect is the first step, and the second step is adjusting policies to be consistent with the expectations.

Note that clarifying expectations is not an easy task—there are many voices representing both broad and narrow interests, which can quickly turn the task of setting expectations into a long wish list of changes. I believe that there are two primary expectations which should be made clear:

- It is everyone's responsibility to have health insurance coverage.
- It is the health care provider's responsibility to achieve the most efficient and highest quality outcome by following the principles of evidence-based medicine.

With these expectations set, it is then critical to follow them up with the appropriate financial incentives, so that our actions and our words are consistent.

Accessibility: The Uninsured Problem

The working assumption for many years has been that we have a large number of uninsureds because of barriers in the system, such as high price or medical underwriting restrictions. Remove the barriers—we have assumed—and we can fix the problem. With that as a hypothesis, a number of states have proceeded to remove the barriers, with little effect. States from Maine to Washington have introduced low cost options for people with relatively lower incomes—some as high as four times the federal poverty level—only to get a very low percentage (in the 10 percent range) of the uninsured to take the option.[1] Even free expansions of Medicaid often experienced take-up rates of only 30 percent.[2] Other states have put in restrictive rules on medical underwriting and/or community rating to find a similar result—little change in the uninsured rates.[3] If you build it, they still won't come.

Along comes Massachusetts, and it breaks down the same barriers that the other states have broken down, but it also includes a tax penalty for individuals without health insurance. The take-up rates skyrocketed from the experience of all the other states. The tax penalty was well below the actual cost of insurance. I would argue that it was not the economic incentive to get health insurance by itself that caused the change, but more importantly the expectation that you should have coverage that drove the much higher take-up rates. As a society, we have expressed this view for auto insurance and even quitting cigarette smoking to great effect. As the expectations are set, we often start to back them up with laws, but I believe the greatest impact comes from setting the expectation. In Massachusetts, the take-up rates were nearly 54 percent,[4] and the number of individuals without health care insurance has decreased by 324,000 in the first year of the legislation (2006).[5]

Affordability And Efficiency

We currently rely on subsidies in order to remove the barriers to getting coverage. Governments subsidize the lower income individuals, employers subsidize employees, and the younger healthier individuals subsidize the older less-healthy individuals. To some degree this will always be true. Sometimes those subsidizing others cannot afford the subsidy. Even if they can afford it, there is always an alternative economic use that the money could be put toward (from other investments to lowering prices or taxes). We all understand that health care is very expensive in the United States, and it is expensive in other parts of the world. Medical costs in the United States have steadily outpaced inflation and now comprise over 16 percent of the Gross Domestic Product (GDP). This figure is projected to increase to 20 percent in the next 10 years.[6] It is critical that we find a way to reduce the cost of health care, and in turn reduce the burden of this cost on the subsidizers and on the direct purchasers.

In health care, less can be more. When back surgery and bed rest have equivalent clinical outcomes for certain

types of back pain, why would you attempt surgery? Other than optimal care is delivered in many situations and for many reasons. The reasons include out-of-date information, the wrong financial incentives, bad habits and inefficient structures. The result is bad care and bad outcomes for patients and inefficient use of resources. The inefficient use of resources also means that other patients may get no care at all. In the United States, the more treatments that are given, the more the providers are paid, independent of the value of the intervention.

This leads to the second expectation I think we need to set: it is health care providers' responsibility to achieve the most efficient and highest quality outcome by following the medical evidence. Further, because this is our expectation, our payments to providers need to reflect that. Recently, CMS has stopped paying for "never" events, like surgery on the wrong body part. This is a good start, but its expectations are significantly below the level I suggest. Recent movements toward pay for performance or medical home are also moves in this direction, but all are within the context of more is better. In a fee-for-service system, each additional service generates an additional fee.

Private sector evidence-based medical guidelines are well established, and the vast majority of third-party payers rely upon them to determine the medical effectiveness. (This is best left to the private sector, as public efforts get bogged down in politics, are less likely to be deployable, and rarely get updated in a timely fashion.) This same level of evidence-based guidelines needs to come to the bedside, and we need to expect physicians to follow these guidelines in each decision they make.

