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Citation: 4 Yale J. Health Pol'y L. & Ethics 431 2004

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The Market Matters: Reforming the U.S. Health Care System

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Epidemic of Care: A Call for Safer, Better, and More Accountable Health Care. By George C. Halvorson & George J. Isham. San Francisco: Jossey-Bass, 2003. Pp. 271.

Imagine a world where few can afford necessary and life-saving treatments, where hospitals and physicians can no longer provide uncompensated care, where government and employers can pay for only the barest safety net, and where health care facilities are so understaffed that they are dangerous. That world may be closer than you think.

This nightmare scenario is suggested by recent trends cited in *Epidemic of Care: A Call for Safer, Better, and More Accountable Health Care*.¹ This book, written by George Halvorson and George Isham, is a wonderful primer on why health care in this country is as flawed and as expensive as it is, and it presents information about which everyone should be concerned. Medicare recipients, retired workers, active workers, the poor, the unemployed, and children are all adversely affected by the poor quality of care too often provided by today's health care system. No economic class will go untouched if the disturbing picture *Epidemic of Care* paints of the future of health care becomes a reality. But, perhaps more importantly, *Epidemic of Care* is also a call to action.

Epidemic of Care begins with an extensive review of the twin crises of escalating cost and questionable quality facing the American health care system. This overview describes not only the present situation, but also forecasts the likely economic implications of the current trajectory of American health care.² Halvorson and Isham both identify the problems and, toward the end of the book, forward a "national health strategy" with

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1. See GEORGE C. HALVORSON & GEORGE J. ISHAM, EPIDEMIC OF CARE: A CALL FOR SAFER, BETTER, AND MORE ACCOUNTABLE HEALTH CARE (2003).

2. See *id.* at 35-45.

clear initiatives to streamline and improve the current system.³ They admit that certain problems, such as the nursing shortage in this country and the anticipated shortfall of other health care professionals in the near future, do not seem to have easy answers.⁴ But they do suggest proposals—seven broad, national initiatives—that adequately address other, perhaps more pandemic problems, including the poor quality of health care delivery today and the apparent paradox in the medical community’s over-provision of care despite being in the midst of a resource shortage.

Specifically, *Epidemic of Care* insists that before change can come, the problems detailed in the first half of the book—specifically, the problems with the cost and quality of care—must be recognized on a national level. Only that national recognition will produce the resolve necessary to pursue the seven broad initiatives that the authors argue will cure the woes of the current system. The last seven chapters provide an analysis of the proposals: (1) provide safer care; (2) create savings accounts for health care to improve market dynamics for buying and selling health care; (3) improve prevention efforts; (4) prevent provider monopolies and anticompetitive behaviors; (5) fund programs for the uninsured; (6) continue to fund training, education, and research; and perhaps most importantly, (7) create an “automated medical record that will give the doctor and patient in the exam room all of the information needed to provide best care efficiently and consistently.”⁵ The authors persuasively argue that this last initiative is a prerequisite for successful implementation of the other six.

Certainly, adoption of these recommendations would do much to improve the delivery of care. Unfortunately, their seven initiatives alone will not fully address the problems the authors so elegantly point out in the first half of *Epidemic of Care*. Because the authors have paid insufficient attention to issues of feasibility and implementation and the importance of the market place, their proposals will not end the irrational financial incentives and the vast clinical gray zone (i.e., the ever expanding number of treatment choices and the imprecision and variability of arriving at correct diagnoses) that exist in much of medicine. The authors have suggested an intriguing, but ultimately only partial cure for what ails the American health care system. The missing ingredients in this prescription are a more thoughtful consideration of how their proposals might be implemented and a more robust use of the power of market forces to

3. *Id.* at 155.

4. *Id.* at 234-35.

5. *Id.* at 157.

achieve that end.

I. THE AUTHORS' BACKGROUNDS

To fully appreciate the perspective that Halvorson and Isham advance in *Epidemic of Care*, a brief understanding of their backgrounds is critical. Their proposed solutions are based, in part, on their experiences managing regional health plans with large, closely affiliated physician practice groups and hospitals. Halvorson is the chairman and CEO of Kaiser Permanente, the nation's largest integrated, non-profit health care delivery system.⁶ As a fully-integrated provider, Kaiser Permanente offers multi-specialty insurance, hospital, and pharmacy services to its members. Prior to Kaiser, Halvorson worked in Minnesota at HealthPartners,⁷ where George Isham still serves as chief health officer and medical director.⁸ HealthPartners offers an integrated package of health coverage, insurance, and services.⁹ Both authors have been leaders in improving clinical processes and measurement, in part through their adoption of electronic tools and support processes for physicians.

