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# How Physicians Can Change the Future of Health Care

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**T**HE HEALTH CARE POLICY DEBATE is stuck in a place that undermines physicians and the nation's health. Although reform proposals differ, they have this in common: each examines today's system and asks what incremental change, imposed from the outside, can effectively rein in costs that are both high and increasing. That approach will fail because it starts with a flawed premise. The purpose of the health care system is not to minimize costs but to deliver value to patients, that is, better health per dollar spent.

We offer a different approach. If one were to design a system focused on value and on rewarding innovation that advances medicine, what would that system look like? The next question would be, how can the system migrate from one that clearly is not working to one that is value based? This approach sounds utopian and impractical to some critics. Experience with the restructuring of industries across the economy gives a different perspective. This is precisely the way industries are actually transformed. Furthermore, some leading physicians are already demonstrating that both they and their patients can benefit as they restructure their own practices and organizations to improve value.<sup>1(pp149-228)</sup>

More leadership from physicians is needed, and now. The only real solution to the national health care prob-

lem is to dramatically increase the value of the care delivered for all the money being spent. That will never be achieved from the outside, by tinkering with payment schemes and incentives. Increasing the value of care is something that can be done only by physicians. If physicians in significant numbers are willing to tackle this challenge, it is not too late to tip the balance in favor of reform that is medically sound and physician led.

**Today's preoccupation with cost shifting and cost reduction undermines physicians and patients. Instead, health care reform must focus on improving health and health care value for patients. We propose a strategy for reform that is market based but physician led. Physician leadership is essential. Improving the value of health care is something only medical teams can do. The right kind of competition—competition to improve results—will drive dramatic improvement. With such positive-sum competition, patients will receive better care, physicians will be rewarded for excellence, and costs will be contained. Physicians can lead this change and return the practice of medicine to its appropriate focus: enabling health and effective care. Three principles should guide this change: (1) the goal is value for patients, (2) medical practice should be organized around medical conditions and care cycles, and (3) results—risk-adjusted outcomes and costs—must be measured. Following these principles, professional satisfaction will increase and current pressures on physicians will decrease. If physicians fail to lead these changes, they will inevitably face ever-increasing administrative control of medicine. Improving health and health care value for patients is the only real solution. Value-based competition on results provides a path for reform that recognizes the role of health professionals at the heart of the system.**

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**When Competition Is Dysfunctional**

To create a high-value health care system, competition is needed. Lessons from all other fields, such as telecommunication services, computers, finan-

cial services, and aerospace, show that competition stimulates innovation and drives value. Yet many physicians are rightly suspicious of competition and market-based solutions because they have experienced a kind of competition that does more harm than good. The problem in health care is not too much competition nor is it that competition per se is inappropriate. The problem is that the health sector has the wrong kind of competition. Competition is dysfunctional when partici-

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pants work at cross purposes with each other and with the needs of the ultimate customer: the patient.

Today's dysfunctional health care competition is *zero sum*—one player's win is another's loss. Costs are "reduced" by shifting them to others. Physicians are pressured to "improve productivity" by skimping on time spent with patients. Physicians "win" by cutting better deals with their hospitals or by setting up their own profit-making ventures. Hospitals "win" by merging into groups to gain more bargaining clout on rates or by signing up more physician groups to guarantee referrals. Health plans "win" by restricting services and muscling physicians to accept lower pay. In ways such as these, each player in the system gains not by increasing value for the patient but by taking value away from someone else. None of this improves health outcomes per dollar spent—in fact, it often does the opposite. Such a model of competition is unhealthy. No wonder many physicians see competition in health care as simply inappropriate.

In contrast, positive-sum competition is about creating and improving value—more customer benefit per dollar spent. When competition is based on value, industry participants focus not on amassing bargaining power or limiting customer choice but on enhancing the quality of their products and services and the efficiency with which they are produced. When companies compete over the value for customers, the capable ones grow and prosper, innovation is rewarded, efficiency increases, and customers can afford more of an ever-improving product. This dynamic is at work in many fields, such as electronic banking, stock brokerage, and plasma televisions. Rapidly increasing value is why there is no hand wringing over the percentage of the gross domestic product spent on mobile communications or information technology. Society is best served, in any field, when competition works in this way.

