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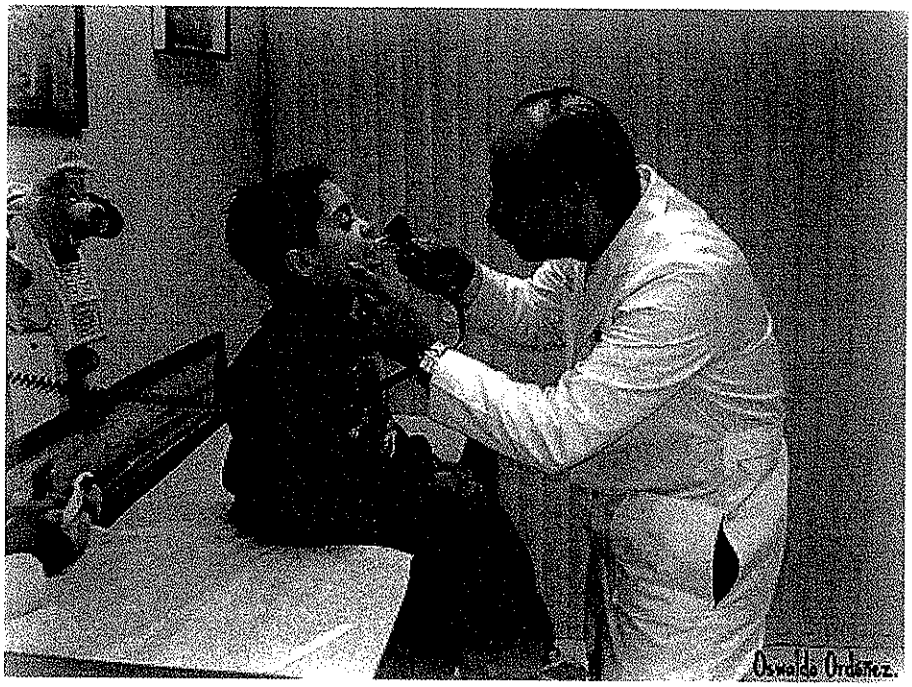
HEALTH / MEDICINE

Fixing Healthcare, Part One: An Inventory of Cost-Containment



For the past few weeks, I've been talking with healthcare experts with a variety of perspectives, trying to discover coherent principles for overhauling American healthcare. This requires, in my view, testing every idea against its likely effect on the real people who provide healthcare services and on the real people who need those services. What's ultimately required is to change the *culture* of healthcare delivery.

Congress doesn't seem to be tethered to the realities of healthcare delivery, and its proposed bills seem to have been tossed in a storm of special interests. The refusal of the Democratic

leadership to consider pilot projects for more reliable systems of justice--see my recent op-eds in the *Wall Street Journal* and *Washington Post*--is just one example of special interests trumping the needs of the common good.

It's hard to put pressure on Congress without a coherent point of view of what a new system should look like. In the first part of this post, I describe the aspects of current healthcare that drive up costs and must be addressed by a new framework. In the second part, I describe a framework for reform which would provide universal coverage with incentives to contain costs.

Part One: An Inventory of Cost-Containment

The healthcare debates have focused on ways to expand coverage--by mandates, by a public option, and by various forms of subsidy. But the underlying problem remains one of affordability, and, specifically, how to bring efficiency to a healthcare system notorious for its inefficiency.

Few concrete solutions have emerged because the healthcare industry itself is not sure what to do--its economic model is the product of the bureaucratic reimbursement and regulatory framework that drives providers towards always doing more. Moreover, the Congressional Budget Office cannot "score" most proposed solutions because it is impossible to quantify with any precision the main drivers of inefficiency--for example, the fee-for-service delivery model, or the amount of defensive medicine--or to quantify the potential savings of changing the legal and reimbursement framework.