The authors contend that the example of improvements cultivated in tightly controlled physician organizations similar to the ones with which they have experience has relevance in a larger, more fragmented system (i.e., the U.S. health care system). This is possible, they believe, if government funding can be expanded to support technological improvements such as automated electronic medical records, additional training and education, and more research.¹⁰ However, neither author has had the opportunity to apply these same solutions on a truly national scale to an unorganized delivery system, which is what any solution must do if it is to be applied to the entire U.S. health care system. Indeed, the financial structure of systems like Kaiser Permanente and HealthPartners of Minnesota provides incentives to rationalize, without necessarily rationing, medical care.¹¹ Such organized delivery systems, though imperfect, are capable of fostering wide adoption of clinical practice standards rarely seen

6. *Id.* at xxix.

7. *Id.*

8. *Id.* at xxx.

9. *Id.*

10. *Id.* at 180, 235.

11. Rational care makes trade-offs and judgments about efficacy within the context of evidence-based medicine, but still provides the highest quality care. For example, using an expensive anti-inflammatory when aspirin might be equally safe and efficacious would not be condoned in a rational system.

in the broader physician population. A different solution, however, may be required for widespread implementation across the nation's health care system.

II. THE HEALTH CARE CRISIS

In making their case that there are serious problems ailing the current health care system, the authors point to several facts that have already been widely publicized. They note that health care expenditures have risen for the past five years at an alarming pace that is several times the rate of inflation. However, while health care expenditures consume an increasing percentage of the gross domestic product (GDP), the care received is often unsafe, highly variable, and frequently falls far short of known clinical standards in a way that few other industries would tolerate. The authors draw the link between poor quality and higher cost, but do not stop there. They also examine the role of private insurance as a funding mechanism for health care and as an arbiter of societal mandates, the role of market forces in the cost equation, and the mistakes of managed care over the past decade.

Indeed, cost is unquestionably a significant issue. Affordability and access to health care perennially rank high among the concerns of Americans in Kaiser Family Foundation annual surveys.¹² The popular press echoes this sentiment. Over the past three years, health care issues, particularly cost, have been the topic of innumerable, often front page, stories in the national press.¹³

This past year, the Medicare reform bill that included a Medicare prescription drug benefit appeared to be one of the most closely watched and hotly debated issues in Congress.¹⁴ At the core of this issue was affordability for the nation—who should receive the benefit and who should not, what would be covered, what the true projected cost of providing such a benefit would be, who should pay and how much, and how pharmaceutical manufacturers would be affected if the government

12. KAISER FAMILY FOUND., HEALTH CARE PRIORITIES (JAN./FEB. 2004), AT [HTTP://WWW.KFF.ORG/HEALTHPOLLREPORT/CURRENTEDITION/CARE/INDEX.CFM](http://www.kff.org/healthpollreport/currentedition/care/index.cfm) (LAST VISITED MAY 8, 2004).

13. See, e.g., Chad Terhune, *Fast Growing Health Plan has a Catch*, WALL ST. J., May 14, 2003, at A1; Milt Freudenheim, *Employees Paying Bigger Share for Healthcare*, N.Y. TIMES, Sept. 10, 2003, at A1.

14. For information on the Medicare Prescription Drug Improvement and Modernization Act (MMA) of 2003, see <http://www.cms.hhs.gov/medicarereform> (last visited May 8, 2004).

entered the prescription business for Medicare recipients. In this way, the Medicare reform bill debates were similar to previous national discussions on health care: Cost played a central role in every argument. The General Accounting Office (GAO) estimates that, if the current rate of increases in health care spending continue and if certain other assumptions are met, the growth in percent of GDP consumed by health care could materially affect our nation's ability to borrow from other nations within ten years. This impact on the United States's ability to borrow could, at worst, precipitate a call for repayment of existing debt.¹⁵ If this scenario were to play out, it could cause a national financial crisis. Indeed, one could argue that were it not for cost, much of the discussion about quality would not take place and many of the discussants, particularly purchasers, would not be as engaged.

