

# REAL HEALTH CARE REFORM IN 2009

Getting to Better Quality, Higher Value,  
and Sustainable Coverage

STRATEGIC REVIEW • NOVEMBER 2008

## Turning Collaborative Policy Solutions into Action for Better Health Care

The Brookings Institution is committed to producing innovative policy solutions to our nation's most difficult challenges. The country may face no more important domestic policy challenge than the much-needed reform of our health care system. To help turn health care reform ideas into action, the Brookings Institution established the Engelberg Center for Health Care Reform.

Much of today's debate about health care reform focuses primarily on strategies to increase access to coverage for the uninsured. However, meaningful improvements in health care will depend on dramatically reforming the structure of the delivery system at large – a challenge that is made more difficult by current fiscal realities. Given budget deficits, long-term fiscal projections for Medicare and Medicaid, and the state of the economy itself, it is unlikely that new revenues will be available to finance major new initiatives. Still, current circumstances should not encourage inaction; they should instead underscore the need for strategies that both address gaps in quality and efficiency and further the advances that have already been made in health status and medical innovation.

The Engelberg Center's mission is to be a catalyst for change by developing data-driven, practical policy solutions that will foster high-quality, innovative care – care that is both more affordable and more effective at actually improving patient health.

But the Center goes beyond merely studying the issues and making policy recommendations. It promotes the broad-based exchange of ideas to develop consensus around practical steps, and then takes it one step further by providing technical support for collaborative work among a wide range of health care stakeholders and actual implementation.

The Center's focus is on key priority areas that are critical to the kind of reform that will improve not just the health care system, but the health of individual patients.

## Introduction

**D**espite other urgent national priorities, health care reform will receive major attention next year. While the economic downturn has replaced health care reform as the top domestic priority, it has also raised public concerns about the affordability and security of health care and health care coverage. The president-elect has promised major reforms, and health care is also a top issue for many congressional leaders, who are already hard at work on proposals for 2009. A broad range of stakeholder groups, including those representing consumers, employers, health plans, and providers, are all taking more steps to support reform this time around. Consequently, this topic should be one of the top issues for transition planning for the president-elect.

Although there is a strong foundation for health care reform, the challenges and obstacles have never been greater. Simply put, there is little additional federal funding available to expand coverage and reduce out-of-pocket costs in our current health care delivery system. This is not the result of the recent crisis in financial markets and the expanding resources required from the federal government to address it. The economy will recover. In contrast, as a result of existing health care financing commitments, the nation's fiscal outlook – and consequently its ability to sustain new health care spending – will continue to deteriorate.

Consequently, health care reform efforts will be both technically and politically difficult. Reforms may come through some combination of redirecting federal health care funding, now and in the future, and promoting changes in the way that health care is provided to reduce costs and get more value for the dollars spent. These reforms must also gain broad support in a political environment where most Americans are satisfied with many aspects of the care they receive, and are understandably wary

of big changes that could impact how and where they get their care.