Cost-containment can be viewed through many perspectives, which often overlap--for example, ineffective chronic care can be viewed in part as a problem of fee-for-service reimbursement. But categories of waste and inefficiency can nonetheless be identified, which any reform package should attempt to address. Here they are:

1. Chronic care. Care for chronic illness--mainly diabetes and heart disease--accounts for roughly 75 percent of all healthcare costs. About half of this is attributable to obesity, smoking, and other bad habits. There are several potential ways of cutting these costs:

   --First, create incentives and other programs for healthier lifestyles. Safeway offers its employees reductions in premiums for losing weight and quitting smoking.

   --Second, change the model of care delivery, from fee-for-service to a capitated "medical home" (or "accountable care organization"), in which providers are paid so much per patient per year, with incentives to push patients towards healthier lifestyles and with pay-for-performance adjustments to reward providers who succeed. There was a discussion among leading experts at NewTalk.org. Much of this work requires the work of social workers, not expensive healthcare professionals. Most experts agree on the need to shift to a medical home model; there is less agreement on how to get there.

2. End-of-life care. Nearly one-third of Medicare's yearly expenditures are on patients in the last year of their lives. There is a wide disparity in care for terminal illness, especially for the elderly. Palliative care in a home or hospice setting is often the most humane solution, but many doctors feel compelled to try to "cure" old age with dramatic and expensive interventions. Sometimes these are driven by an insistent child, sometimes by fear of lawsuits, sometimes by medical self-interest. Professor Marshall Kapp and Dr. Diane Meier review some of these problems.

   The solution to inappropriate interventions at the end of life is not to put government in the position of making life and death decisions. But there must be a reliable legal framework in which doctors feel comfortable offering ethical leadership in end-of-life situations. Third Way provides an excellent summary of the situation and its solutions. Committee for Economic Development (CED) fostered a discussion on its sponsored 2007 proposal, beginning on p. 38.

3. Over-treatment. The pioneering work at Dartmouth by Dr. John Wennberg and colleagues exposed the inconvenient fact that healthcare is often driven by supply of doctors and machines, not by need for care. Costs in Florida are almost double that in Minnesota, with no better outcomes. The recent report in the *New Yorker* by Dr. Atul Gawande revealed th[redacted]Wire[redacted]xas are almost double that in El Paso, with no better results[redacted]d to be that doctors in McAllen had become entreprene[redacted] clinics, buying expensive diagnostic equipment and then giving their patients the works--paid for by the clunky fee-for-service reimbursement schedules.

   The solutions for over-treatment include:

   --Change the reimbursement model for primary care and chronic care, migrating from fee-for-service to a capitation model with pay-for-performance adjustments. To avoid under-treatment, there needs to be end-of-year audits to review effectiveness. The CED report sited above provides descriptions of successful models, starting on p. 41. Making this transition is unavoidably complex. The best approach, which is embodied in various proposals but not in a simplified form, is to provide a voucher redeemable at a "health exchange," offering annual coverage at a fixed price. This has the enormous potential advantage of driving insurers and providers to a capitation-based model of delivery for the simple reason that fee-for-service providers will become uncompetitive. I discuss this in the second part of this post.

   --Eliminate incentives for "defensive medicine." Fear of unreliable justice, and apprehension at the prospect of years of gut-wrenching litigation whenever there is a malpractice claim, have corroded the culture of healthcare delivery, such that many doctors seem to focus on self-protection as much as the needs of the patient. The solution is a reliable system of justice that renders consistent rulings based on standards of care, not a jury-by-jury system that encourages inconsistency and

thrives on emotion. A broad coalition has come together behind the idea of special health courts, developed jointly by Common Good (which I chair) and the Harvard School of Public health, with funding by the Robert Wood Johnson Foundation.

--Some believe that patients must have more "skin in the game," with substantial co-pays for expensive diagnostic tests and optional surgery. This is part of the logic of health savings accounts. Substantial co-pays would need to be means-tested, so that those without resources would not be disadvantaged. One defect of health savings accounts is that they encourage saving the first dollar, when most experts, including Professor Tim Jost, believe there should be more spent on primary care, in order to avoid expensive care later on. A better option is to provide care for everyone on a fixed annual fee, but create a list of optional interventions that require significant co-payments by the patient or the employer--in effect, defining a baseline of care.