If cost is central to the debate, who or what are the culprits? In *Epidemic of Care*, the authors suggest many of the possible causes of spiraling costs: health plans, providers, purchasers, patients, and medical technology firms. They rightfully identify the changing payment mechanism—from traditional indemnity insurance to HMOs to a more relaxed managed care—as an additional cause.¹⁶ The loss of defined fee schedules and a reversion to a more conventional fee-for-service model to cover procedures and services fundamentally changed the contract with the insured and altered the dialogue between patients and insurers. During the economic boom of the late 1990s, consumers resisted the restrictions of traditional HMOs, and employers, eager to retain employees during a tight labor market, paid for broader access to providers. Because profits were high, they could afford these increased costs. This led to a relaxation of tight managed care controls, resulting in diminished control by the health plans over processes and costs.¹⁷ Meanwhile, medical malpractice claims escalated, spawning medical necessity determinations. Medical necessity led to increasing denials of care, which led to consumer backlash. The backlash created loose or no controls and further escalation of costs.¹⁸

Halvorson and Isham tend to view these changes as unique to the health care industry, but one could argue that they are more directly linked to economic factors external to the health care system. Arguably,

15. U.S. Gen. Accounting Office, *Health Care System Crisis: Growing Challenges Point to Need for Fundamental Reform*, <http://www.gao.gov/cghome/healthcare> (Jan. 13, 2004).

16. HALVORSON & ISHAM, *supra* note 1, at 117-26.

17. *Id.* at 142.

18. *Id.* at 134-36.

almost all cost developments—the demand for plans to leverage volume to get price discounts; the Balanced Budget Act, which is curiously not mentioned in the book but appeared to be responsible for a huge shift in hospital pricing dynamics;¹⁹ and even the backlash against managed care—were lagging indicators directly linked to the overall state of the economy. In fact, there have been cyclical expansions and contractions in health care expenditure increases for the past forty years, roughly related to economic cycles.²⁰

Yet even while recognizing that the health care system does not exist in a vacuum, it is also important to recognize that some of these cost developments do result from factors unique to the health care system. Indeed, the authors draw the inevitable link between poor quality and cost. Five years ago a firestorm was unleashed when the national press, in headline stories,²¹ seized upon an as yet unreleased report by the Institute of Medicine which declared that the health care received in America's hospitals is fundamentally unsafe and cited avoidable medical errors in hospitals as one of the leading causes of death in this country.²² The story is echoed in reports of high profile medical error cases such as that of Jessica Santillan, the young woman whose death was due to an error in matching blood types.²³

Safety in the health care system is a pervasive and sentinel quality issue, and this concern extends beyond the hospital safety concerns cited in the original IOM report to the omissions of care in the ambulatory care setting. As Beth McGlynn and others have reported, these omissions occur at an alarmingly high rate,²⁴ and the consequences of these omissions are many: additional procedures, suffering, and years of life lost. Six sigma, a

19. The Balanced Budget Act of 1997 contained provisions on payment to physicians. *See, e.g.*, Balanced Budget Act of 1997, Pub. L. No. 105-33, 111 Stat. 251, 298. Hospitals, often with forty percent or more of their revenue coming from Medicare, saw revenues fall, which created pricing pressure on the private insurance market.

20. *See, e.g.*, CTRS. FOR MEDICARE & MEDICAID SERVS., AN OVERVIEW OF THE US HEALTHCARE SYSTEM: TWO DECADES OF CHANGE 1980-2000, <http://www.cms.hhs.gov/charts/healthcaresystem/all.asp> (last modified Oct. 27, 2003).

21. *See, e.g.*, Bob Davis & Julie Appleby, *Medical Mistakes 8th Top Killer*, USA TODAY, Nov. 30, 1999, at A1.

22. For a copy of the report, see INST. OF MED., TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM (2000), <http://www.nap.edu/openbook/0309068371/html>.

23. *See, e.g.*, Dan Vergano, *Teen Has 2nd Chance After Mismatch Forces 2nd Transplant*, USA TODAY, Feb. 21, 2003, at A1.

24. *See* Elizabeth A. McGlynn et al., *The Quality of Healthcare Delivered to Adults in the United States*, 348 NEW ENG. J. MED. 2635 (2003).

statistically driven approach to process control used by many manufacturers, teaches us that defects or mistakes represent waste, and waste is costly.²⁵ Manufacturers focus on controlling process to reduce the number of defects and thus the amount of waste in producing a higher yield of reliable goods. Almost by definition, this results in a cost benefit as long as the price of achieving process control is less than the cost of the waste being eliminated.

