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THE OLIVER C. SCHROEDER, JR. SCHOLAR-IN-RESIDENCE LECTURE

RATIONING VS. REENGINEERING: THE 21ST CENTURY CHALLENGE FOR AMERICAN HEALTH CARE*

David Blumenthal†

I'm going to talk today about what I see as a major policy choice that we confront as a country and which we are making as we speak, though it may not be apparent to everyone who is looking at the healthcare system broadly. This is a choice between rationing care and reengineering care. And I'll explain to you why I think that choice is facing us and why I think those are the paths that we are considering at this point. What I'm going to do is talk about the challenges that we face, which I'm sure will be familiar to many of you, but it's always helpful to keep them in mind because their size can be obfuscated by the conversation going around. I'm going to talk about the big alternatives, the fork in the road, which I will describe to you in a moment; what I think of as some next steps and how the Affordable Care Act fits into those; and how the Commonwealth Fund and other policymakers have been coming together in a consensus around what we need to do with our healthcare system.

So you are aware, I'm sure, of the fact that our healthcare system is excessively costly; that its quality does not match the expenditures that we make on healthcare in the United States, and that, as the icing on the cake, we have extraordinary coverage problems, fifty-five million uninsured according to the latest data and prior to the full implementation of the Affordable Care Act.

Just to remind you, if you look at adult Americans –working age Americans –between 19 and 64, in 2012, 30% of them were uninsured or had been uninsured within the previous year and that number was growing steadily over time up until the current moment when we are watching to see whether insurance spreads as a result of the Affordable Care Act.

* Edited from the annual Schroeder Scholar-in-Residence Lecture sponsored by the Law-Medicine Center on October 10, 2013, at Case Western Reserve University School of Law. This version has been edited for publishing purposes and does not contain the lecture in its entirety. The full transcript is on file with the editors of Health Matrix. Please direct all inquiries to h-matrix@case.edu.

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There's also another problem, which is hidden from view, and that is the phenomenon of under-insurance: people with insurance who are not truly insured against the high cost of illness. If you combine the fifty-five million who have been uninsured in a given year with the additional thirty million Americans who are under-insured, you get to a total of eighty-five million Americans with inadequate protection against the cost of illness, which is quite an extraordinary statement about a country of this wealth. Under-insurance, by the way, has been tracked over many years by the Commonwealth Fund. Under-insurance includes individuals who spent more than 10% of their income out-of-pocket on healthcare services in a given year. That's the definition of under-insurance the Commonwealth Fund has used. The under-insured also include people with less than 200% of poverty as income who spend more than 5% of their income.

One of the reasons why we have uninsurance in the United States is that it has become increasingly unaffordable to purchase insurance because the cost of care and the premiums for care have gone up at multiples of the rates of increase of wages and of the cost-of-living in the United States. And since, increasingly, the cost of insurance within the workplace is passed on to workers directly in addition to their reduction of wages, more and more workers decline to purchase insurance. That's one of the reasons that they remain uninsured.

Now, we also know that we have a phenomenon of shorter lives and poorer health in the United States compared to most other industrialized countries. If you look at people of comparable education and comparable income in the United States and around the world in countries with industrialized bases and with a standard of living that parallels ours, you will see that we are less healthy. Some of this may be due to obesity, but we also smoke less than other countries, so it's probably not entirely a lifestyle-related issue. The extent to which this is the result of poor healthcare quality remains to be established, and it is certainly one of the questions that arises. In particular, not having access to any healthcare services, which is a factor in uninsurance, is probably contributing to this disparity in health across Western populations.

Another interesting thing that has emerged from work at the Commonwealth Fund is the extent to which there are disparities within the United States in healthcare. If you look at states' performance in quality of care and in the health status of their populations, you see that there are remarkable differences between regions of the United States with the Northeastern, Northcentral, and Northwestern United States consistently performing better than the South and Southwest and some of the areas of the Mountain states. This difference in performance, which is measured by sixty variables that are publicly available in national data sets, has been consistent over the many years in which the Commonwealth Fund has measured these differences.

This regional difference also shows up, as you would expect, when you examine how low-income people fare compared to higher income individuals in the same geographic locality. What you see is that, again, the South and Southeast and to some degree the Southwest perform consistently more poorly than the Northeast and the Northcentral part of the United States. One of the most telling aspects of these statistics is that if you are low-income in the Northcentral part of the United States or in the Northeast, you likely have better healthcare and may have better health than if you have higher income in the low-performing states. So, in the United States, low income does not condemn you to poor health or healthcare, and high income does not assure that you will have good health or good healthcare. Where you live may be more important than your income.