4. Bureaucracy and Overhead. Administrative costs have been estimated to account for about 11.5 percent for private insurers, 3.8 percent for Medicare and Medicaid, and some larger number for diversion of time by providers for reimbursement and legal compliance. (The CED report elaborates on this idea on p. 29, as does Uwe E. Reinhardt). The fee-for-service model is notoriously inefficient: reimbursement paperwork for each aspirin and syringe administered and a costly gatekeeper function for each intervention. Private health plans are criticized for adding overhead, especially compared with Medicare and public plans, but some of that difference is offset by the losses to fraud and abuse in public plans and by disease management services provided by insurers. More could be saved if insurers agreed upon common forms and protocols.

   The transition from fee-for-service to capitated payments will reduce much of this overhead. Creating accountability mechanisms that rely on audits at the end of the year to evaluate the appropriateness of services already rendered, not a gatekeeper function for each and every intervention, should also reduce overhead costs. Probably the best way to enforce guidelines on "comparative effectiveness" (for example, avoiding costly and unnecessary CT scans for a headache) is through penalties and bonuses following year-end audits, not arguments over each and every medical decision. Another layer of overhead are the middlemen who broker health plans to groups and individuals, adding 2 to 6 percent in the group market, and much more for individual plans. A public exchange should eliminate the need for brokers for individual policies.

5. Barriers to Productivity. Healthcare is delivered in a legal jungle, thousands upon thousands of rules that require compliance. The body of unknowable law also contributes to a mindset of inertia. When in doubt, do it like it was done yesterday. Most doctors don't use email because it leaves a written record that might be used against you in a lawsuit, and might unintentionally violate requirements of privacy. Email communications are also not reimbursed. Innovation is not on anyone's top list of priorities, and, in any event, will usually be squelched by the

risk managers, who basically have the job of saying no to anything new.

Better productivity requires incentives to innovate, which the shift from fee-for service to a capitated model with pay-for-performance incentives should provide. Better productivity also requires legal trust and legal clarity: providers must feel free to focus on better care, not self-protection or unnecessary bureaucratic compliance. Special health courts will allow providers to rely on sound medical judgment. A medical Federal Reserve can offer oversight and draw lines on what's needed. Legal uncertainty is the enemy of innovation, and of productive activity generally; I have a few suggestions to remedy the issue.

(Photo Credit: http://www.flickr.com/photos/orcoo/345583754)

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Comments (8)

D Perkins **August 6, 2009 5:01 PM**

Thank you for providing such an informative article. There is one point however that needs correction. Most Health Savings Account (HSA) compatible High Deductible Health Plans (HDHP) provide first dollar, zero cost coverage for preventative care. Some HDHP plans charge a small copay not subject to the higher annual deductible of an HDHP. Multiple studies on healthcare utilization comparing traditional coverage to HDHP plans show individuals with HSA compatible coverage are far more likely to have annual exam and take part in wellness programs and smoking cession programs than individuals on traditional coverage. So the assertion that "One defect of health savings accounts is that they encourage saving the first dollar, when most experts, including Professor Tim Jost, believe there should be more spent on primary care, in order to avoid expensive care later on." is factually inaccurate. Regards, D Perkins San Jose.

REPLY

Philip K. Howard (Replying to: D Perkins) **August 6, 2009 7:31 PM**

This is helpful. Thank you. Do you have a cite to the study on better habits of those with health savings accounts? Best, Philip K. Howard

REPLY

Kris (Replying to: Philip K. Howard) **August 7, 2009 5:24 PM**

Both CIGNA and Aetna have studied the results of their members who are in HDHPs with HSAs or CDHPs with HRAs. I can e-mail you a couple of articles if you like. D Perkins is correct about their results.
Also, to zic: You are thinking about FSAs, which have the "use it or lose it" feature. HSAs roll over each year. But, to have an HSA you must also have an HSA-qualified High Deductible Health Plan.

REPLY