Another major problem that the authors address is the threat that the uninsured pose to the current system. As employers, particularly small businesses, scale back or even cancel health benefits, the number of uninsured will rise, and, as a voting bloc, they will wield significant political power.²⁶ Additionally, this will cause an increase in the amount of uncompensated care, the cost of which is currently being shouldered by others who use the system, including employers, payers, and hospitals. Ironically, on a percent of charges basis, the greatest burden is shouldered by those who fully pay their own bills since they do not enjoy the discounts of group purchasers.

Thus, Halvorson and Isham persuasively argue that there are serious problems in the United States health care system as it currently operates. Yet because Halvorson and Isham fail to fully appreciate how these problems influence—and are influenced by—market forces, their solutions are necessarily limited. While they offer the beginnings of needed reform, their recommendations by themselves do not go far enough to cure what ails the U.S. health care system.

III. EPIDEMIC'S RECOMMENDATIONS

Solving these problems will undoubtedly require a political solution.²⁷

25. For additional information about six sigma, see <http://www.6-sigma.com> (last visited May 8, 2004).

26. While the uninsured today may be less likely to vote or contribute to political campaigns, it is reasonable to assume that if their number increases and their demographic profile shifts, the issue of coverage may become politicized. For example, if more active, white collar workers lose health benefits and pay for an increasing share of their health care costs, or as retirees find their private or federal health benefits shrinking, they will be more likely to voice their concerns. For further discussion, see HALVORSON & ISHAM, *supra* note 1, at xx-xxvii.

27. The problem of the uninsured presents just one example. Employers have long been too inactive in this arena, but a sizable group of employers, under the auspices of the Human Resources Policy Association (HRPA), have identified this issue as their number one concern and are seeking to tackle it through a collaborative process. For more

As they transition toward their discussion of solutions, Halvorson and Isham are correct in dismissing a single payer national health care system solution. Even with age and other demographic adjusters, the United States is an outlier on medical per capital expenses.²⁸ Beside the vested interests of many incumbent stakeholders, the costs of centrally funding benefits for all Americans would likely prove prohibitive given current expense levels. The ability to control costs would hinge on politically painful decisions such as rationing care. The authors cite the lack of a Medicare drug benefit as proof of the government's willingness to ration care, but the recent passage of the Medicare drug bill may have altered their views.²⁹ The core of the Medicare drug debate centered around funding, and the design of the final plan was largely crafted to make it affordable and its passage possible. The Medicare drug bill is a study in the political challenges a single payer system would face. Even Senator Hillary Clinton now acknowledges the failures of the Clinton Administration proposal and is instead proposing precisely what the authors suggest in their seventh—and fundamental—initiative: the creation of an electronic medical information infrastructure.³⁰

Although Halvorson and Isham list their recommendation to provide electronic medical records (EMR) and aids last, it is actually the most important as it is the critical underpinning of their other six ideas. Improving quality care, their first initiative, as well as ensuring productivity and consistency in the health care system, will be aided by an automated medical record tool that enables access to legible, organized, historical health information at multiple points of care. Additionally, this tool, as envisioned by the authors, will support evidence-based clinical decision processes, provide reminders, and generate data on performance. This data will make it possible to evaluate process, thus providing another opportunity for improvement in the quality of care.³¹

information on the HRP, see <http://www.hrpolity.org> (last visited May 12, 2004).

28. For more information, see Org. for Econ. Co-operation & Dev., *Health at a Glance 2003 - OECD Countries Struggle with Rising Demand for Health Spending*, at http://www.oecd.org/document/38/0,2340,en_2649_201185_16560422_1_1_1_1,00.html (last visited May 12, 2004).

29. HALVORSON & ISHAM, *supra* note 1, at 145.

30. Senator Clinton made this remark during her keynote address at the World Health Congress in Washington, D.C. on January 25, 2004. For more information about the World Health Congress, see <http://www.worldcongress.com> (last visited May 8, 2004). For a review of her speech, see Erik Goldman, *Online Claims Processing: Sen. Clinton Eyes EMRs as New Key to Reform*, OB/GYN NEWS, Apr. 1, 2004, at 26.