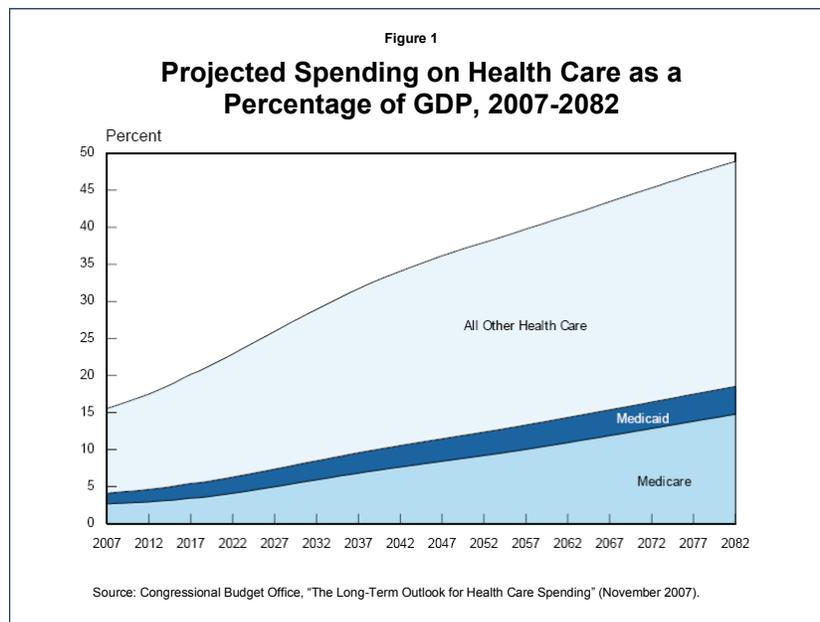
Against this backdrop, most experts believe that major reform efforts will fail and that Congress will enact at most minor reforms next year. Instead, they expect to see the typical “incremental reform” approach – expand health care programs a little by squeezing health care payments or access elsewhere. But this approach is becoming more difficult to finance, and it is increasingly clear that it does not improve the way that care is delivered. On the contrary, it is contributing to a vicious cycle of rising avoidable costs, reductions in prices, and gaps in quality.

From the standpoint of presidential and congressional leadership heading into 2009, one thing is clear: Now is the time for action on a different vision for health care reform. Instead of promising unaffordable steps to expand access to coverage that in turn become the subject of a divisive debate about the role of government protection versus individual choice, this vision would highlight how providing support for reforming health care delivery can help make coverage and care more affordable for all Americans. This emphasis on truly reforming health care was reflected in both presidential candidates' health care reform proposals, yet did not receive much attention during the campaign. By bringing a focus on changing how health care works to next year's health care reform strategy, the new president and Congress may be able to craft a bipartisan path forward that makes real progress on the nation's core health care challenges. Doing so will require leadership not only in developing policy ideas that can save money and improve care, but also in redefining the problem and in building bipartisan support for taking action to address it. Given the urgent need for action and the absence of other feasible alternatives, however, the timing is right for true health care reform.

## The Fiscal Context for Reform

The current fiscal outlook, and the role of existing federal health care programs in it, is another major factor that will shape the timing and direction of reform. The government already plays a huge role in financing health care. Local, state, and federal government spending together were responsible for nearly half (46 percent) of the estimated \$2.4 trillion spent on health care in 2008, including Medicare (\$461 billion) and Medicaid (\$361 billion)<sup>1</sup>. The income and payroll tax exclusions for employer-provided health insurance, which is not counted in health care expenditures, account for another \$250 billion per year in foregone federal revenues<sup>2</sup> and are by far the largest and among the fastest-growing tax expenditures.<sup>3</sup> The Office of Management and Budget predicts that these tax expenditures will increase by 90 percent between 2007 and 2013.<sup>4</sup>

Because Medicare, Medicaid, and the tax expenditure for employer-provided health insurance grow automatically with health care utilization and costs, the magnitude of the government's financial commitment has expanded along with health care spending, which has risen about 2.7 percent faster than the overall economy for the past half century (Figure 1).<sup>5</sup> Total health care costs are projected to increase from 16 to nearly 20 percent of GDP in the next decade.<sup>6</sup> Combined spending on Medicare and Medicaid alone is projected to account for as much as 13 percent of GDP by 2040, if these programs continue on their current trajectory.<sup>7</sup>



# Pathways to Real Health Care Reform

**G**iven competing policy priorities, budget deficits, long-term fiscal projections for Medicare and Medicaid, and the recession – all of which will further strain state and federal budget revenues – it will be very hard to find significant new funding to support comprehensive expansions in health insurance.

## Moving Beyond Price Reductions

When no other pathway is clear, a common policy response to address rising costs is an incremental squeeze on Medicare and Medicaid prices paid to physicians and other health care providers, or an incremental increase in taxes or fees. For example, Congress has built an automatic across-the-board reduction in physician fees into the Medicare law when Medicare spending on physician-related services grows significantly faster than inflation. At the beginning of 2010, this law is scheduled to reduce prices for physician-related services by over 20 percent. But, because such large reductions are not feasible, what generally happens is that Medicare spreads more incremental price reductions across a broader range of health care providers.