During the 1990s, more physicians were paid based upon treating a number of patients, rather than upon the volume of services generated. Some of the early forms of capitation were not as refined as you might like, and they led to "managed care backlash." However, during the 1990s, medical cost trends were at a lower level than they have been before or since. This was a partial and imperfect beginning to paying our providers consistent with our expectations. One payment solution that has been suggested is offering risk-adjusted payments for episodes of care.[7] Under this reimbursement arrangement, insurers and other payers pay all hospitals or medical professionals fixed amounts per episode of care depending on the condition being treated. Restructuring the payment system has the ability to produce a powerful motivation for health care providers to perform only those procedures consistent with the medical evidence. A system that is driven by results rather than services will allow physicians to be more efficient as they focus on necessity rather than the quantity of services.[8]

Policies Versus Expectations

Most government actions start with one set of rules, and pile more sets of rules on top of those. It is good business for lawyers and other professional advisors, but they usually don't add much stimulus to the economy. Of course, some element of this is necessary, but how far should it go?

In your own workplace, would you rather be subject to a long, detailed list of policies (as most of us are) regarding all form of behavior in your office, or would you rather be given a core expectation—we expect you to treat others with respect, act professionally, and don't do anything stupid. I believe most of us would prefer the latter, and the result is better outcomes.

Of course, changing expectations is actually cultural change, with culture reflecting our country's shared attitudes, values, goals and practices. Individuals learn much of our culture through everyday habits—we all assume that service providers should get paid for each service they perform. For major cultural shift to happen, it usually takes multiple leaders demanding the change, and focusing their behavior on making that change. These leaders come from many sectors—much of the health

care change in the past has been demanded by employers and then reflected by the health care community. In the future, we will need leaders from employers, health plans, health providers and government to accomplish the level of changes we wish to make.

When President Obama starts health care reform, I would much rather that he state these two expectations than to send his policy wonks into action. Although the latter would likely be better for my business.

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[1] *Take-up rate based upon Milliman Analysis and the following sources: Lipson, D., J. Verdier, L. Quincy, E. Seif, S. Shulman, and M. Sloan. "LEADING THE WAY? Maine's Initial Experience in Expanding Coverage through Dirigo Health Reforms." November 2007. Mathematica Policy Research, Inc.* http://www.mathematica-mpr.com/publications/pdfs/Dirigofinalrpt.pdf
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[2] *Take-up rate based upon Milliman Analysis and the following sources: S.Artiga and C. Mann. "New Directions for Medicaid Section 1115 Waivers: Policy Implications of Recent Waiver Activity." Kaiser Commission on Medicaid and the Uninsured. March 2005. Kaiser Family Foundation.* http://www.kff.org/medicaid/upload/New-Directions-for-Medicaid-Section-1115-Waivers-Policy-Implications-of-Recent-Waiver-Activity-Policy-Brief.pdf
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http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/downloads/NJFamilyCareFactSheet.pdf

[3] *Sloan, F. A., and C. J. Conover. "Effects of State Reforms on Health Insurance Coverage of Adults." Inquiry 35 (1998): 280-93.*
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[4] *Take-up rate based upon Milliman Analysis and the following sources: Long, S. K. "Who Gained the Most Under Health Reform in Massachusetts?" Commonwealth Fund. October 2008.* http://www.urban.org/UploadedPDF/411770_Gained_Massachusetts.pdf

[5] *Holahan, J. and A. Cook. "The Decline in the Uninsured in 2007: Why did it happen and can it last?" Kaiser Commission on Medicaid and the uninsured. October 2008.* http://www.kff.org/uninsured/upload/7826.pdf

[6] *Keehan, S. et al. "Health Spending Projections Through 2017," Health Affairs Web Exclusive W146: 21 February 2008.*

[7] *"From Volume to Value: Transforming Health Care Payment and Delivery Systems to Improve Quality and Reduce Costs." Rep. 14 January 2009. Robert Wood Johnson Foundation.* http://www.rwjf.org/files/research/nrhiseriesbettewaystopay.pdf

[8] *Kahan, S. "Creating Value-Based Competition in Healthcare." Essays on Issues: 254a.*