31. HALVORSON & ISHAM, *supra* note 1, at 27.

While an effective EMR tool would be a welcome improvement if available to the broader population, it still falls far short of the goal of aiding the logical clinical decision-making process. Here, *Epidemic of Care* does not recognize the relevance of market dynamics and making use of those dynamics to ensure the implementation of a more robust use of EMR. Indeed, a truly complete EMR tool will tap into narrative records with their wealth of clinical data; of course, the problems presented by varying nomenclature, as well as the sensitivity and accuracy of observed findings during physical examinations, will need to be solved. Technology is rapidly reaching a point where it can support these aims. However, these tools are not currently widely adopted because there is no compelling incentive for health care providers to create that system for the key stakeholders—whether doctors, patients, hospital administrators, health plans, or employers. Market adoption will depend on creating those incentives and disincentives. Although the authors suggest that additional training or government funding will provide a stimulus to invest in change,³² there are other factors that are far more likely to create that effect. In particular, a broad and consistent demand for performance measurement, the sharing of comparative information, and differentiating providers and systems based on performance through information, movement of patients, or financial reward are all powerful market tools purchasers and payers have barely begun to use.

While EMR is Halvorson and Isham's most important recommendation, their other six recommendations are also worthy of brief discussion. Halvorson and Isham's first is to improve safety.³³ Given that it intuitively makes sense that improved quality will lower costs, it is unsurprising that this is their first recommendation. While reducing the number of harmful errors and the overuse of procedures would clearly have this effect, Halvorson and Isham fail to recognize that since the goal of health care is better outcomes *in total* for the patient and her family, better quality may mean higher expenditures in some cases.³⁴ A more

32. *Id.* at 239.

33. *Id.* at 156.

34. For example, a forty-five year old male at risk for a heart attack may reduce his risk by using pharmaco-therapeutic agents and making lifestyle changes. Since his risk of an acute event is not absolute, and the certainty of his fate cannot be determined in advance on an individual basis, he may use the drugs for a lifetime for an event he may never have had, eliminating any return on his investment. Ignoring the impact on mortality and morbidity for a moment, even if he knew with certainty his ultimate fate, the cost of medication and treatment could exceed the cost of treating the acute event and, in the end, is not guaranteed to absolutely avoid it. Prevalence, length of use, cost, adherence to

expensive procedure may be less invasive, mean less disfigurement, or offer greater diagnostic certainty. Patients may define this as better quality, even if the outcome is unchanged. The cost of lifetime medication to prevent a fatal event in a population at risk may exceed the cost of caring for the minority who would suffer an event. While some economists argue that these improvements lead to increased longevity and productivity that exceed the medical expense by a factor of three or more,³⁵ this is a difficult analysis to prove and requires many unknown assumptions.³⁶ Additionally, because the recipient of health benefits is often not the one who pays for those benefits, conventional cost-benefit analyses no longer hold, and our notions of supply and demand curves must account for a system with three (and sometimes even more) stakeholders. Nothing in the cost/quality equation is helpful in dealing with the added expense of new, highly effective, but expensive technology. While the authors identify this as an issue,³⁷ they do not adequately address it in their recommendations.

Halvorson and Isham's second proposal to ameliorate the current crisis—turn the patient into a consumer³⁸—is also not fully grounded in the dynamics of the market. They cite the proliferation of the Internet and the high hit rate of medical information sites as proof that patients are interested in being better informed and becoming actively engaged in medical decision making on issues such as choice of health plans, providers, and therapies.³⁹ This is likely true, but given the wealth of information available, its adoption and use by consumers seems underwhelming.⁴⁰ Part of the problem may be that the historical lack of

indications for use, the predictive capability of screening measures, and the efficacy of an intervention including its unintended consequences or adverse side effects all determine if an intervention is in fact cost effective.

35. See, e.g., David M. Cutler, *The Real Medicare Conundrum*, Presentation to the Medical Technology Leadership Forum (Feb. 2004), at http://www.mtlf.org/events/pdf/cutler_Presentation.pdf (last visited May 8, 2004).

36. For example, Cutler's analysis relies on a set of assumptions about death and disability rates and potential earning power and an ideal application of therapeutic interventions. If these assumptions were to change, so would the return on investment he estimates.

37. HALVORSON & ISHAM, *supra* note 1, at 40.

38. *Id.* at 99.

39. For a discussion of the role of the Internet in medical care, see HALVORSON & ISHAM, *supra* note 1, at 99-108.

40. Internet site visit rates or "hits" should not be taken as proof that consumers are factoring what they read on those sites into their decision making in a substantive way. In addition unless we track reasons for usage, we do not know the reasons they visit these sites:

relevancy of consumer information about health care has stymied adoption.