Health care competition does not have to be zero sum. It does not have

to be about shifting costs to someone else or amassing and exercising bargaining power. Competition over better results (better health outcomes per dollar spent) would produce multiple winners: patients would get better care, physicians would be rewarded for excellence, and costs borne by health plans and by society at large would be contained. There can be multiple winners because positive-sum competition is not about winning at the expense of another; it is about creating value.

### Transforming Health Care Delivery

Physicians have the power to lead the reform of health care to a value-based model. Once value improvements begin to be demonstrated, changes in reimbursement and regulation will follow. A value-based system is grounded in 3 simple principles: (1) the goal is value for patients, (2) care delivery is organized around medical conditions and care cycles, and (3) results are measured.

**The Goal Is Value for Patients.** Although it may seem obvious that value for patients is the goal for health care, the current system is not structured that way. Hospitals tend to define success as increasing their revenues or achieving an operating surplus. Health (insurance) plans want to be profitable and sign up more subscribers. Physicians think in terms of delivering their specialty well, seeing more patients, or increasing the revenue of their practice. Patients, on the other hand, want good health outcomes, not more office visits, more procedures, or more tests.

Improving value for patients is clearly the only valid goal for ethical reasons. It is also the only goal that aligns the interests of patients, physicians, health plans, employers, and government. If physicians improve value for patients, they will be able to credibly engage Medicare and health plans in new contracting and reimbursement practices that reward such value.

Some physicians fear their incomes will be compromised if they work to im-

prove patient value given today's broken reimbursement system. There are 2 answers to this concern. First, waiting for the right reimbursement system leaves responsibility for reform to government and health plans. This simply invites increasing administrative management of medicine as cost pressures increase. Second, despite the current skewed incentives, win-win opportunities abound.<sup>1,2</sup> Consider the breast cancer specialist in independent practice who hired someone to counsel patients through the cycle of care. Although there was no added reimbursement to cover the physician's cost, patient outcomes improved while freeing significant amounts of the physician's time. In today's system, much of physicians' time is wasted by poor coordination, redundancy of effort, and poor information sharing, all of which can be addressed to allow simultaneous improvement in physician incomes and patient outcomes.<sup>3-5</sup>

**Organize Around Medical Conditions and Care Cycles.** To make dramatic progress in improving value, health care delivery needs to be restructured. Physicians tend to define their activities by their specialty. For patients, what matters is their medical condition. Organizing care around medical conditions, rather than specialties or procedures, is key to improving value to patients. A medical condition is a set of interrelated patient medical circumstances that are best addressed in an integrated way. This encompasses conditions as physicians usually define them, such as diabetes, congestive heart failure, arthritis, or breast cancer. But this definition differs by including all needed specialties and the prevalent comorbidities, such as diabetes combined with vascular problems or hypertension.<sup>1(pp5-6,40,44-45,105-107)</sup>

Effective care for a medical condition usually requires the combined and coordinated efforts of multiple physicians and other health professionals. For virtually every condition, the cycle of care begins with screening and prevention and extends all the way through

preparation, treatment, recovery, ongoing monitoring, and active disease management in the case of chronic conditions. Multiple specialties, services, and even entities are involved in the cycle of care. Value for patients comes from the overall effect of the entire sequence of activities, not from any individual service. Patient value is enhanced by organizing practice around medical conditions in tailored facilities, rather than shuttling the patient among numerous offices and departments. These are not focused factories, but sets of facilities or areas within larger facilities that integrate the care cycle.<sup>6,7</sup>

Most physicians know that their own efforts are undermined by the way care is currently organized. Yet the practice of medicine has become more fragmented, more focused on discrete services or interventions, and more skewed toward treatment than health, even in health care organizations that offer a broad array of specialties. Care is fractured by numerous handoffs and by a host of artificial distinctions, such as inpatient vs outpatient care and acute care vs rehabilitation. By reorganizing their services around the integrated care of medical conditions, physicians will help to reverse these trends.<sup>8</sup> Better integration of treatment with prevention, rehabilitation, and disease management will reveal obvious ways to improve the overall outcomes and reduce costs.<sup>9-12</sup> It will also point the way to how to change the broken reimbursement system.