So, we've got problems of quality of care and of health status. We, of course, also have problems of cost. If there were an Olympic competition for high healthcare costs per capita, the United States would win gold, silver, and bronze –hands down. We have higher rates of increase, higher absolute levels. This is extraordinary display of exceptionalism compared to the rest of the world, including countries with comparable incomes like Switzerland, Austria, and Germany.

This combination of underperformance is increasingly weighing on policy makers. Those of you who follow the day-to-day ins and outs of our completely paralyzed federal government may have noticed that the conversation about the funding of the federal government and the raising of the debt ceiling seems to be turning away from whether to fund, repeal, or delay Obamacare to a broader conversation about entitlements. That entitlement conversation is really a conversation about the U.S. healthcare system, its expense, and whether it's affordable. President Obama, himself, has said that we don't have a deficit problem in the United States; we have a healthcare problem. And as this conversation proceeds, as I expect it will, if not now then in the near future, there are going to be two broad choices facing the reform of our healthcare system and our entitlement programs and the constraining of costs while trying to preserve or improve performance.

One route is the simple, easy, and fast route and the one that will, undoubtedly, lead the conversation. That route is to: reduce benefits; shift costs to beneficiaries of entitlement programs, something that has been going on in the privately-insured population for quite a long time; reduce the prices paid to providers; and change eligibility requirements. This route, which will result in taking things away and reducing access to care, might be loosely termed rationing and might make it harder to get services that people are currently getting.

The alternative is to get more for what we currently spend or to get what we currently do for less money. In other words, the

alternative is a change in delivery system to make healthcare less expensive, more efficient, higher in quality, and, ultimately, less costly. Now it's hard to argue that it would be better to ration care than to get more care for less money. It's hard to argue that it wouldn't be better to do fundamental delivery system reform, but the question then becomes how do we accomplish that –something we've been talking about for generations, and as much as we talk about it, not much seems to happen.

So how do we think about the delivery system reform? I'm not able to keep a lot of things in mind so I have a very simple model for thinking about delivery system reform. It is actually a great simplification of some terrific work that was done by the Institute of Medicine as part of its landmark report called *Crossing the Quality Chasm*. If you want to go back to the appendices of that volume you will find a much more complicated and sophisticated version of what I'm going to describe to you right now.

I think of the healthcare system's performance in terms of quality and cost as being a result of the direct influence and interaction of macrosystems and microsystems. So what do I mean by macrosystems and microsystems? If you're a clinician, like I was for most of my professional life, microsystems are where you live. If you're a patient, it's where you experience the healthcare system. It's where care is provided to patients or where patients' needs are met by direct interaction between people or the direct interaction between technology and consumers of healthcare. They're things like intensive care units, emergency departments, hospital floors, a clinical office, an operating room, and an admitting department. Systems analysts call these the sharp end, where the rubber hits the road.

Now, microsystems and the people who work in them or receive treatment, care, or service in them, often seem to those present as though they are independent and autonomous, that they are not subject to external influence. But, in fact, they are influenced constantly by larger forces that bear down upon them. And those larger forces are the macrosystems. They're the organizations in which those microsystems are embedded. They're environmental forces that support and influence microsystems. So they include federal law and regulation, local law and regulations, and licensing systems. They include the educational infrastructure of our healthcare system, certifying and accrediting organizations, and even things like the national boards that test and certify specialists as competent to practice a specialty, like cardiology or internal medicine.

Now, the interesting thing about healthcare is that we know a lot about microsystems. As a longtime academic, I can tell you that the reason we know a lot about microsystems is because you can study them. There are enough of them so you can create an intervention group and a control group, and you can do an experiment with the intervention group compared to the control group. That data is

publishable in our eminent journals, like the *Journal of the American Medical Association* or the *New England Journal of Medicine*, and such publications ultimately will get you promoted and tenured in our academic environment. One of the reasons we know a lot about microsystems is because they are integral to the system of scholarship and promotion.

As a result of all this work, we've established that certain things do influence microsystems performance and can elevate it. One of the simplest influences on microsystems, which I wrote about thirty years ago in a review of the literature, is something called reminder systems. So anyone who has a significant other or children will know that if you want to change their behavior, reminding them to do something is not a bad idea. The same is true for clinicians. If you want a clinician to check blood pressure, perform a test on a diabetic, or remember to give antibiotics at a particularly critical window of time prior to a surgical procedure, reminders have been proven, time and time again, to change behavior and improve conformance to guidelines.