More importantly, consumer health care decisions are emotive as well as cognitive; not all individuals approach decision making in the same way, and under different circumstances the same individual may place different weights on what they value. For example, what one is willing to do for a terminally ill child may differ from what one would be willing to do for oneself in the same condition. The difference in risk between one health care choice versus another may seem small in the eyes of a consumer. But in a heavily personalized transaction it may well be that people value trust and the personal relationship highly. The argument for providing as much relevant and timely information as is feasible to consumers is strong. Some will use it and benefit from it; others will not, but will at least have had the opportunity to do so. If the goal is to influence patient decision making, we may need tools that go well beyond the cognitive in order to reach patients and address their more fundamental needs. To not anticipate this is to be disappointed by the results. The drug makers who are successful in their direct advertising appeal to consumers do this well, albeit to improve sales, as do the makers of soap, coffee, and many other consumer commodities.

The third initiative, improving population health, is addressed through the development of local community prevention goals.⁴¹ Setting prevention targets for health plans is a bold and laudable move especially for primary prevention efforts. The authors should also recognize the need for public accountability in this regard and the benefit of community-wide actions. The authors cite the obesity epidemic as an opportunity for prevention efforts,⁴² but do not fully incorporate the way we work and play, the food choices most widely promoted, and the relevant community resources and social factors, all of which are tied into the obesity problem. In addition, the authors have omitted the few relevant examples where market-based forces have changed individual behavior. Johnson and Johnson pioneered research in providing individuals with financial and other incentives to adopt healthier lifestyles with some reported success.⁴³ One of the more intriguing elements of the Bridges to Excellence program

We do not know if they use them to research personal questions, questions for family members, or if they are simply looking for general information.

41. HALVORSON & ISHAM, *supra* note 1, at 199.

42. *Id.* at 195.

43. Ronald Ozminkowski et al., *Long-term Impact of Johnson & Johnson's Health & Wellness Program on Health Care Utilization and Expenditures*, J. OCCUPATIONAL & ENVTL. MED, Jan. 2002, at 21.

is a schedule of rewards, very much like frequent flyer points, which can be earned for certain behaviors and then redeemed for tangible items.⁴⁴ Such designs are still novel and their effectiveness is not yet proven, but they are intriguing in the context of creating new benefit designs with market incentives (beyond the goal of improved health) for the patient.

As the authors point out in their explanation of the fourth initiative, consolidation was a predictable response to market forces.⁴⁵ As payers became larger and began to demand deeper discounts, providers responded through a series of mergers and acquisitions to protect their slim margins. Unfortunately for Halvorson and Isham, it may be too late for antitrust efforts to remedy the problem in many markets. The government is partly culpable not only because of the judiciary's unwillingness to enforce antitrust law,⁴⁶ but also because of its role as a purchaser who sets the price in the marketplace. In the future, the government must behave responsibly and use its leverage to further performance reporting and create performance-based rewards. For example, CMS could provide direct payments to any providers that improve outcomes in a pre-determined set of clinical performance measures. Other purchasers then need to follow suit and push for reporting at the facility and provider level.

As mentioned above, the issue of the uninsured—initiative five—is incredibly complex, and Halvorson and Isham have proposed a piecemeal approach that would alleviate, but not solve, the problem.⁴⁷ Their ideas are based on the fact that all uninsured are not equal. In particular, the chronically uninsured account for about half of the national number. To prevent corporations from dropping or drastically reducing coverage for some employees, Halvorson and Isham suggest a “pay or play” model that would require all employers to make a contribution toward health coverage for each employee.⁴⁸ However, this sort of mandated change is likely to be vigorously resisted by small employers.⁴⁹ Similarly, it may be

44. Bridges to Excellence (BTE) is an employer sponsored initiative which aims to reward physicians and patients for adhering to a set of evidence-based clinical practices in managing chronic conditions such as diabetes and cardiovascular disease. Rewards for physicians are based on qualification under the NCQA/DPRP program. For more information, see Bridges to Excellence, *at* <http://www.ncqa.org/Programs/bridgestoexcellence/index.htm> (last visited May 8, 2004).

45. HALVORSON & ISHAM, *supra* note 1, at 81.

46. *Id.* at 80.

47. *Id.* at 219-21.

48. *Id.* at 229.

49. This opinion is based on the reasonable assumption that small employers are less

politically untenable to publicly fund even a minimum set of benefits for the working poor. Such an action removes much of the motivation from the employers who currently fund such programs for low wage earners. Vouchers which would capitalize on private markets for supplying insurance or care and which would limit the financial liability of the government might have more political traction.⁵⁰ In today's political climate, one that seems ill-suited to addressing the needs of the uninsured, the system of utilizing and expanding community-based clinics is likely to be the most practical, although limited in its impact given current resource allocation.⁵¹ However, the initiation of change in any of these policies will require both broad purchaser support and organized lobbying by the medical community. Unfortunately, there is no ready prescription for getting this to happen. Hospitals will likely continue to watch their payer mix and devise strategies to avoid being swallowed by the cost, and the current system will continue providing care until it becomes untenable.