In the rest of the economy, huge gains have been made by better integrating and coordinating all activities required to serve customers. Seamlessly coordinated networks and partnerships have replaced adversarial or arms-length relationships in delivering value for end users. Health care is long overdue for such a transformation. Physicians, to their credit, are beginning to organize care around medical conditions, and, further, they are forming institutes, centers, and other types of integrated structures that bring needed specialties and

expertise together and encompass the care cycle. The M. D. Anderson Cancer Center in Texas, for example, organizes patient care into centers for the type of cancer for which a patient is treated. All the relevant medical specialties practice in dedicated, collocated facilities for consultation, therapy, and follow-up.<sup>1(pp175-6,207)</sup> The Cleveland Clinic in Ohio has created integrated practice units in cardiac care and in eye care, and it is moving toward using the integrated practice unit model in all major fields.<sup>1(pp175,226)</sup>

This approach to care can be adopted in every practice, not just large centers. ThedaCare, a small Wisconsin hospital group, has established an integrated orthopedic practice.<sup>1(pp177,227)</sup> Four independent physicians in Massachusetts formed the Boston Spine Group, which has developed a virtual integrated practice unit with New England Baptist Hospital including dedicated nurses and anesthesiologists and coordinated care from physical therapists.<sup>1(pp173-175,185-188)</sup> Even small steps in the direction of integrated care can have a big payoff. One hospital in New Hampshire, for example, experienced dramatic improvements in outcomes when physicians simply adopted the practice of doing rounds together rather than individually.<sup>13</sup>

Organizing around medical conditions and care cycles will be a major change for physicians, but the reorganization of care will be most effective if it is physician led and motivated by the goal of improving value for patients. The shift from practicing a specialty to organizing around medical conditions will shift affiliations away from traditional departments toward the network of physicians and other health care practitioners who are jointly responsible for care cycles.

This approach will also change the way physicians manage their practices. Traditional academic definitions of specialties will evolve into patient-centric definitions of medical conditions that include the prevalent co-occurring conditions. A nephrology practice, for example, will partici-

pate in several distinct medical conditions, such as hypertension, chronic kidney disease, end-stage renal disease, and kidney transplantation. Each one needs to be organized differently, with physicians and staff integrated around a different care cycle. Primary care will evolve from a catch-all category into a variety of models, including practices that focus special attention on diagnosis, those that provide early stage care for particular conditions, those that provide disease management for combinations of conditions, and those that concentrate on screening and health management. Most primary care practices will participate in a number of care cycle teams for medical conditions, in addition to offering routine health screening and maintenance.

Integration of care across the full cycle of a medical condition is the first order of medical integration needed because it benefits every patient: organizational structure and financial management should be centered at this level. Coordination of care across medical conditions, required for patients with unusual or complex comorbidities (such as a patient with cancer who needs heart surgery), is the second order of integration. This could be accomplished by a formal coordination mechanism involving a lead physician responsible for the overall care of the patient and an incentive structure that motivates all the groups involved in care to be responsive and work together. The need for this far rarer coordination, however, should not define the primary organization of care delivery.

Today, there are artificial impediments to medical condition and care-cycle integration, such as the relatively low compensation for consultative care, the separate payment structures for inpatient and outpatient care, the Stark laws<sup>11(pp74,357-358)</sup> limitations of coordination among independent physicians (designed to prevent abuses of self-referral), and the archaic corporate practice of medicine laws<sup>1(pp358)</sup> in many states.<sup>1(pp323-380)</sup> These obstacles can be surmounted at a cost today, but

they will give way as the focus in the health sector shifts from dysfunctional competition to improving measured value for patients, medical conditions, and care cycles.

