

TAMING HEALTH CARE INEFFICIENCY: PHYSICIANS AND OTHERS EXPLORE SOLUTIONS

Report from the 2006 ABIM Foundation Summer Forum

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One hundred and ten leaders from across health care came together at the ABIM Foundation 2006 Summer Forum, to consider whether there was, among them, a shared vision of a path to make our health care system more efficient. While discussion was vigorous, a high level of consensus emerged: we have a common problem; it is understandable; it is solvable; but solving it will require leadership and commitment, and a willingness on the part of each sector to forego its narrow self interest. Forum participants developed recommendations for key sectors of health care, with detailed recommendations for certifying boards.

INTRODUCTION: PROTECTING THE MEDICAL COMMONS

Christine Cassel, ABIM and ABIM Foundation, introduced the 2006 Summer Forum by quoting Howard Hiatt's reflections—from 1975—on Garrett Hardin's work. "Surely nobody would quarrel," Hiatt wrote, "that there is a limit to the resources any society can devote to medical care...The dilemma confronting us is how we can place additional stress on the medical commons, without bringing ourselves closer to ruin."

We are now appreciably much "closer to ruin" than in 1975. Health care consumes a much larger fraction of our economy, and tens of millions of Americans have no—or minimal—protection against medical catastrophe. Health care costs are rising at nearly three times the rate of general inflation, and powerful forces—among them an aging population and dazzling yet enormously expensive new technology—will only exacerbate that trend. Yet we seem no closer to a solution than we were in 1975.

The *status quo* cannot be maintained or the commons will be exhausted. But what are we to do? "It is surely not fair," Hiatt wrote, "to ask the physician to set (limits) in a context of his or her own medical practice. The challenge for the medical profession is how to join with others in effective decision-making."

That is the challenge to Forum participants.

OUR COMMON PROBLEM: WASTE

Karen Davis, Commonwealth Fund, launched the 2006 Forum with the Kimball Lecture, in which she argued persuasively that the enormous variation we see in health care costs and quality in the United States establishes unequivocally that health care is not delivered efficiently across the country. That failure to address inefficiency is creating a crisis that is making quality health care unaffordable—and unavailable—to more and more Americans. The fundamental issue here is one of waste—which is raising the cost of care for those with insurance, and stealing resources that are needed to provide care to those with no or inadequate insurance.

Others confirmed, from their different perspectives, that the problem of waste is undeniable and urgent. While John Rother, AARP, pointed out that for consumers "efficiency could be a code—a *negative* code—for cost-cutting or time-cutting," he pointed out as well that "efficient health care is certainly in the consumer's interest because ultimately we pay for it."

Jim Naughton, a practicing physician, argued that efficiency is about doing "the right thing"—in the right way, at the right time, for the right patient. Other Forum participants suggested adding "every time" and "at the right cost" to Naughton's definition of "right thing." To deliver the right care requires professional behavior and that physicians challenge each other – to speak out, when they observe colleagues delivering the "wrong care." It also requires knowledge and timely access to information about patients, yet the current state of medical science and of information systems limits physicians' ability to get it right on all these dimensions.

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THE TRAGEDY OF
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– GARRETT HARDIN

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– JOHN ROTHER
AARP



UNDERSTANDING THE PROBLEM: HOW CAN THE BEST MEDICAL CARE IN THE WORLD COST TWICE AS MUCH AS THE BEST MEDICAL CARE IN THE WORLD?¹

Meeting participants spent much of the Forum exploring the issues that account for inefficiency in our health care system. Four factors emerged as primary:

“AS WE THINK ABOUT THE POTENTIAL “TRAGEDY OF THE COMMONS,” THE PRIMARY CARE PHYSICIANS ARE PICKING BLADES OF GRASS OFF ONE-AT-A-TIME. THE SPECIALISTS HAVE LAWNMOWERS.”

– GEORGE ISHAM,
HEALTHPARTNERS, INC

“THERE’S AT LEAST AS MUCH OPPORTUNITY FOR ELIMINATING INEFFICIENCY ON THE ADMINISTRATIVE SIDE AS THERE IS ON THE CLINICAL SIDE.”