The sixth initiative is aimed primarily at reducing the impending shortages in many health care fields and calls for government to fund training. More importantly it calls for research and support for the “re-engineering” of health care.⁵² Most industries that embark on this kind of change do so because there is a critical business imperative.⁵³ That does not exist in health care—yet. The good news is that there is precedent for this kind of government funding. Taxpayer dollars have been used, not always prudently, to support key industries and maintain a technical advantage both in defense and in health research.⁵⁴ Such a mechanism could be used

equipped to absorb additional costs relating to health care since many currently do not offer or subsidize health insurance to their employees. For more information about small business owners and health care coverage, see Kaiser Family Found., *National Survey of Small Businesses*, at <http://www.kff.org/insurance/20020402a-index.cfm> (2002).

50. This statement is based on the historical lack of political action to support the uninsured working poor and the current environment that exhibits reluctance to fund new or additional entitlements for the poor.

51. Capitalizing on an existing structure of publicly funded clinics may prove more practical, since new funding may not be required if these clinics have unused capacity or could inexpensively be offered as an option to those meeting income requirements.

52. HALVORSON & ISHAM, *supra* note 1, at 233-40.

53. For example, U.S. automotive manufacturers responded to the competitive threat of imported makes with higher levels of quality by changing quality control, design engineering, and manufacturing processes and ultimately improving the quality and reliability of American manufactured automobiles.

54. Examples include the National Institute of Health (NIH), the space program, weapons development, the formation of the RAND corporation in the 1940s in response to

here, but as a nation we seem divided over how to view our health care delivery infrastructure. Is it a public resource or a private industry? The recent bio-terrorist threats certainly exposed fault lines in our thinking about public health resources. Will market forces provide adequate incentives and coherent direction to produce meaningful change? We know we need hospitals and physicians, like fire stations, to be available and prepared to respond in a crisis; but unlike most fire stations, we have not yet decided how to fund them or make them completely adequate to the task. Most care processes have not been engineered for efficiency. As hospitals nurse thin margins and competitive forces siphon off profitable procedures, a new urgency and focus on process efficiency may evolve. Another catalyst may be the growing demand for comparative efficiency measures.⁵⁵ The ultimate marriage of reliable effectiveness and efficiency measures will provide a powerful vehicle for channeling patients and rewards and creating a strong market incentive for improvement.

IV. CONCLUDING THOUGHTS

Not only does *Epidemic of Care* fail to incorporate the realities of market dynamics in its proposed solutions, but it also fails to mention several promising market-based efforts to promote better care. For example, the Bridges to Excellence program sponsored by GE, Ford, UPS, Verizon, and other large employers in concert with health plans such as Humana, United Healthcare, and others focuses on improved diabetic care in three markets and supports the adoption of automated clinical office tools to improve care.⁵⁶ It relies on the American Diabetes Association/National Committee for Quality Assurance (ADA/NCQA) physician recognition program to achieve better outcomes and uses both benefit design and patient incentives to achieve results. In fact, the authors cite the ADA/NCQA program favorably.⁵⁷ It is one of a handful of programs that pays physicians in the form of an annual per patient bonus based on clinical performance.

the need for technological superiority in war, and, more recently, the support of the airline industry following 9/11.

55. Examples of this growing demand include employer initiatives such as the Leapfrog Group, which plans to look at efficiency measures in addition to quality outcomes. For more information, see The Leapfrog Group, at <http://www.leapfroggroup.org> (last visited May 13, 2004)

56. See Bridges to Excellence, *Overview*, at http://www.bridgestoexcellence.org/bte/bte_overview.htm (last visited May 13, 2004).