We also know that this is true for computerized decision support, which sometimes functions as a reminder system and can also be a form of instruction and coaching at the time of clinical decisions. These are programs built into electronic health records that teach or inform clinicians about indications for tests and procedures or about optimal care at the point of decision. That they also elevate the quality of care is proven in multiple studies; you can find reviews and literature that will document this. We know that primary care in cross-national studies seems to be one of the critical factors that elevates the performance of other Western countries above the United States. The U.S. primary care system is vestigial. We have here anywhere from a third to one-eighth as many primary care physicians per capita as European and other advanced industrial nations that perform better than we do on healthcare.

So we know a lot about microsystems. But nothing happens with this knowledge. In the foundation, health services research, and policy worlds, we spend enormous amounts of time standing around or sitting around tables scratching our heads over the lack of dissemination of knowledge about how to improve the functioning of our healthcare system. You can find a whole literature on this as well. I would suggest that one of the critical reasons that we don't use what we know in healthcare is that we've failed to create macrosystems that encourage the use of knowledge about how to improve microsystems and that take microsystem reform and improvement to an industrial scale.

Not only have we failed to encourage microsystem improvement, but also, in many cases, we've actively discouraged it. The key to fundamental delivery system reform at this point in our history –and that's not to say we couldn't learn more about how to make

microsystems work better –is to make it easier to do the right thing: to change microsystems so that the easiest thing to do is to improve performance rather than stay with the status quo.

This is where the Affordable Care Act comes in because in my forty years in this field –maybe it’s only thirty-five –the Affordable Care Act is the single most important intervention related to health care macrosystems that has ever been undertaken. This may not be apparent to those of you who follow the implementation of the Affordable Care Act, especially in the post-October 1, 2013 period. Most of the controversy is about the coverage-related provisions of the Affordable Care Act, but there is as much ink and print and as much policy attention in the Affordable Care Act devoted to ways to reform the delivery system as there is to ways to improve coverage for healthcare. That’s a little known and well-kept secret but one that, I think, offers enormous opportunities for us to make positive change right now.

As a matter of fact, as a result of the Affordable Care Act, we have more tools to change macrosystems than we have had in the history of our healthcare system. So this toolbox, which is full to overflowing, includes things like: reduced payments for avoidable complications within hospitals; reduced payments for avoidable readmissions to hospitals; bundling of payments so that hospitals or healthcare systems can receive a single payment for the care of the patient in the hospital, the patient’s post-discharge care, and, potentially, for physician as well as hospital care; requirements for hospitals to report and be compensated for quality of care in those hospitals and the same for physicians; and accountable care organizations, which are the one system reform element that has gotten a modicum of attention in the post-ACA debate. And I would include meaningful use in this toolbox, though it’s not part of the Affordable Care Act, because it is part of the macrosystem changes that are ongoing in the United States right now, and meaningful use is one of the aspects of the national effort to disseminate electronic health records to providers of care.

Now one of the problems with a full toolbox is trying to figure out which tool to grab first, and that is a big problem, actually, for people who run healthcare organizations right now. They can work on hospital-acquired conditions. They can work on bundled payments. They can form an ACO. They can become meaningful users of electronic health records. They can form patient-centered medical homes. They can do all of these things and more, but they can’t do them all because they don’t have the resources or the attention spans. So the question is: how do we put these tools together into a synergistic program of performance improvement?

And that’s one key to the challenge we face right now. The Commonwealth Fund, through its Commission on a High Performance Health Systems made a series of recommendations about

how to take the available authorities in the Affordable Care Act and weave them together into a comprehensive program of national delivery system reform. I'm not going to go through the details of those; I'll just make a couple of notes.

First of all, the Commission report focused on payment reforms, getting consumers more engaged in healthcare choices that they make on a daily basis, and efforts to improve market function in healthcare generally.

One of the things that's most interesting about the current healthcare policy environment is the extent to which consensus has been growing about what we need to do to make the delivery system reform work better. A whole bunch of organizations have come out recently with large, synthetic reports, which have come to very similar conclusions. These include both relatively partisan groups, like the Center for American Progress, and also groups that are bipartisan, like the Simpson-Bowles group, that have studied budget deficit problems for some time. The Brookings Institution also released a report that had very similar recommendations.