– BILL JESSEE
MGMA

Supply

Markets vary both with respect to the availability of resources (e.g., specialists and hospitals) and with respect to how those resources are organized (e.g., the extent to which physicians practice solo or in small groups, or in larger and more explicitly structured groups or delivery systems). Elliott Fisher, Dartmouth Medical School, reviewed data that clearly suggest that costs and rates of service vary directly (and quality may vary inversely!) with supply—high cost markets are characterized by higher ratios of hospital beds and specialists per capita; and with the organization of practice—high cost markets are characterized by significantly higher proportions of physicians in solo or two person practices.

Physician practice style

Physicians vary with respect to their tendency to treat—to order tests, follow up visits, and refer to specialists; this is particularly so in the “gray zone” where care is neither clearly indicated nor clearly contraindicated. Elliott Fisher reviewed data that establish not only wide variations in rates of cost and service across markets, but also that those variations correlate (positively) with “physician propensity to intervene.”

Rebecca Lipner, ABIM, summarized preliminary results from research ABIM has done with investigators at Dartmouth. These data suggest that physicians with more knowledge tend to treat patients appropriately but more conservatively. Eric Holmboe, ABIM, summarized the theoretical rationale for this: knowledge reduces the size of the “gray zone,” and may increase physician tolerance for uncertainty. The implication is an important one: knowledge leads to more efficient care.

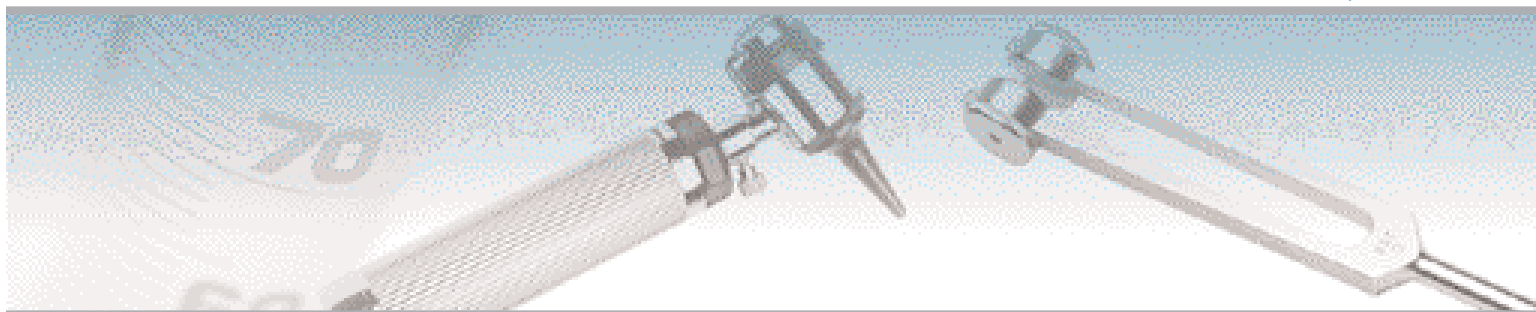
Patient expectations

Although data do not as strongly support the correlation between variations in cost of care and patient preferences for specialty care and discretionary testing and referral, there was broad consensus that the current “more is better” paradigm is both a threat to efficiency and a threat to quality. John Rother pointed out that unnecessary care is bad quality care—yet few consumers understand that this is a problem that affects them. Debra Ness, National Partnership for Women and Families, suggested that this might in part be a reaction to managed care; in an environment in which a powerful force is clearly acting to limit access to care, consumers view limits to care as a threat to quality.

Operational waste

Finally, Forum participants offered many examples of operational inefficiency; both clinical and administrative. Many participants noted the clinical waste that attends uncoordinated care: redundant lab tests and x-rays that result when information does not flow from one physician to another. Jim Naughton spoke of the ramifications of the multitude of health plan formularies on his practice and its economics; how his practice’s commitment to finding the most cost-effective medication for each patient effectively reduces the number of patients each physician can see by 15 percent. And Bill Jessee, Medical Group Management Association (MGMA), suggested that as much as 25 to 30 percent of the nation’s total health care bill is for administration; that there is enormous waste in the administration of the almost infinitely variable fee schedules both within and between insurance carriers, as well as unconscionable redundancy in administrative processes like credentialing.