U.S. prices for the physicians, hospitals, brand-name drugs, and other products and services that account for a large share of overall health care spending are indeed higher than those in most other countries. However, it is not clear how much further prices can be squeezed. Many state Medicaid programs already have limited provider participation because regulated rates are so low, threatening access to care. More important, price increases are not the main driver of rising health care spending around the globe. Spending is ‘prices times quantities,’ and quantity is the main reason that health care spending is going up – more people are being treated more intensively for more health problems.

Thus, even if it is possible to lower prices further, this will not address long-term spending trends and the fiscal challenges associated with them. In fact, squeezing prices may worsen the problem by encouraging providers to invest in the capacity to provide more services that have relatively favorable reimbursement because of low “marginal” costs (e.g., more lab tests, imaging, and minor procedures). In turn, this may make it more difficult for patients to get treatments that keep them well in the first place – and exacerbate the problem of rising quantities of services. If debates over containing health care costs focus on reducing prices or finding additional sources of funding, and if coverage reforms are based on providing additional subsidies to make health care marginally more affordable, health care reform will neither address the underlying problems in the U.S. health care system nor be sustainable.

## Encouraging Innovation and Value

Focusing primarily on squeezing prices across the board could also threaten valuable innovations in health care and in how medical treatments are used. Health has improved in the United States in conjunction with substantial increases in spending. For example, rates of mortality from cardiovascular disease have declined by approximately 43 percent between 1950 and 2005.<sup>8</sup> Some studies have estimated that the value of the increases in longevity enjoyed over the past five decades, in which health care has played a major role, not only exceeds simultaneous increases in cost but also is worth as much as all U.S. economic growth over the same period.<sup>9</sup>

Nonetheless, while spending growth has achieved real gains in health, much of it is not clearly linked to such improvements. Wide variations exist in

how similar health problems are treated in different regions of the country, which in turn leads to variations in the volume of care used to treat similar patients. Residents of regions in the highest-spending quintile receive about 60 percent more care than those of regions in the lowest-spending quintile.<sup>10</sup> Some estimates indicate that as much as 30 percent of Medicare spending does not contribute meaningfully to patient outcomes.<sup>11</sup>

In addition to the apparent substantial overuse of many treatments, underuse of proven-effective treatments is also common, leading to costly, preventable complications and worse health outcomes. For example, problems with patient adherence to proven-effective treatments for diabetes, high cholesterol, blood pressure, asthma, and other chronic conditions are common, even for insured patients with modest out-of-pocket costs.<sup>12</sup> And Medicare beneficiaries receive evidence-based effective treatments for their chronic diseases only about half the time, even though these treatments are covered by Medicare (Figure 2).<sup>13</sup> The health care delivery system does not assure that the right care is delivered to the right patient at the right time. This leaves physicians, pharmacists, hospitals, and other providers in our fragmented health care system understandably frustrated that problems with health care quality at the person level are not within their control.

A very large proportion of our health spending is currently going toward chronic diseases whose progression could be slowed or eliminated with more effective care, and with more prevention. Treat-

ment and management of chronic disease account for about 75 percent of health care spending in the United States.<sup>14</sup> A significant part of the growing health and economic burden of chronic disease is associated with the increasing prevalence of obesity over the last two decades. Some estimates suggest that, due to changes in both the prevalence of obesity and relative spending on obese versus non-obese individuals, per-capita health care costs are almost 30 percent higher today overall than they would have been if obesity levels had remained constant over the past 20 years.<sup>15</sup> While many factors contribute to obesity and other chronic diseases, there are clear, modifiable patient behaviors that can influence their prevalence and severity. Traditional approaches to health care, which put much more emphasis on treating complications after they happen, do not do much to support needed behavioral changes.

