

OPENING STATEMENT

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HEARING ON CROSSING THE QUALITY CHASM

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The United States spends more than \$2 trillion per year on health care, but the Institute of Medicine reports that between 44,000 and 98,000 Americans die from medical errors each year, killing more people than breast cancer, AIDS, and motor vehicle accidents combined.

Despite the numerous and significant advances in medical science over the past few decades, the system has fallen short in translating this new knowledge and technology into practice. On average, there is a 17-year time lag between the discovery of more effective treatments and their incorporation into routine patient care. However, even when advances are included in clinical guidelines, there is no guarantee that patients will benefit. One study found that only 55% of patients received care consistent with clinical recommendations, and less than half of Americans living with chronic

conditions such as diabetes, asthma, and hypertension obtained disease management treatment according to practice guidelines. Furthermore, these gaps in quality disproportionately affect those most in need of care. The uninsured and racial and ethnic minorities are much more likely to receive sub-standard health care.

The overly complex and fragmented structure of our health care delivery system contributes to the lack of quality. Our fee-for-service system does not reimburse coordination among health care providers, and as a result, omitted or duplicative procedures, delays in care, and medical errors are common. Less than 25% of health care providers use electronic medical records, a lost opportunity for an efficient and reliable means for recording and coordinating patient information.

While the health consequences of poor-quality health care is reason alone for policy action, the economic impacts of medical errors and inefficiencies lend further support for a *Call to Action*. Preventable medical errors cost between \$17 and \$29 billion dollars annually in additional necessary health care services errors, lost

income and productivity, and disability. Medication-related errors in hospitals alone cost an estimated \$2 billion each year.

Expanding insurance coverage alone will not solve this crisis. Indeed, as our history can tell us, holding out the promise to receive care when that care is poor quality, or even dangerous, is perverse. The human and financial costs of low-quality health care demand immediate attention.

Fortunately, innovations in system delivery provide several promising strategies for improving quality. First, we can establish standards of health care so all patients receive the services they need. Second, we can improve care coordination by building our Health Information Technology infrastructure, like the economic stimulus package proposes to do, particularly in rural and underserved areas, using the medical home model, and attaching financial incentives to provider communication. Third, the \$1.1 billion in the economic stimulus devoted to comparative effectiveness research can help us identify what works and what we have yet to learn.

Furthermore, it is essential that these initiatives be paired with coordinated efforts for quality measure development, implementation, evaluation, and accountability. These measures must reflect best practices, patient outcomes, and quality of life. There are many important organizations that have begun work in this area, and should be supported to continue it.

We cannot continue to have a “siloed” health system and classes of care. I look forward to working closely with my Senate colleagues on the HELP and Finance Committees and President Obama to ensure that we not only improve access to care, but make sure that it is truly high-quality, safe, health care. Thank you, Senator Mikulski, for your diligent work in this essential area of health care reform, and I look forward to learning from each of our witnesses today on how we can address quality in our health system.