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Chairman Kennedy, Chairwoman Mikulski, Ranking Member Enzi and members of this Committee, thank you for inviting me here today to talk about health care quality and improving health care value for every American.

My name is Elizabeth Teisberg. I am a tenured professor at the University of Virginia and co-author of Redefining Health Care.[1]

Access, Measurement and Payment: Key Dimensions of Health Care Reform

Improving our nation's health care is an urgent priority, made more critical by the current economic crisis.

- Health is essential to productivity – if health is undermined because of tough economic times, the nation becomes less productive, less competitive, and less able.
- The health sector is a large and vibrant part of our economy and te economic recovery will be stronger and faster with an effective and efficient health sector. There is no greater short or long term economic

[1] M.E. Porter and E.O. Teisberg, 2006, **Redefining Health Care**, Harvard Business School Press, Boston, MA.

stimulus than attending to the health of Americans. We must keep and expand meaningful jobs that create value by enabling health.

- The crisis in health care that preceded this economic downturn remains and won't disappear simply because of a recession. The problems are well known: costs are spiraling upward while quality in care and outcomes suffers from wide variance; good practice is undermined by inconsistencies in care, disjointed coordination and poor communication hinder care and hamper health outcomes; alarming numbers of deaths and serious injuries result from preventable medical errors, and over 40 million Americans lack the health insurance that would provide appropriate access to preventive and early stage care.

Action on health care reform is a critical priority for the nation. For over a decade, repeated efforts to contain health care costs have met with, at best, limited success. To change that result, to create a world-leading health care system, the nation needs clear, new goals, new policies that are rapidly implemented and a government structure that prompts, supports and rewards ongoing and dramatic improvement. My recommendations address **access**, **measurement** and **payment –** issues essential for quality and for success. But first, consider the goal of genuine health care reform.

The Goal of Improving Health for America

The Goal of Health Care is Health, so the Goal of Health Care Reform must be to Improve the Value of Health Care

I am neither a physician nor a Washington health policy insider. My expertise in this field comes as a scholar and professor of Innovation and Strategy, as a Ph.D. in engineering economic systems analysis, and as the mother of a child who was chronically ill and in pain for most of a decade before his full and complete recovery. As a professional, and as a mother, I have questioned the conventional wisdom that has blocked change and retained a system that everyone agrees could be significantly improved.

The real goal of health care is health. Yet, policy discussions are often framed as if the goal of health care delivery were cost reduction. If the goal of health care was simply cost reduction, the solution would be to offer pain killers and compassion. Clearly, that is not the solution for health care in our nation. Successful health care reform efforts must do more than cut costs. **The real goal of health care reform is, and must be, to drive dramatic and ongoing improvements in the value of health care.** This means improving health care outcomes relative to the cost of achieving these outcomes.

Improving value in health care means improving health care outcomes for the money spent. This is a critical idea and an intuitive one. In most choices, people seek value – not the lowest cost regardless of poor quality, and not the highest quality without regard for cost. The tremendous opportunity in health care is how powerfully improvements in quality actually drive costs down. To see this, one must simply recognize that **Americans desire more health, not more treatment**. Improvement in health care need *not* mean more treatment and more cost. Often, improved quality means more effective treatment, better health, and *lower* costs. The essential insight is this: **Living in good health is inherently less expensive than living in poor health**. Improving health, improving the quality and the value of health care will save money, not cost money.

In this era of chronic disease, there is clear evidence that costs can be lowered through quality.

- Stroke is the leading cause of long term disability. Preventing a stroke or fully recovering from a stroke are – in every circumstance - less expensive than long term disability.
- Diabetes has become a pandemic, and people with diabetes have four times the health care costs of people without diabetes. Preventing disease progression and enabling people to live in ongoing health is far less expensive than paying for the compounding problems of amputations, heart disease and blindness. Healthy Americans work, provide for themselves and their families and pay taxes. Those afflicted with diabetes, and without access to effective care, can do less of those things.

- For breast cancer, early treatment enables better results at lower costs. A woman with stage one cancer may be cured. A woman whose disease has reached stage 2B will face more invasive, more expensive care with less promising results.
- For any disease, quality of diagnosis is critical: a wrong diagnosis leads to care that costs time, wastes money, and adds risk and discomfort.