57. HALVORSON & ISHAM, *supra* note 1, at 22.

In addition, there is a wealth of activity in the marketplace focused on the broad provider community. The National Quality Forum created under the Clinton Administration has worked to endorse valid quality and safety measures for the industry.⁵⁸ Some large national plans, such as United Healthcare, are adopting these measure sets and actively encouraging their collection and dissemination.⁵⁹ CMS has been active in piloting quality performance demonstration projects and voluntary hospital measure collections and in paying for performance initiatives.⁶⁰

Other efforts driven largely by national self-insured employers are pushing for provider level quality and efficiency measures. One of the most notable is the Leapfrog Group, a consortium of over 150 large employers who banded together initially to promote hospital safety through public reporting about three important “leaps.” Responding to the Institute of Medicine report, *To Err Is Human*, which attributed between 44,000 and 100,000 deaths in hospitals to avoidable medical errors,⁶¹ the Leapfrog Group adopted three initial “leaps” correlated with lower incidences of avoidable medical errors.⁶² They asked hospitals to report on intensivist staffing and rounding in intensive care units, adoption of computerized order entry to reduce the number of drug errors, and the number of a select group of surgical procedures performed in each hospital annually. Each leap is measurable, attainable, and capable of producing safety and outcome improvements immediately. It is curious that the authors, who must have been familiar with this national effort, chose not to explore this market based initiative in their discussion of safety. It is arguable that many of the quality initiatives that followed, such as the partnership on voluntary reporting of hospital performance measures sponsored by CMS, JCAHO, and the AMA may have been directly influenced by the pressure of Leapfrog.⁶³

58. See Nat'l Quality Forum, *About the National Quality Forum*, at <http://www.qualityforum.org/about/home.htm> (last visited May 13, 2004).

59. For general information on UnitedHealth Group, see <http://www.unitedhealthgroup.com/> (last visited May 22, 2004).

60. See, e.g., Ctrs. for Medicare & Medicaid Servs., *Premier Hospital Quality Incentive Demonstration*, at <http://www.cms.hhs.gov/researchers/demos/phqidemo.asp> (last visited May 13, 2004).

61. INST. OF MED., *supra* note 22, at 1.

62. See The Leapfrog Group, *Fact Sheet*, at http://www.leapfroggroup.org/FactSheets/LF_FactSheet.pdf (last visited May 13, 2004).

63. For more on the voluntary reporting of hospital performance measures sponsored by CMS, JCAHO, and AMA, see Ctrs. for Medicare & Medicaid Servs., *Hospital Quality Initiative*, at <http://www.cms.hhs.gov/quality/hospital/> (last visited May 13, 2004).

The results can be heartening. One integrated care system in Virginia estimates that their new electronic intensive care unit will improve care while generating nearly two million dollars in cost savings.⁶⁴ The ultimate impact of these efforts is yet to be measured in full, but would seem to be significant as adoption spreads. It is against this background that the seven recommendations for new initiatives should be weighed. Efforts to improve quality and safety will benefit from provider level data, but comparative data for plans will evolve from the HEDIS-like data of the past and will begin to focus not on average performance, but on how many patients receive the correct care and how efficiently this care is provided. Plans will be held accountable for encouraging reporting on critical measures and for supporting processes that improve care. It is as yet unclear how large a role government funding will play in supporting these efforts, but cost will be an issue, and the cost is likely to be born in part by purchasers. Agency funding has begun enabling research to help this effort.

The authors have also omitted another common argument in discussions about changing the current system of health care delivery. According to economist Milton Friedman, today's system is an aberration of market forces because it is structured around a tax code favoring employers over individual purchasers of health insurance.⁶⁵ If individuals could claim the same deductions for health insurance that corporations currently do, a very different market would exist. Friedman may well be right. Products that have not yet been offered, such as an evidence-based benefit design that would pay differentially for highly effective treatments, or share more of the cost of treatment based on the known potential clinical benefit, have not yet been tried and could help shape the market.

For any solution to be successful, it will have to be feasible in today's environment of a dispersed, fee-for-service marketplace with a fragmented physician corps and an increasingly consolidated hospital and specialist system. These are not trivial considerations. Given this, Halvorson and Isham have achieved the goal of providing a clarion call for action and in dismissing the notion that a single payer system is a tenable solution for this nation's health care woes. The seven initiatives that they propose are important and should be recognized as steps in the right direction. The most glaring problem with *Epidemic of Care*, however, is that it fails to

64. Cinda Becker, *Telemedicine System Helps Manage ICUs*, MODERN HEALTHCARE, Sept. 4, 2000, at 62.

65. See, e.g., Milton Friedman, *How To Cure Healthcare*, THE PUBLIC INTEREST (2001), <http://www.thepublicinterest.com/archives/2001winter/article1.html> (last visited May 13, 2004).

recognize something that is of critical importance in assessing the feasibility and effectiveness of suggested reforms in the United States: The market matters. Had they recognized that fact and modified their recommendations accordingly, their call to action could have been much more; indeed, it could have served as a roadmap to implementation and, ultimately, to change.