**Measure Results.** There is simply no way to achieve large and sustained improvements in value for patients without measuring results: the set of risk-adjusted outcomes of care for each medical condition, together with the costs of achieving those outcomes. Processes of care, the focus of much of today's quality movement,<sup>14</sup> are not results. Good outcome measures are vital feedback indicating what works and what does not. These measures enable professional insight and the development of expertise.<sup>15,16</sup> Good cost measures also provide vital feedback that indicates whether a physician or team is achieving those outcomes efficiently. Every thriving sector of the economy harnesses this kind of information to spur learning. Health care is the outlier.

Outcome measures are necessarily multifaceted, including not only mortality and morbidity but also factors such as complications, recovery time, and the need for further treatment. Each medical condition should have its own outcome measures, stratified or risk-adjusted by the patient's initial conditions. To be most useful, outcomes should be measured over the full cycle of care (or over a time period in the case of a chronic disease), not for individual services or even care episodes (such as surgery).

Designing risk-adjusted outcomes measures is not easy, but their practicality has been convincingly demonstrated.<sup>17-20</sup> In some very complex areas of care, such as intensive care, transplant surgery, cardiac surgery, and long-term care for cystic fibrosis, validated measures have been available for many years. Clinicians can and should develop meaningful measures. This is an area in which physician leadership and medical society coordination would make a huge difference.<sup>1(pp128)</sup> To be sure, progress is not uniform. In general, outcomes measurement is better

developed for surgery than for medicine. Medical specialists will come to understand that outcome measurement is the only convincing way to make the case for more generous reimbursement for non-procedure-based services.

With anything as complex as outcome measures, there will always be imperfections and room for improvement. Nothing, however, will speed that improvement faster than putting the measures to use. Organizations such as The Cleveland Clinic,<sup>1(pp387-395)</sup> Intermountain Health,<sup>1(p183)</sup> Dartmouth-Hitchcock,<sup>1(p189)</sup> ThedaCare,<sup>1(p187-188)</sup> and numerous others are measuring outcomes now, at least for some medical conditions. In these organizations, outcome data, combined with study of what causes them, is driving rapid learning about both quality and efficiency.<sup>21,22</sup> Some medical associations, such as the Society of Thoracic Surgeons<sup>1(pp131-133,344,348-349,428)</sup> and the American Society of Breast Surgeons,<sup>1(p348)</sup> are using analysis of outcome data to understand and expedite the adoption of best practices.

Family practitioners associated with Life Laboratory in Pennsylvania have created a culture of attention to outcomes through chart review and physician performance feedback. Their efforts to achieve "optimal quality care" at lower costs have yielded significantly higher rates than the regional average of compliance with screening tests (mammography, Pap smears, colorectal screening, and bone density scans), as well as lower overall use of medications (David Badolato, MD, Life Laboratory, written communication, January 16 and February 1, 2007).

In fact, where well-constructed outcomes information is available to physicians, gains for patients have been stunning, whether physicians have developed their own measures or adopted those developed by others.<sup>23-28</sup> When outcome measurement began in cystic fibrosis, for example, the average life span of a patient with cystic fibrosis was 18 years. Today, the aver-

age life expectancy is 33 years, and at the leading centers, 47 years.<sup>29</sup> In coronary artery bypass graft surgery, mortality among New York state patients decreased 41% in the first 4 years of outcome reporting.<sup>30</sup> In Minnesota, MN Community Measurement began reporting 5 diabetes outcome measures to medical groups in 2002, with full public reporting beginning in 2004. Success was defined as a patient passing the specified thresholds on all 5 measures. In just 2 years of public reporting, the statewide percentage of patients meeting this success measure more than doubled.<sup>31</sup>

Physicians must lead the development and use of outcomes measures. Cost measures are also important, and the current state of cost information is abysmal.<sup>32</sup> Today, costs are often confused with charges, reimbursements, or prices and are not measured for individual patients. But, in value-based competition, costs would become better understood and reflected in prices. Ideally, physicians would have good cost information not just for procedures or drugs, but for the full care cycle. Just as with outcome measures, good cost information leads to insights about what is truly efficient. Analysis of results (putting outcomes and costs together) is the only way to enable decisions about health care delivery that maintain or improve quality while reducing costs.