In example after example, **improving health outcomes reduces costs**. Some of the savings result from reduction of waste and errors in the current fragmented organizational structures. Even more significant gains come from restructuring care into teams, coordinated over the full cycle of the patient care. Innovation in the structures of care delivery can yield better prevention and improved solutions for patients and families. In spite of the conventional wisdom, we *can* afford to improve quality. **Improving quality will drive dramatic improvement in value.**

Health policy reform can and should use improvement in health outcomes to drive down costs, rather than bowing to cost pressure and pushing down quality of health care or undertaking more efforts (and more administrative expenses) to limit access to care.

Why Results-Driven Competition?

Results-Driven Health Care will improve value more than Government-Driven or Consumer-Driven approaches

In most sectors of the economy, the dynamic of competition drives improved value. In a functioning market, both quality and efficiency increase over time. But health care has been different. Quality has suffered while costs have increased. Waste is rampant. Why?

The problem in health care isn't too much competition or too little. The problem in health care is the wrong kind of competition. Health care lacks positive sum competition to improve value in health care. Instead, health care is

replete with examples of zero sum competition that shift costs through the exercise of bargaining power. Today's competition occurs among systems of providers and health plans over capturing contracts and resources, shifting costs to each other, to employers, to the government and to consumers. This zero sum competition destroys value, rather than creating value for patients. Health policy reform needs to disable the gains from zero sum competition. A key implication of this insight is that universal access is essential to effective, value-creating competition in health care.

The right competition is competition to increase value – to improve health care results. In positive sum competition, the patient wins with better health outcomes, the clinical team succeeds professionally, and the employer, government and health plans gain through more efficient care and increased productivity. **Policy needs to support positive sum competition.** This means that policy needs to require measurement of health care outcomes. Value is created in improving the health and health care outcomes of people.

Productive competition is one of the most powerful forces for change, for economic stimulus and for improvement. As President Obama stated in his inaugural address: *the question before us [is not] whether the market is a force for good or ill.* The market is a powerful force for change, and the right kinds of policy can set a dynamic of positive competition and increasing health care value for all Americans.

Universal Access

Access for All Americans is Essential not only for Equity, but for Economic Efficiency

The dysfunctional competition in American health care is endlessly fueled by opportunities for one party to shift costs to another, to win by forcing another party to lose, rather than to win by creating value, by improving health and health care outcomes. To stop the cost shifting games, everyone must be brought into

the system. As long as parties gain by avoiding serving the uninsured, the tremendous energies to win at cost shifting will continue. **Shifting costs does not create health care value.**

Lack of access reduces efficiency, shifts costs and, overall, raises costs of U.S. health care.

- Those without access to early stage and preventive care tend to seek care only after problems have advanced. **Treatment for later stage disease is both more expensive and less effective.** This is part of the reason why every country with some form of universal coverage has lower per capita health care expenditures than does the United States. It is simultaneously more effective and less expensive to treat early stage disease and prevent disease progression.
- In this country, **everyone may go to the emergency room, but thousands lack access to care in less expensive, more effective settings**. Those who argue that U.S. emergency rooms offer access for all must recognize that this is the highest cost way to provide access. Emergency rooms are not the venue for treating chronic disease or delivering preventive care. Emergency room physicians and nurses cannot create coordinated care for people who lack access to care in other settings. The efficiency gains from better coordinated care are unattainable with today's limited access.
- An enormous amount of effort goes into shifting and recovering the expenses of uncompensated care. These efforts create no value. Instead, they reduce value by **increasing administrative costs**. Costs of uncompensated care end up raising the charges to employers, the government and other patients, adding to the upward cost spiral.

There will be transitional costs in giving everyone access to more appropriate health care settings and at earlier points. Over time, however, it will be more efficient and more effective for all to have access to care and to dispense with the cost shifting efforts that consume vast amounts of resources without creating value for patients.

Achieving Universal Access through Mandatory Coverage

Mandatory health plan coverage is the surest way to achieve universal access. This will require vouchers or subsidies, in appropriate amounts, for those who need them. The obvious objective is universal coverage, not simply expanded access with the known holes and obvious incentives to continue cost shifting. Gains from reducing administrative costs will be largely sacrificed by expanded coverage that is not truly universal.

Universal coverage (with measured results) will enable quality gains. With a health plan, every person becomes a paying customer. That creates incentives to provide quality care for all.

Universal coverage will also need rules that require all payers to cover their fair share of the most expensive patients. Financial risk pooling can address this, so that payers who cover more of the highest risk members receive an allotment that is collected from those who cover the lower risk members. This reduces the incentives for cherry picking only healthy customers. It is worth noting that the often-touted Swiss system has used a risk pooling mechanism for decades. The alternative of high risk health plans that are insurance of last resort for the sickest people leave in place the incentive for insurers to dis-enroll or discourage potentially expensive people.