### The Need for Better Evidence

The fact that the evidence base for care that is known to be effective and safe is quite limited provides an added challenge.<sup>16</sup> This is particularly true for the capacity-associated differences in practice styles that account for most of the large regional variations in cost, as documented by researchers at Dartmouth and elsewhere. These differences include how often patients are seen and referred for chronic diseases, which lab and imaging tests are performed, how often they receive minor procedures or have admissions to the hospital, and so on.

Despite improvements in analytical capabilities that can help develop better evidence, there is no systematic or coordinated framework for using newly available electronic data and methodological approaches to assess the effectiveness of different treatment options or delivery models on a broad scale. Nor does an adequate framework exist for linking new evidence to benefits and payment policies to support effective treatments or delivery models that work while holding down costs. For all these reasons, real health care reform must address the core reason why it is so difficult to provide affordable coverage in for all Americans: the need for fundamental improvements in the quality and efficiency of our health care system. The available evidence suggests big opportunities for achieving better results.

Figure 2

#### Lack of Adherence to Recommended Care

Adherence to Quality Indicators, Overall and According to Type of Care and Function

Variable	Percentage of Recommended Care Received
<b>Overall care</b>	<b>54.9</b>
<b>Type of care</b>	
<b>Preventive</b>	<b>54.9</b>
<b>Acute</b>	<b>53.5</b>
<b>Chronic</b>	<b>56.1</b>
<b>Function</b>	
<b>Screening</b>	<b>52.2</b>
<b>Diagnosis</b>	<b>55.7</b>
<b>Treatment</b>	<b>57.5</b>
<b>Follow-up</b>	<b>58.5</b>

Source: Elizabeth McGlynn et al., "The Quality of Health Care Delivered to Adults in the United States," *The New England Journal of Medicine* 348 (2003).

# Moving Forward with Coverage and Delivery Reforms Together

Achieving real health care reform will depend on taking steps to reform care delivery along with coverage – one cannot occur without the other. This new vision for health care reform has started to gain traction. During the presidential campaign, both candidates included proposals not only to expand coverage, but also to implement a range of other reforms including prevention, disease management, care coordination, and greater use of health information technology (IT) to support all of these steps while preventing errors and improving quality. This is not surprising: Without taking steps to reduce the cost of health care, neither candidate could come close to paying for their proposals to make health care and coverage more affordable.

While there is growing emphasis on the connection between expanding access to care and improving care delivery, fundamental questions remain about how to close the big gaps in the quality, efficiency, and value of our health care system. On the one hand, the evidence of these gaps is clear; on the other, the evidence on how to go about closing them reliably is not.

## Lessons Learned from the Current Environment

Efforts to reform health care delivery have achieved at best mixed results to date. This is likely due at least in part to the uncertain benefits of various approaches to reform. For example, despite much enthusiasm about the potential for broader adoption of health IT to improve quality and lower costs, a recent review by the Congressional Budget Office (CBO) highlighted the complexity of estimating the likely savings to accrue from broader health IT adoption.<sup>17</sup> CBO also suggested that it will be difficult to maximize the cost

savings achievable with health IT without complementary, systematic changes in the incentives presented by the health care system.

The evidence is similarly mixed on almost every type of reform that involves up-front “investments” intended to save money and improve care through incremental additions or modifications to health care delivery. In addition to health IT, these reforms include strategies like disease management and care coordination, approaches that are typically designed to function within the current payment and regulatory system. These and other delivery reforms have shown some potential, but there is limited evidence that they alone can achieve consistent results on a large enough scale to close major gaps in quality and cost. In part for this reason, independent analyses of the health reform plans offered by Senators Obama and McCain during the presidential campaign showed high and dramatically varying estimates of the substantial net additional costs that would be incurred – e.g., of well over \$1 trillion over 10 years.<sup>18,19</sup>

Clearly, to achieve savings and improved care, much more serious attention needs to be directed toward policy options that can reliably promote reforms in how health care is delivered. This can be done. We have seen plenty of examples of innovative approaches to care delivery, including the Geisinger Health System’s use of the “patient-centered medical home” concept and electronic health records, and the Mayo Health System’s efforts with respect to quality improvement and patient-centered care, among many others.<sup>20</sup> Despite these particular instances of achieving measurably better quality at a lower cost, this does not happen reliably. Our overall approach to health care financing does little to promote more-efficient care delivery and even, at least in some instances, penalizes innovation.