Results information reveals one of the most crucial insights about health care delivery: truly high-quality care is usually less costly.<sup>1(pp107-117,249),33</sup> One of the most important reasons to measure results is that the best way to reduce costs is to improve outcomes.

The idea of measuring and publishing results has too often been seen by some physicians as a threat. It is easy to see how poorly constructed measures used inappropriately can do harm. Properly understood, however, measuring and analyzing results provides a tremendous opportunity for improvement. Overwhelming evidence suggests there is much room for value improvement in all fields of

medicine.<sup>3,33-37</sup> Only by systematically tracking results will physicians have the tools they need to improve quality and simultaneously reduce costs.<sup>38</sup>

The resistance to results measures has been perhaps the medical profession's deepest self-inflicted wound. If physicians do not demand the information they need to improve themselves, programs dictating how they should practice medicine will continue to proliferate. If physicians lead in creating the right kind of results information, they will come to appreciate the power of demonstrated excellence to enable further improvements in care, more appropriate reimbursement, and greater control of medical practice by medical professionals.

### How Value-Based Care Delivery Could Change Medicine

The 3 principles for transforming health care delivery are tightly interrelated. Good results measures require clarity that the goal is value for patients and that value is created in the treatment of medical conditions over the full cycle of care. The widespread availability of reliable results measures by condition and by medical team will produce powerful ripple effects throughout the system. Several kinds of change will be set in motion.

**Pursuit of Excellence in Service Line Choices.** Today, practice choices are made based on traditional patterns, with a bias toward offering a wide range of services in a physician's specialty field. Many physicians seek variety in their practice to avoid boredom. One anesthesiologist, for example, explained to us that he occasionally handles pediatric patients whose differing needs make them interesting. But would he do so if results data showed him that his practice falls short of excellence?

Similarly, most hospitals offer a full array of services. Even hospitals in the same hospital system usually act as stand-alone entities.

Value-based competition would encourage depth, rather than breadth, of practice. There is compelling evidence that patient value increases with

physician and team experience and volume, and with deep expertise in particular medical conditions and surgical procedures.<sup>39-45</sup> Experience allows learning, and learning leads to faster and fuller recovery, fewer errors, and a better patient experience.<sup>46,47</sup> Volume supports dedicated teams, tailored facilities, peer feedback, better information technology, and the ability to integrate and widen services over the care cycle.<sup>1(pp111-117,425-426)</sup>

As physicians focus on improving value for patients, they will gravitate to areas in which they can achieve true excellence. This does not imply an ever-narrowing spiral of hyperspecialization. Physicians can broaden and deepen their expertise through understanding the interdependencies across specialties and across the care cycle. Rather than focus on particular procedures, physicians would become more expert in the total success of the patient. For example, the cystic fibrosis practice at Fairview<sup>1(pp160-161)</sup> now includes a specialized reproductive practice as well as specialized diabetes and gastrointestinal clinics to address the needs of these patients with the conditions that frequently co-occur. Some physicians would concentrate on managing co-occurring chronic diseases, while others would more sharply define their practice, for example, by shifting from general surgery to breast cancer care. Each of the surgeons in the Boston Spine Group,<sup>1(p179)</sup> for example, has gravitated to treating some, but not all, spinal conditions. The group's clinical results have steadily improved, as has its market share. Physicians seeking to practice at such state-of-the-art levels would never get bored.

As physicians pursue excellence, the choices made by thousands of individual physicians—each playing to strength—will produce 3 important changes in medical practice. First, the performance of the average physician will rise, as each physician provides more of the services he/she does best and learns fastest. Second, truly excellent teams will treat a greater propor-

tion of patients in each medical condition. And third, the overall value of patient care will improve dramatically.