The other essential enabler of universal access is a list of what insurance must cover. Clarity that reduces arguments about coverage creates enormous administrative savings. Of course, health plans could cover more than the minimum, but the minimum must be specified to make coverage meaningful. A logical starting point is to use the requirements for the Federal Employee Health Benefits. Simultaneously with starting mandatory coverage, a panel of experts could be convened to make recommendations about adjustments to the required coverage.

But universal access alone will not fix the system or contain rising health care costs. In the current structure, quality care for all will be difficult to achieve or afford – perhaps impossible. Neither incremental change nor waste reduction

within the current structure will yield enough improvement. The nation needs significant innovation and improvement in health care delivery to achieve a dramatic increase in value for patients. **With improvement in value – the health outcomes per dollar spent – better care will be available to more people.**

Universal access must be accompanied by measures that refocus health care on improving value for patients (and people who need not become patients). ***The single most important step that Congress can take to improve health care value for Americans is to commit to measuring results. The adage applies: what is measured improves.***

Results Measurement

Measuring Results will Unleash Significant Improvement in Value

Measuring results – health outcomes and costs —is critical to enable and drive improvements in value. **Achieving universal access will be far less expensive in a results-driven system where positive sum competition improves value.** Without improvements in the value of health care, the nation will face increasing health care rationing of some form, whether it is explicit rationing of services, waiting lines or degradation of quality. But none of that is necessary or inevitable.

The most critical policy step for enabling improvement in value is to begin results measurement. Through meaningful outcomes measurement, clinical teams are able to accelerate learning about what truly improves health outcomes and what improves the efficiency of effective care. A decade of process measurement has not yielded these desperately needed improvements. Results – the improvement in a patient's health – must also be measured. The health outcomes of care are what matter to patients and families, to the professional success of clinicians, and to the productivity of the American work force. Health outcomes drive value.

The Senate cannot, should not and does not need to specify the exact measures to be used. However, **the Congress must require outcome**

measurement. The Department of Health and Human Services can give the task of developing measures for given medical circumstances (e.g. stokes, diabetes and its co-morbidities, asthma, heart disease, etc.) to not-for-profit organizations, or to established medical boards. The Society of Thoracic Surgeons has been measuring health outcomes for a decade and its efforts have resulted in dramatic improvements in health quality and value. Leaders of four medical boards have approached me with the statements that they already know clinically meaningful measures that could and should be collected. Because medical boards renew accreditation for physicians, the boards are in an able position to require reporting. They can begin simply by requiring reporting and tying board licensure to whether or not reporting was completed, not to the relative performance of the reported outcomes. As the measurements are checked and refined, the system will evolve. The board leaders with whom I've spoken can start quickly and have deep expertise and credibility.

Starting soon matters. Past experience with outcome reporting in this country and in others clearly shows that **the fastest way to improve both results and the measures themselves is to begin collecting the measurements**. Perfect measures and perfect risk adjustment are not required. When government efforts launch outcome reporting, the clinicians most affected are spurred to improve the measures and to create new, more accurate and clinically relevant ones. The state of the art outcome measurement by the Society of Thoracic Surgeons began as a defensive response to government (HCFA) reporting of mortality rates for cardiac surgery (based on administrative data). The universally collected and publicly reported outcome measures for transplants resulted from an Act of Congress establishing an organ sharing network and registry. Clearly, Congress can jumpstart results measurement that improves health care outcomes. Congressional expertise in the measures is not necessary. **Congress simply needs to require registries of outcome measurements and allow appropriate experts to specify the measures.**

The point of measurement is not to enable consumer shopping. Report cards are not the goal and assertions that consumers do not use outcomes measures is simply a distraction. **The objective of requiring measurement is to**

improve health care results by accelerating learning and improvement. When the state of New York began public reporting rudimentary mortality outcomes, mortality from CABG surgery fell 41% in the first four years. The evidence was clear that patients did not use the data to shop. **Physicians used the data to improve.** The drop in mortality vividly indicates that patients benefited.

Measuring results will help clinical teams develop the needed insight to improve the structures and processes through which care is delivered. Clinical teams need to know what they do well. They need to know when they are improving and where they need further work. They need to know when they are achieving superb results so they can share their approaches with others. Indeed, the history of these efforts shows that when the teams with excellent results teach others, results improve overall and, importantly, the team doing the teaching improves even faster.