So what are the areas of agreement? They are: provider payment reform, paying for value not for volume; moving to support primary care by compensating primary care practitioners, whether they're nurses or physicians, more generously; encouraging the development and implementation of innovative delivery models –something that is actively encouraged in the Affordable Care Act through the Center for Medicare and Medicaid Innovation (but at the same time, improving the protection of beneficiaries to enable them to have more integrated and coordinated care is frustrated right now by the fact that the Medicare program is divided into multiple parts which are funded differently and managed differently); reforming Medicare to encourage Medicare beneficiaries to make good choices about their care through an approach called value-based insurance design; more patient and consumer engagement so that consumers can and are encouraged to make better choices, which depends on market reforms that increase the transparency of information about the performance of providers and about the care available to patients in the open markets; and then systematizing the billing and payment processes that private insurers employ so that we reduce the number of billing clerks who inhabit both our nation's healthcare systems and our nation's insurance companies, whose only job is to fight with one another about whether bills get paid.

It so happens that there's some good news about healthcare costs. At about the time that our great recession began in 2008, but even starting before then, there was a reduction in the rate of increase in annual healthcare costs that affected both commercial and Medicare insureds. National health expenditure per capita growth is around the 2% range, which is very low historically and compared to the consumer price index is only a couple of percentage points or maybe

1.5% above it, which is also a historically low gap between the trend in consumer prices and the trend in healthcare expenditures.

There's also good news about the spreading of some of the reforms that are included in the Affordable Care Act. So there has been much more uptake in one integrated care intervention, called the Accountable Care Organization (ACO), than might have been anticipated. ACOs are not distributed evenly across the nation, but there are substantial numbers of these organizations, in the order of 400 to 500, taking root around the country and managing care in a different way than has been traditionally the case in the U.S. healthcare system.

Now this good news has to be balanced against the underlying reality of our healthcare system. If the United States healthcare system were put on an island and floated out into the North Atlantic or the Pacific, it would have the fifth largest gross domestic product of any country in the world. The U.S. healthcare system is larger as an economy than the economies of France, the United Kingdom, Canada, Australia, or New Zealand. So we have a system that is immense in aggregate size and creates all kinds of opportunity costs. We know that there is a huge amount of waste buried in the economy of the U.S. healthcare nation. That waste comes in many forms. It comes in the form of the administrative inefficiencies I referred to earlier, but it also come in the forms of fraud and abuse, overtreatment, and uncoordinated, duplicative healthcare delivery that results from lack of coordination of care in the healthcare system.

The opportunity costs associated with this waste are hard to get your head around. So a couple of us at the Commonwealth Fund decided that we ought to think about what you could buy with the waste that is embedded in our healthcare system. So one way to think about this is to ask yourself how much money would we have saved if the United States healthcare system had grown in spending at the same rate as the Swiss healthcare system over the last thirty years. If this had been the case, we would have saved \$15.5 trillion over the last thirty years. It's very hard to know what \$15.5 trillion means, but here are some illustrations. We could have retired our national debt and turned it into a national surplus of \$3.6 trillion. We could have sent 175 million students to four-year colleges for free. We could have increased spending on public health by 20,000% and we could have bought everyone in the world four iPads. So you can do a lot with \$15.5 trillion, which is, as I said, what we would have spent if our healthcare costs had grown at about the same rate as the Swiss. The Swiss have a not-bad healthcare system. No one is leaving Switzerland in search of better care. So we wouldn't have lost a whole lot in terms of the quality or accessibility of care.

Going forward, if we could maintain the rate of growth of healthcare at the current rate as opposed to the pre-recession rate, we would save about \$770 billion over the next eight years or so. So, in

order to achieve this, or avoid this opportunity cost, we just have to keep healthcare costs growing at the rate they're growing right now. So this is not a problem that we can avoid even if we take heart over the last two or three years' rates of healthcare cost growth.

Is this the dawn of a new day? Are we over the hump? Have the changes that have been made as result of the Affordable Care Act been sufficient, or has the reaction of the private system to fundamental delivery system reform, been sufficient so that we can be confident that rates of healthcare cost growth and rates of healthcare performance will continue to improve over time? I don't think we can. I think we have an enormous job to do in terms of fundamental delivery system reform, using the macrosystem opportunities that were created by the Affordable Care Act and others that are emerging in the private sector. That, I think, is a much greater challenge facing government at every level and the private sector than is obtaining the coverage benefits of the Affordable Care Act. And while both are critical, the latter will require much more work on behalf of many more people than making sure that our marketplaces work as they were intended. Thank you for your attention.