Data Needed on Consumer-Driven Health Care

HMO leader calls for more information on providers, outcomes; advocates electronic medical records.

BY JOYCE FRIEDEN
Associate Editor, Practice Trends

WASHINGTON — Consumer-driven health care may be the "next big thing" in health insurance, but it won't go anywhere until more data on plans, providers, and outcomes become available, George Halvorson said at a health care congress sponsored by the Wall Street Journal and CNBC.

"It's time for an industrial revolution in health care," said Mr. Halvorson, who is the chairman and CEO of Kaiser Foundation Health Plan, Oakland, Calif. "We need to set a much higher standard for ourselves as an industry."

He noted that many major and expensive trends in care "too often lack scientific backing," citing the examples of hormone therapy for heart attack prevention in women, knee surgery to relieve osteoporosis pain, and cyclooxygenase-2 (COX-2) inhibitors for arthritis pain, where the therapy turned out not to work as well as expected.

"These are significant issues. Because there's no consistent database in health care, people did not realize this kind of outcome was happening with something that was a very popular treatment," he said.

Mr. Halvorson recommended that health care executives follow the example of other industries that have turned themselves around.

For example, General Electric instituted a program of "measure, analyze, improve, and control" to weed out errors in its manufacturing process.

Health care doesn't do any of those four steps with any great consistency, he continued. "Where does health care get the data that are used? We get it from paper medical records, which are not even complete per patient."

For instance, Mr. Halvorson said, "we have one patient, four doctors—four unrelated, unconnected, noncommunicative, nonintuitive, noninteractive, too often inaccessible, and often illegible, paper medical records from which to derive the database."

In addition to the well-known data-collection tools such as electronic medical records (EMRs) and computerized physician order-entry systems, the health care system also should be systematically collecting other information, such as whether patients fill their prescriptions, Mr. Halvorson said.

Another subject about which more data are needed is the hospital shift change, "the most dangerous time to be in the hospital," he said.

"It takes an average 43 minutes to do a shift change [and exchange information about patients], and during that time, patients are hitting their buzzer and taking their own steps to the restroom and falling," Mr. Halvorson commented at the meeting.

"This is literally when accidents happen. And the information transferred in that process is not all that accurate. By automating that process, you can take the shift change from 43 minutes down to 12, improve patient safety, and significantly improve the quality and accuracy of data that are involved." he said.

Although the United States health care system is better than it has ever been, and the technology is better than it has ever been, "we will not be able to realize the full potential of it until we can get an information flow, and the flow has to come from an EMR," Mr. Halvorson said. He added that a single nationwide EMR system would not be necessary as long as local systems could transport data to one another if needed.

To make data collection part of the national agenda, the impetus needs to come from a large government program like Medicare, according to Mr. Halvorson.

"Medicare is the key, and hospitals are the leverage point," he said during the meeting.

"Medicare accounts for about 40% of hospital revenue," he added. "If Medicare decided to do this, it could make this happen with a rewards system … relatively quickly. Investment dollars are needed, and Medicare needs to support that." ■

Incremental Changes Called Key to Health Care System Reform

BY JOYCE FRIEDEN
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WASHINGTON — Consumer-driven health care may be all the rage right now, but there's no single cure for the nation's ailing health care system, several experts said at a health care congress sponsored by the Wall Street Journal and CNBC.

"There are no silver bullets," said Douglas Holtz-Eakin, Ph.D., director of the Congressional Budget Office (CBO). "There is no single item—technology, disease management, tort law—that is likely to prove to be the answer to aligning incentives, providing high-quality care at reasonable costs, and financing it in a way that's economically viable. More likely, we'll have a series of incremental changes" that will shore up the system.

"Rising health care costs represent the central domestic issue at this time," Dr. Holtz-Eakin said. For example, over the next 50 years, if nothing is done, "the cost of Medicare and Medicaid will rise from 4% of the gross domestic product to 20%—the current size of the entire federal budget."

Because the population is aging, "we indeed may spend more than we do now" on health care, Dr. Holtz-Eakin continued. "But the key issue is to make sure we do not overspend, that the dollars per unit of high-quality care match up with our desires."