**More Effective Collaborations.** Many physicians today are frustrated by the organization of care with its poor coordination, inefficiency, redundancy, and poor information sharing. Most full-service health care provider networks are not integrated. The current specialty and procedure-based model creates the need for exponentially more coordination among separate entities but makes coordinating extremely difficult. Value-based competition will trigger the proliferation of integrated practice units, in which physicians can operate with greater effectiveness than today's isolated units. Physicians will be enabled and encouraged to make better choices about their collaborations with other physicians and teams in the care cycle, whether in making referrals, affiliating, or developing other kinds of partnerships. Today, referrals are often based on either informal personal networks or captive financial networks.

Physicians focused on value for patients will no longer see themselves as self-contained, isolated actors. Instead, they will build stronger professional connections with complementary specialists who contribute to patient care across the care cycles for their patients. Integrated practice units may involve groups of independent physicians or may be built within hospitals or clinics. Either way, physicians will form or join organizations that give them access to world-class care cycles because the results their patients achieve depend on the quality of care throughout the cycle. In their field, physicians will want to affiliate or share insight with other excellent teams. This may take the form of shared databases, as are used by the Society of Thoracic Surgeons,<sup>1(pp131-133,344,348-349,428)</sup> nationwide clinical trials; as are pursued in pediatric oncology,<sup>1(pp127-128)</sup> or comparative results and process measurements as has occurred in the management of patients with cystic

fibrosis.<sup>1(pp128,426),29,48</sup> Integrated practice units together with reliable results information will produce major gains in every medical condition.

**Greater Patient Engagement.** Health care is unusual in the degree to which it is a service that must be jointly produced by the medical team and the patient. As physicians embrace the cycle of care concept, they will innovate and find better ways to enlist patients in their own care and send a strong message about patient responsibility for health. This is a more appropriate path to change than requiring consumers to become medical experts.<sup>49</sup> The cycle of care needs to include patients as engaged participants who adhere to their treatments and act responsibly, not as passive receivers of care. Physicians have just scratched the surface in developing effective approaches to engage patients, largely because current care is so fragmented. Better integrated care cycles will make it far less complicated for patients to become informed and involved.

**Fewer Malpractice Suits.** Many physicians fear that more outcome measures would increase the risk of malpractice claims. The opposite is true. With good data on the actual risks of care, physicians will be better able to defend themselves from the prevailing mindset that any bad outcome is the fault of an incompetent physician. It will be easier to document, for example, that a specific proportion of all patients who undergo a given procedure experience a given complication.

**More Supportive Health Plans and Government Payers.** The more physicians lead the way in reorganizing care and measuring results, the less administrators and insurers will be driven to intervene in medical practice. Instead, health plan decision makers will see the benefits for themselves and their members.<sup>1(pp229-281)</sup> Then health plan administrators, with their eye on the bottom line, will move away from payments for isolated treatments, restrictive contracting, and discount-driven networks and encourage referrals

based on merit. They will become allies in informing patients and rewarding excellence, rather than adversaries.

In fact, this model is already used in organ transplantation, for which outcome data are universally collected and publicly reported. Some health plans subcontract with United Resource Networks—a service company for health plans and patients—to counsel patients and referring physicians, providing such information as mortality rates, graft survival times, repeat transplants, waiting times, and out-of-pocket expenses for the patient.<sup>1(pp247-256)</sup> Sometimes referring physicians are inclined initially to refer to a nearby center until they learn from United Resource Networks, for example, that the patient's insurance will cover both treatment and travel costs at a more distant but better qualified center.

Although the notion of a supportive health plan stretches the imagination of many physicians, risk-adjusted results information will enable this seemingly radical idea. The focus on measurable value aligns everyone's goals. Without a value mindset and without actual results data, it is not surprising that health plans resort to cost control. Ultimately, health plans will also be measured by the health results they deliver to their members.

**New Bases for Reimbursement.** As long as the driving principle of the health care system is to contain costs in paying for services, reimbursement will be intensely adversarial and subject to the exercise of pure bargaining power. Demonstrable improvements in value, however, will change the basis on which payments are made.

