

What's Driving Health Care Costs and the Uninsured?

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Testimony

I am Dr. Arnold Milstein, Medical Director of the Pacific Business Group on Health and a physician consultant at Mercer Human Resource Consulting. I also head performance measurement activity at the Leapfrog Group. My comments this morning are my own and not intended to represent the views of these organizations.

The problem of health care uninsurance has multiple root causes. I will focus my remarks on one of these causes, large inefficiencies in America's health care delivery systems. Eliminating these inefficiencies would be feasible over a 10-year period, offset projected health insurance cost increases by as much as 40 percentage points, and make health care insurance more affordable for private sector purchase or public program sponsorship.

I will briefly outline what current science and expert clinical opinion tell us about the nature and magnitude of capturable health care delivery system inefficiency and link its persistence to our failure to collect, publicly report, and reward excellence in nationally standardized measures of efficiency for hospitals, physicians, and major treatment options. Throughout my remarks, I will use the term efficiency to refer to the total cost of all health care services used in treating an episode of acute illness or a year of chronic illness and preventive needs at a specified level of quality. This is a critical distinction, because some physicians, hospitals or treatment options may carry a higher unit price, but incur for health benefits plans and consumers a much lower total cost of all health care services over the duration of an illness. I will refer to this form of efficiency as "longitudinal efficiency."

An inferable estimate of current waste in American health care spending is in excess of 40%. This estimate is rooted in two sources. First, analysis of Medicare data published by Drs. Elliott Fisher, David Wennberg, and other Dartmouth researchers shows that hospitals and physicians in the 10% of U.S. communities which spend the least per capita, (after adjusting for community differences in demographics, morbidity, and input price levels) achieve this result by providing much lower frequencies of specialist physician visits, tests and minor procedures, non-surgical hospitalizations, and admissions to ICUs. More important, they show that available indicators of quality of care, patient health status and patient satisfaction with care, are the same or higher than in the other 90% of communities that spend much more per capita. The researchers estimate that if hospitals and physicians in other communities adopted similarly efficient patterns of service use, U.S. per capita Medicare spending would be 30% lower (see Attachment A).

Their unpublished work and estimates from other nationally respected researchers and actuaries suggests that similar inefficiencies exist for other American health benefit programs. They also show that even small degrees of improvement in physician efficiency could transform this waste into lower per capita health insurance costs (see Attachment B). This prediction has been confirmed by employer innovators such as Pitney Bowes and Union Carbide that have either incentivized physicians to improve their efficiency or incentivized their health insurance beneficiaries to utilize physicians with more efficient practice patterns, as identified through health insurance claims data analysis (see Attachment C).

The Dartmouth team estimates significant additional potential spending reduction opportunities in all U.S. communities from (1) adoption of the patterns of service use by the most efficient, high-quality providers within low-spending communities; and (2) allowing patients to make better informed decisions about high-cost, discretionary surgeries. These include surgeries such as elective coronary bypass graft that are on average no less frequent in low spending communities. Note that all of these analyses are predicated on preserving or improving quality of care.

A second large source of wasted spending is in the inefficiency with which we produce all treatments, however valuable. The Institute of Medicine's (IOM) Crossing the Quality Chasm report on opportunities to improve the performance of U.S. health care delivery systems details the types of inefficiencies that could be eliminated if best operational practices were consistently assured in producing all current treatments. These opportunities are embedded in six "care redesign imperatives," described in the IOM report. They include mainstreaming the use of interoperable electronic clinical information systems and other applications of operations engineering in assuring the reliable selection of evidence based treatments and error-free treatment administration.

The IOM report and many other scientific publications describe hospital and physician leaders who have begun to capture these operational efficiencies and achieve accompanying reductions in medical errors (see Attachment D). These leaders have persisted in the face of a market environment that does not distinguish or reward providers who capture efficiencies for CMS and health insurers, and often penalizes them. America's foremost experts on operations engineering in health care, such as Dr. Brent James of Intermountain Health Care, estimate such operational waste at 30% of current health care spending.

In essence, two largely separate 30% pools of waste are available for capture and redirection into funding wider American health insurance coverage. Since transforming these inefficiencies into reduced rates of spending will require offsetting investments such as improved electronic clinical information systems, I have estimated a net savings opportunity approaching 40%. Precise estimation is not possible for interventions in complex, adaptive systems such as U.S. health care.

I realize that these hearings focus on the problem of uninsurance, rather than its solutions.

Suffice it to say that America's innovators in health care efficiency capture have generated savings far in excess of their costs and that a few strategic public policy changes would enable the market to encourage many more to follow their example. The most important of these changes are: (1) routinizing and publicly releasing longitudinal efficiency and quality ratings of doctors, hospitals, and major treatment options; and (2) encouraging CMS to share with private sector health benefits plans its patient privacy-protected claims data base, so that all health plans would be able to improve their precision in identifying the best performing providers and treatments options; (3) encouraging CMS and other health plans to reward clinical performance improvements either by more favorable payment for providers and treatment options offering superior quality and longitudinal efficiency, and/or by lowering out-of-pocket costs for patients who preferentially use them.

Americans have standardized longitudinal efficiency measures for appliances and for automobiles, but not for the industry that consumes a much greater share of their income and benefits. Methods of quantifying longitudinal efficiency and quality for hospitals, physicians, and major treatment options are already developed and easily within the capability of American health services researchers to further refine. The National Committee for Quality Assurance (NCQA) plans to release standardized efficiency measures for physicians and hospitals during this calendar year.

Absence of such measurements keeps American hospitals, doctors, and patients in the dark with respect to comparative health care efficiency and unable to identify opportunities to make their health insurance much more affordable. When paired with standardized, publicly reported quality measurements, longitudinal efficiency measurements would comprise a new navigational system for patients, providers, and insurers to improve America's health and substantially reduce future increases in health insurance premiums. It would also send an important signal to new medical technology developers that market receptivity to new products and services will become more sensitive to their effect on the affordability of health insurance, in addition to their effect on health.

Thank you for the opportunity to share my thoughts on how large, invisible, and substantially capturable inefficiencies in American health care delivery contribute to the unaffordability of health insurance..