¹Uwe Reinhardt, as cited by Elliott Fisher



SOLVING THE PROBLEM: WE CAN, TOGETHER

Appreciating that the causes of inefficiency are many and complex, there was both a surprising amount of optimism that the basic problems could be solved, and a surprising degree of convergence as to the nature of those solutions. Five core strategies emerged:

Changing the way we pay for health care

No matter what the specific cause of inefficiency, Forum participants almost always were able to trace it back to our current system for financing care. The incentives in a fee-for-service payment system encourage capacity expansion, and reward the physician who is inclined, in the “gray zone” of uncertainty, to offer the extra test or referral. Insulation of patients from the true cost of care, by an insurance system that reduces consumer cost-sharing to a small proportion of that cost, encourages patients to seek more, and more costly, care than they need. And the multitude of payers and payment policies has bred administrative complexity and operational redundancy.

That the financing system needs to change was clear; how it has to change was less so. Karen Davis proposed a payment system that blends fee-for-service and case-rates, and that includes bonuses specifically designed to reward clinical quality, patient-centered care, and efficiency. Such a system could limit the incentive to provide unnecessary care and create meaningful and powerful incentives to improve quality and efficiency. Francois de Brantes, Bridges to Excellence, offered a specific option for case-based reimbursement, in which rates are set based on optimal (evidence-based) care.

Strengthening primary care

A wealth of data suggested that costs vary inversely with the strength of primary care; this provided strong empirical support for sophisticated primary care as a central element in a more efficient delivery system.

Several models were offered. John Tooker, American College of Physicians (ACP), described the “Advanced,” or “Patient Centered,” Medical Home, the roots of which are in pediatrics but which has gained considerable attention as the ACP has worked with the American Academy of Family Physicians to develop the concept for adult medicine. Arnie Milstein, Mercer Health and Benefits, described the “Ambulatory ICU;” an alternative (and potentially complementary) strategy for organizing primary care more effectively.

What is common to these models is the emphasis they place on a physician-patient relationship and on an effective clinical team—and on the active partnership that must exist toward managing illness. What is common, as well, is the demands they place on the primary care physician, who plays a critical role in management and care coordination.

These demands will challenge the system to produce a generation of internists who have the skills that are needed to play the role required of them in a Patient Centered Medical Home or an Ambulatory ICU. And they will challenge the system to create the incentives that are necessary to attract, and to retain, the best and the brightest medical school graduates to primary care specialties.

Revising the “more is better” paradigm

“Patient-centeredness” requires careful consideration of what patients want as well as what they need; what are we to do in an environment in which patients want care that is not only wasteful, but may in fact be harmful to them? There clearly is a need to revise how patients think about care and to help them understand that “more care” is not always “better care.”

Participants spent considerable time exploring how consumer and patient attitudes about health care could be changed. It seemed clear that there was opportunity for education, particularly from sources that patients trust—their doctors, and organizations that represent and speak for them. But participants recognized that opportunities existed to construct benefit plans that create incentives for patients to choose the right amount of care. And opportunities exist for physicians to challenge each other—to speak out, when they observe colleagues delivering the “wrong care.”

