THE COMMONWEALTH FUND

In the Literature

OBTAINING GREATER VALUE FROM HEALTH CARE: THE ROLES OF THE U.S. GOVERNMENT

Stephen C. Schoenbaum, M.D.
Anne-Marie J. Audet, M.D.
Karen Davis, Ph.D.

Health Affairs
November/December 2003
22 (6): 183–90

Copies of the full article can be downloaded at:

www.healthaffairs.org

For more information about this study, please contact:

Stephen C. Schoenbaum, M.D.
Senior Vice President
The Commonwealth Fund
TEL 212-606-3505
E-MAIL scs@cmwf.org

or

Mary Mahon
Public Information Officer
The Commonwealth Fund
TEL 212-606-3853
E-MAIL mm@cmwf.org

Commonwealth Fund Pub. #686
November 2003

In the Literature presents brief summaries of Commonwealth Fund–supported research recently published in professional journals. To read or learn more about new publications as soon as they become available, visit **www.cmwf.org** and register to receive Commonwealth Fund e-mail alerts.

THE COMMONWEALTH FUND
ONE EAST 75TH STREET
NEW YORK, NY 10021-2692
TEL 212.606.3800
FAX 212.606.3500
E-MAIL cmwf@cmwf.org
http://www.cmwf.org

U.S. health care costs, already highest in the world, continue to rise, and strategies to shift and minimize costs have not worked well. According to a recent commentary, the problems in the U.S. health care system are unlikely to be solved without strong leadership from the federal government in establishing an agenda to set national priorities, develop guidelines for health care, and help to implement measures to track provider performance.

By focusing on quality improvement, the government would get better value from its substantial investment in health care, say Stephen C. Schoenbaum, Anne-Marie J. Audet, and Karen Davis of The Commonwealth Fund in "Obtaining Greater Value from Health Care: The Roles of the U.S. Government" (*Health Affairs,* Nov./Dec. 2003).

This effort, however, would require a major expansion of federal involvement, best accomplished through legislation and the creation of a new federal agency, the authors say. Many of the health care system's current problems stem from a lack of leadership in a highly fragmented delivery system. The country has more than 5,500 acute care hospitals, 18,000 nursing homes, 800,000 doctors, and multiple accrediting and licensing groups.

The cost of inaction is high. An estimated 44,000 to 98,000 lives are lost annually in the United States from medical errors in hospitals, and more lives are lost in other settings. The development of federal guidelines for standards of care and performance would constitute a classic public good, like sharing the results of medical research. Moreover, the federal government has an interest in improving quality and controlling health care costs over the long run. It is the single largest payer for health care as well as the single largest provider, through the Veterans Health Administration, Department of Defense, and Indian Health Service.

The authors note that the private market is failing to improve care sufficiently on its own and is doing little to increase the value Americans receive for their health care dollars. Under the current system, payers do not differentiate between poor or good quality. For example, when a hospital provides premium-quality care, it cannot expect to receive more money from payers.

There is precedent for federal intervention in the private sector. In the auto industry, the government sets standards for automobile safety and highway standards. It could take on a similar role in organizing or structuring the health care sector, while preserving the private nature of the health care industry.

The government's current efforts to boost quality get relatively little funding. The federal Agency for Healthcare Research and Quality (AHRQ) manages an active research program in quality of care and patient safety, although funding for this is less than 0.02 percent of national health care expenditures. There is a public–private partnership working on improving quality measures; a research program on the quality of care and patient safety; quality improvement activities sponsored by the Veterans Health Administration; and a quality assurance program supported by Medicare. Collectively, these efforts fail to bridge the chasm between the quality of care Americans expect and the care they actually receive. The table below lists past and present activities of the federal government

and proposes ways in which it could go further to improve the quality of U.S. health care.

Setting Priorities and Standards

A new federal agency could set national priorities for health care quality by defining the most critical problems and setting standards for care. It also could develop clinical guidelines and national performance standards, and track data on performance to gauge if these goals are being met. In several other countries, including the U.K., government agencies have taken on the roles of developing guidelines on effective care and examining cost-effectiveness.

In addition, the federal government could collaborate with states to set performance-based payment policies. Medicare and Medicaid, for example, should give financial incentives to high-quality care providers.

Improving quality requires investment in infrastructure, particularly clinical information systems. Through loans, the government can help provide the capital that health care providers need to adopt information technologies (IT). Medicare payment rates could also provide an incentive for adoption of quality-enhancing IT. It also could increase funding for research on effectiveness and cost-effectiveness, and help to translate local initiatives into national practices.

Finally, public reporting of how health care providers and institutions perform is essential for creating an accountable health care system.

Federal Roles in Improving Quality of Care

	Past/Present	Proposed/Projected
Setting of Priority Areas	Diffuse responsibility: federal interagency committee; Institute of Medicine (private org.)	New agency as leader and convener
Generation of Evidence, Effectiveness, and Cost-Effectiveness	Agency for Healthcare Research and Quality, National Institutes of Health	Enhanced funding for existing agencies
Clinical Guidelines	Agency for Health Care Policy and Research (no longer being done)	New agency
Performance Measures	Not a federal function. Has been a function of National Quality Forum (a public/private partnership)	New agency working with and leading NQF and other interested parties
Standards of Quality	Not a federal function	New agency working with and leading NQF and other interested parties
Performance-Based Payment Policies	Health Care Financing Administration/Centers for Medicare and Medicaid Services — (relatively small effort)	Significant changes in Medicare reimbursement policies
Information Technology (IT) to Develop and Support Improved Practices	National Library of Medicine, Veterans Health Administration	Core function of the Department of Health & Human Services
Technical Assistance	Medicare Peer Review Orgs./ Quality Improvement Orgs.	Enhanced role for QIO's beyond Medicare
IT Standards	Recent initial actions by the Department of Health & Human Services	Regularly set and updated by the Department of Health & Human Services
IT Capital	----------	Federally administered loans or loan guarantees and Medicare reimbursements
Human Resources	----------	Training of a cadre of clinical IT professionals and persons skilled in the methods of quality improvement, patient safety, and clinical effectiveness
Demonstration Projects for Chronic Diseases, IT Development, and Primary Care Enhancement	----------	Core function of the Department of Health & Human Services