Ultimately, to reward value and improve results, reimbursement should be based on care cycles, not discrete services. Payment should cover the full care cycle for a patient with a given condition including all services and drugs and treating inpatient and outpatient services together. This not only rewards true value but encourages innovation, because physicians will no longer be penalized for

reducing the need for additional care, as they are in the current system. Although these changes will not happen overnight, physicians can initiate new reimbursement structures with health plans and with Medicare if they come to the table with results information and a care-cycle perspective. As broken as the current health care system is, it is wishful thinking to suppose that it can be fixed in the current morass of payment for treatment and no results measurement.

A new model is already in place in some areas. In organ transplants, United Resource Networks negotiates a single, bundled price for much of the care cycle, with an escape clause to cover truly unanticipated complications. At the very least, hospitals and physicians can encourage referrals based on value by moving away from charging full list prices for out-of-network patients or negotiating special deals with each payer and instead charge a reasonable, standard price for each service bundle to all comers.

### Avoiding False Solutions

Each of today's most popular health care reform proposals tackles a piece of the problem and contains some truth. But each is fatally flawed when viewed in the context of how the entire system would work. In fact, each proposal perpetuates the kind of zero-sum competition that plagues health care today.

**Single Payer.** Single-payer advocates correctly highlight 2 real problems. First, the current system carries a huge administrative cost burden that a single payer could reduce. Second, the current system leaves millions of uninsured individuals with limited access to care. Yet moving to a single-payer system could easily make things worse because the single payer would have even more power to achieve its cost-reduction goals by setting arbitrary prices, dictating practice standards, shifting costs, and restricting services. This would only exacerbate the zero-sum competition that pervades health care today. By rewarding cost containment rather than value

improvement, the single-payer model would stifle the very innovation that medical progress and improving patients' lives depend upon. The fragmented, poorly integrated structure of health care delivery would remain unchanged.

The important insight in the single-payer model is the need for universal coverage including access to primary care. The unfairness of the current system is intolerable, and the resulting gaming and cross-subsidies to address the uninsured create needless costs and complexity. Too many health problems are unattended until they reach advanced stages, which are more difficult and more expensive to treat. Access to early stage care partly explains why countries with universal coverage achieve better aggregate health results at lower costs. But universal coverage does not require a single payer facing no competition with excessive bargaining power and with irresistible incentives to control the cost and delivery of care. The same objective can be achieved through a strategy involving competing health plans, risk pools, the mandate that all individuals (including those who are healthy) buy insurance, and subsidies or vouchers for those who need aid. As physicians improve the value of health care delivery, universal coverage will be more affordable.

**Consumer-Driven Health Care.** The consumer-driven model relies not on one powerful payer but on the collective power of millions of consumers, each shopping for the best deals. Proponents of consumer-driven health care primarily use financial consequences to increase consumer responsibility. There are 2 valuable insights here. Patients must be actively informed and engaged in their own health, and choices of physicians and teams should be based on value, which has a cost component.

But shopping is the wrong metaphor for health care. Consumers are simply not equipped to manage their own care in the current fragmented system. Patients have neither the expertise, the information, nor the

choices at an appropriate level to drive the system to produce greater value. The way health care delivery is organized presents patients and their referring physicians with a structure that is nearly impossible to navigate. The lack of integration of services throughout the cycle of care for the patient's medical condition makes it difficult for even an attentive physician to ensure that appropriate care, counseling, and ongoing monitoring are occurring. Expecting patients to manage their own care places an inappropriate strain on them and on the patient-physician relationship. Physicians as vendors and caveat emptor is simply the wrong model.

The role of measurement in the consumer-driven model is also problematic. For consumer-driven advocates, results information should be used primarily by patients and their families to make smarter choices about which procedures, drugs, and clinicians to use and which to avoid. However, many consumers will not use results information effectively. A far greater and faster impact of results measurement will come from enabling and encouraging physicians and medical teams to improve value. When physicians and medical teams strive to improve measured outcomes, even uninformed and uninvolved consumers will benefit.