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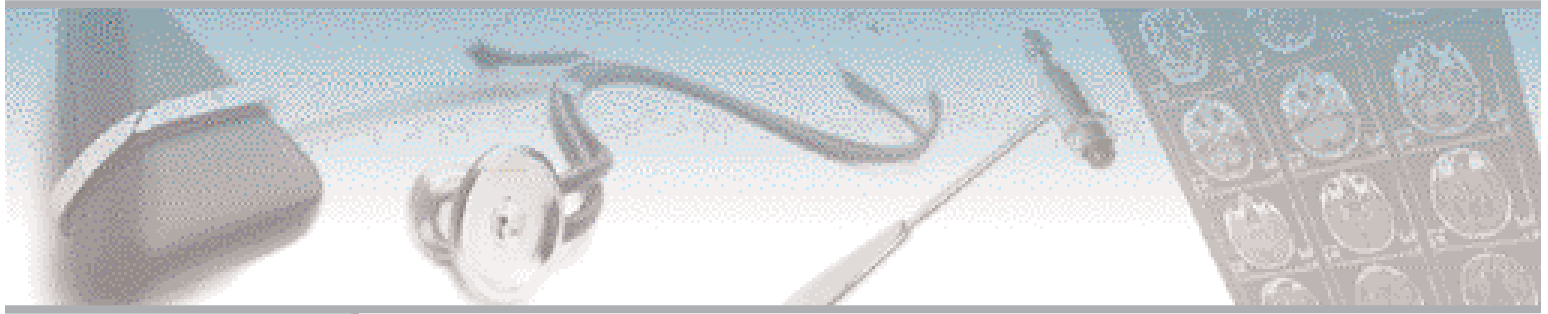
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"THE KEY HERE IS TO GET HOSPITALS AND PHYSICIANS TO START TALKING TO EACH OTHER."

— ELLIOTT FISHER
DARTMOUTH MEDICAL SCHOOL

"EVERYONE OWNS A PIECE OF THE INEFFICIENCY PROBLEM - AND, THEREFORE, OF ITS SOLUTION."

— BRUCE BRADLEY
GENERAL MOTORS

Reorganizing providers

Much of the waste in health care was felt to be due to the redundancy that follows lack of coordination. Forum participants recognized the value of information flow in health care, and the loss of efficiency that attends the weak health care information technology (IT) infrastructure. They also recognized that these problems may be mitigated in large groups with structures that facilitate coordination and information flow. And they recognized that pay-for-performance is unlikely to realize its full potential, until mechanisms exist to encourage and reward investment in IT, and collaboration and integration of care across physicians and other providers.

This prompted active discussion of the potential to create "hospital-centered networks," or other virtual entities, that could be held accountable for—and reimbursed for—the totality of care for a population of patients. The accountability—or the performance incentive—such an entity would face could prompt better capitalized hospitals to offer support (capital and management talent) to small physician practices. The recognition of such entities as reimbursable units would, as well, create incentives for integration and coordination of care, which are difficult to conceive in any pay-for-performance program that rewards hospitals and physicians independently.

Reducing operational waste

Our health care system operates inefficiently; clinical waste follows poor coordination, and administrative waste follows redundant and duplicative insurance process. The solution to the former probably lies in much of the above; Forum participants spent some time considering how administrative waste could be reduced.

Theoretically, a "single payer" would eliminate redundant and variable insurance processes (e.g., credentialing and formularies). This option, however, seems unlikely at this point in time. What seemed likely, rather, were opportunities for collaboration—among payers, among providers, and between payers and providers—to address needlessly duplicative and redundant processes that add little value to patient care. The realization of these opportunities may be challenging—as there may be both business and legal constraints on such collaboration; yet those business and legal constraints may not be immutable, at a time when pressure to find solutions is so intense.

RECOMMENDATIONS:

Forum participants laid out a set of specific steps that organizations in different parts of the health care industry—including certifying boards—can and should take. Certifying boards should:

- Include questions about efficiency in their examinations and knowledge self-assessment programs, and provide feedback on efficiency to diplomates,
- Create a mechanism to use practice performance modules to assess efficiency, and provide feedback describing appropriate treatment or overuse and associated costs,
- Continue to advance our understanding of the relationship of knowledge to appropriate and efficient care.

The complete set of recommendations is available at the ABIM Foundation web site, www.abimfoundation.org/publications

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OPINION LEADER PERSPECTIVES ON HEALTH CARE EFFICIENCY:

Avoiding the Tragedy of the Commons
(http://www.abimfoundation.org/publications/pdf_misc/ABIM_EfficJuly13.pdf)

MEASURING AND IMPROVING EFFICIENCY IN HEALTH CARE:

Report from an ABIM Foundation/IOM meeting
(http://www.abimfoundation.org/publications/pdf_issue_brief/Issue_Brief_06_06.pdf)