Robert Reischauer, Ph.D., a former CBO director who is now president of the Urban Institute, noted that Medicare was a particular concern, since Medicare spending is expected to grow very rapidly over the next 10 years. He listed four possible solutions for the Medicare budget crisis.

The first possibility is to reduce the scope of coverage, but "that isn't a practical course of action," he said. "All forces are moving in just the opposite direction."

Another option is to restrain the growth in payments to providers, but already, Medicare is considered "not too generous," compared with private payers, since it pays on average only about 80% of the private rate. "[Payment restraint] is clearly not going to happen," he said.

The third option is to make beneficiaries pay more for care in the form of higher premiums, deductibles, and cost sharing.

"Some people think that will cause beneficiaries to purchase more rationally and cut out low-value services, but we have to remember, the vast bulk of spending is on individuals who are very sick, have many chronic conditions, and aren't in a position to comparison-shop," he said. "Moreover, the services that they're purchasing are extremely complex and confusing, and providers play a very significant role in determining the demand for and type of services received by beneficiaries.

There is no single item that is likely to prove to be the answer to aligning incentives, providing high-quality care, and financing it in a way that's economically viable.

"Before we bet the ranch on this approach," he continued, "we're going to have to see what happens to spending patterns among the under-65 population as they are faced with high-deductible plans, health savings accounts, consumer-driven health plans, and other approaches to incentivize them to purchase more rationally. If this proves to be a successful approach for the under-65 population, one can see it gradually angling into the bag of tools that Medicare has."

However, Dr. Reischauer noted, the potential for shifting more costs onto beneficiaries is limited, "because they already spend a considerable amount of their incomes on Medicare cost-sharing of one sort or another. By 2025, the average 65-year-old Medicare beneficiary will be paying more than the size of their Social Security check in cost-sharing and deductibles."

A fourth approach is to restructure Medicare in ways to generate competition among providers, Dr. Reischauer said. This would mean emphasizing technologies that improve efficiency, such as electronic health records and electronic prescribing. It also would involve decreasing the volume of unneeded services being provided.

He noted that researchers at Dartmouth University have looked at health care utilization across geographic areas and found that beneficiaries receiving higher volumes of services generally have poorer health outcomes, even after differences in their health status are accounted for.

"It's conceivable that as our ability to measure differences in quality and to reward quality effectively improves, the Medicare system could be transformed into one that pays only for care which is both necessary and beneficial, but this is likely to be a long and difficult row to hoe," he said.

Gail Wilensky, a former administrator of the Centers for Medicare and Medicaid Services who is now a senior fellow at Project HOPE in Bethesda, Md., expressed disappointment that Congress did not do more to address the issue of rising costs when it passed the Medicare Modernization Act of 2003. That law "is a good example of eating dessert first," she said. "There was an opportunity to try and slow down spending in a significant way while a new benefit was being introduced, but primarily, what [the law] does is provide a new benefit and some additional payments to providers of services, but not very much in terms of trying to restructure Medicare for the future."

One little-known provision of the law does attempt to address the cost issue, she added. "Starting in 2007, Part B will be much more related to income. The subsidy will start declining significantly for those with higher incomes. As the baby boomers begin to retire, some of them with higher incomes and assets, this is at least one opportunity" to help with the cost problem.

Americans are going to need to rethink the entire issue of retirement, predicted Dr. Wilensky.

"A couple of weeks ago, [Rep.] Bill Thomas [R-Calif.] talked about the need to think about Social Security and Medicare together. Both represent transfers from the working population to the dependent, nonworking population. To begin thinking about this as a joint issue may allow us to make more sensible decisions," Dr. Wilensky said.

For example, Americans should consider "how we can change both fiscal policies and cultural expectations so our whole concept of retirement begins to … reflect the increasing longevity and, for many individuals, the increased well-being and health status they have at age 65 relative to what 65 meant when Medicare was introduced in 1965," she said. "We need to think about fiscal policies to encourage continued labor force participation for people at 65 and 70." ■