The nation's health depends on this. **Don't accept delay,** and **don't settle for only process measures.**

- There have been significant and laudable efforts over the past decade to develop measures of accepted practice. These are important to understand and to share. But the promised progression to outcome measurement still lies ahead. **Congress needs to require outcome measurement to begin by a specified date.**
- The **measures must go beyond process compliance.** Measuring processes and measuring health outcomes are different. Indeed, many studies confirm that teams complying with the same process specifications get different health outcomes for their patients. Measuring only process compliance diverts health care down the road of administratively managed care and ever-increasing bureaucracy. It is easier to achieve consensus on process metrics because inputs are more readily controlled than the output of health results. But the past decade of process measurement has not yielded the needed improvements. **It is time to require measurement of outcomes.**

Outcome measures are also critical to ending the unacceptable disparities in American health care. Mandatory results measurement will mean that substandard care for any group, including minorities or people with low incomes, will be unmasked. Once unmasked, disparities are unacceptable and most are wholly unintended. At the same time, poor results for any patient will lower a team's outcome measures. On every dimension, results measures, more than any other policy, will accelerate elimination of substandard care for any group.

Outcome measurement will spur improvements in health and health care value for all Americans. Attention to health care outcomes also offers the potential to align interests across the health sector. Knowledge of what a clinical team is doing well and how it is improving restores pride and professionalism for physicians and nurses who are so often today beaten down by reimbursement hassles and bureaucracy that overshadow their heartfelt desire to care for patients. For patient and for health care professionals, results measures will refocus the system on its intended purposes of ***health*** and ***care***.

Payment

In the current system, financial success and medical success are not aligned. There is much discussion of the fact that some of the most effective work that physicians do is uncompensated. But the even bigger problems is that many of the structural improvements needed to allow greater leaps in health care value will not be supported by current reimbursement systems. Our piecemeal system of payment by procedure, by visit, by intervention and by hospital stay encourages poor coordination, redundant processes and lack of attention to the patient's full cycle of care. In addition, prices for a particular service vary widely by payer, which shifts costs and increases complexity, but creates no value.

Instead, **payment systems can support value-enhancing innovations in health care organizations by offering reimbursement for the full cycle of care needed by a patient**. Rather than numerous prices and bills, comprehensive reimbursement would essentially pay the clinical team as a whole, rather than

create negotiated prices for all of the components of care. Prices for episodes, service bundles and ultimately full cycles of care will require teams to apportion payment, as occurs in other services in our economy. While that might sound a bit daunting to some teams today, the process of considering the full suite of services needed to restore the patient's health will lead to improved communication and improved awareness of the patient's full experience. Some hospitals and clinics, usually with salaried medical staff, have already begun paying teams in this way.

Today's pricing depends as much or more on who is paying than on the services being delivered. Reduced administrative costs, improved transparency and incentives to improve efficiency would result from requiring prices to depend only on medical circumstances and services and be the same for all payers. Large payer organizations find threatening the idea of reducing their bargaining power, but their negotiated discounts backfire by increasing the list prices and the costs of uncompensated care. Over time, cost shifting only fuels the spiral of increasing costs. **Aligning payment with the patient's care will refocus competition on improving health care value and bring down price increases over time.**

Dramatic improvement in value will result from restructuring care in ways that are genuinely patient-centric. Today's physician-focused organizational structures deliver visits, interventions and procedures. **A patient-focused organizational structure delivers coordinated solutions for improving health results.** Teams could accelerate improvements in value by addressing clusters of medical circumstances that patients commonly face – what Prof. Michael E. Porter and I called "medical conditions" in Redefining Health Care. There is ample evidence that coordinated teams delivering care for patients with shared medical circumstances improve health outcomes and efficiency faster. They would be best supported by a system that includes all Americans with universal coverage for preventive, early and essential care, that has measured outcomes to enable learning and improvement, and that pays for the bundle of services needed to provide patient solutions.

Conclusion

Access to health care for all Americans is essential to both equity and efficiency. Dramatic improvement in value (health outcomes per dollar spent) is necessary to provide quality care for all Americans. Health outcomes will improve faster and more dramatically if they are widely measured. Coordination of care that improves both outcomes and efficiency will progress more readily if payment becomes team-based for cycles of care. Congress can make huge strides by requiring mandatory health plan coverage and setting outcome measurement in motion. The time to begin is now.

My thanks to the members of the Committee and to its diligent and knowledgeable staff for the opportunity to share my thoughts with you.