**Pay for Performance.** There is growing momentum for programs that purport to reward physicians for achieving good performance, as measured by various types of quality indicators. Although such programs often have names that suggest a focus on results, in practice the vast majority rely on process standards and compliance with process guidelines. In fact, many physicians prefer this kind of process compliance because it is easier to achieve and seems consistent with evidence-based medicine.<sup>1(pp134-135)</sup>

Standardization on evidence-based processes is seductive because of the obvious and immediate benefits of reducing substandard care. However, basing reporting and rewards on process

compliance is the wrong way to go. It will lead inevitably to the micromanagement of medical practice. Practice guidelines tend to freeze today's best practices and retard innovation. Pay for performance will become a new vehicle for administrative control of medical practice.

Measuring actual results, as defined earlier, is a far better alternative to imposing practice guidelines and mandating protocols. One of the most basic tenets of modern management is that rewarding results is almost always preferable to micromanaging processes. Results measurement provides professionals with the information that enables learning and improvement, rather than constraining them by imposing rules and tracking compliance. Also, because high-quality care should be less costly, the focus should be on helping patients access excellent clinicians rather than presuming the need for bonuses simply for good care process.

**Integrated Payer-Provider Systems.** One way to eliminate some of the dysfunctional competition and cost shifting that are so prominent in the current system is to create organizations that provide both health insurance and multispecialty medical care. In theory, these organizations can better coordinate care among physicians and bring together clinical and financial records to gain insight into the relationship between cost and health outcomes.<sup>50</sup>

Yet there are 3 reasons integrated payer-providers are not the ideal model for the system as a whole. First, a system consisting solely of financially integrated payer-providers creates competition only at the overall level of the health plan, while eliminating competition where it is most important—in delivering value by addressing the patient's particular medical conditions. In the payer-provider model, patients are directed to the system's physicians whether or not they have demonstrated excellence for the patient's circumstances, so in-house clinicians have a guaranteed flow of patients. Second, integrated

payer-provider systems seek to maintain a full array of services, which can lead inadvertently to supporting substandard care in particular areas. Third, integrated payer-provider systems have incentives to minimize the cost of care because they operate under global capitation per member. There are grave risks that costs will be controlled by restricting choices or delaying care unless these incentives are balanced by transparent results measurement.

Proponents of payer-provider systems argue that financial integration is the fastest or best way to achieve integrated care, more attention to the full cycle of care, and improved information sharing—all of which are essential to value. Payer-provider systems, such as the Veterans Health Administration, Kaiser, and Intermountain Health, have made impressive improvements, but so far mostly measured on process standards, rather than results.<sup>51-54</sup> More important, health plan-provider systems are not the only or necessarily the best way to increase value, and they do carry significant risks. Integrated payer-provider systems have a role in a value-based system, but they must meet a high standard of results transparency at the medical condition level. Independent providers and physicians must comprise a major part of the system so that there is adequate competition and results measurement in the care for medical conditions.

### Creating a Health Care System That Works

Value, measured by health outcomes per dollar spent, aligns the interests of every stakeholder involved in health care. Value improvement in health and health care is a shared goal from which everyone, including physicians, can benefit. In a value-based system, revenue and profit come from delivering value, not from merely providing treatment. Delivery and reimbursement are organized around cycles of care for medical conditions. Patients flow to the high-value providers.

All patients, including those with low incomes, benefit because high-quality care is less costly. Low-income patients in a value-based system are cared for by excellent physicians and teams who are motivated to achieve good results in serving them.

This strategy for reform is market based but physician led. A value-based system offers physicians new credibility and new influence. Health plan administrators will see the benefit of working cooperatively with physicians and come to understand that the best way to control future costs is to encourage and reward quality and value. Paying for care cycles and rewarding value is ultimately the only feasible way to change a reimbursement system that everyone knows to be broken. When value rules, the nation will finally get better outcomes for every dollar spent on care.

Competition on value, then, must become the nation's health strategy. Improving health and health care value for patients is the only real solution. Value-based competition on results provides a path for reform that recognizes the role of health professionals at the heart of the system. In the economy at large, competition on value underlies the wealth of nations. It can transform the health of nations as well.

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