Consider a physician thinking about investing in an electronic record system. Such an investment would help avoid duplicative lab tests and imaging procedures, manage patients with chronic diseases over the phone or the Internet, prevent hospitalizations, exchange information to assure a patient's smooth transition out of the hospital, coordinate care, and keep costs down. However, all of these effects will reduce the physician's reimbursement from Medicare. In sum, under the current system, there are substantial barriers for providers seeking to improve care while still making ends meet. Further, simply providing a new subsidy for health IT would not change the underlying lack of financial support for using health IT to achieve improvements in care.

### **Reforming Provider Payments**

One very promising direction for achieving real changes in care and savings from avoiding unnecessary costs is reform in how providers are reimbursed for delivering care. Today, health care payments are largely tied to the volume and intensity of services. At a minimum, these payments should not penalize better value; if we really want to drive better value, payments should support it, by creating accountability for quality and efficiency rather than volume and intensity.

Previous payment reform efforts have emphasized limited approaches – like Medicare paying hospitals for reporting on specific process-related aspects of quality and publicizing the results. Not surprisingly, however, such limited changes in payment are able to achieve only incremental impacts on outcomes. The impact on costs is also generally modest at best, particularly after accounting for the additional payments that led to such quality improvements in the first place.

To change how care is delivered, a critical element of health care reform should be a transition toward payment systems that directly support better value – that is, reform based on improving overall quality and reducing overall costs, rather than only addressing limited aspects of costs or quality. Although the evidence is currently mixed on a number of major delivery system reforms, transitioning toward payment based on overall quality and value will help assure that payments will increase only when they actually improve care at the person level. There are several examples of promising new approaches to provider reimbursement, including

Medicare's Physician Group Practice (PGP) demonstration, launched by CMS in 2005. The PGP demonstration rewards providers when they can document actual improvements in the health of the population served as well as lower overall health care spending through better prevention, chronic disease management, care coordination, health IT, and other efforts. The 10 multispecialty groups participating in the demonstration have shown significant improvements in quality and reductions in cost trends that are growing over time.

### **Reforming Consumer Incentives**

Just as important as giving providers better financial support for improving quality and lowering costs is the need for complementary reforms on the demand or consumer side of health care delivery. These reforms would help people save money when they get high-quality care at a lower cost. In contrast, traditional insurance typically pays 80 percent of medical costs after a deductible, and usually an even larger share of all costs after out-of-pocket limits are met. This approach offers little or no savings when patients make the effort to seek higher-value care – particularly patients with costly chronic diseases, who often have a good idea about what works best for them. Instead, cost control tends to occur by restricting access to services. Models like high-deductible plans linked to health savings accounts are unlikely to reduce costs for the higher-risk patients who account for most costs because, even in these plans, most spending actually occurs beyond the out-of-pocket limit.

Some large-scale reform experiences offer insights with respect to reforming consumer incentives. For example, Medicare Part D was designed to give enrollees flexibility in choosing a benefit design. On the one hand, this requires beneficiaries to spend more time and effort choosing a plan, which has led to some confusion and frustration, especially when the program first began. However, this approach also enabled enrollees to choose coverage designs other than the standard benefit included in the legislation. In particular, beneficiaries have overwhelmingly chosen "tiered" benefit designs, which are required to have the same actuarial value as the traditional benefit (which has 25 percent coinsurance and then catastrophic protection), but offer much greater out-of-pocket savings when enrollees opt for less-costly medications that meet their health needs.

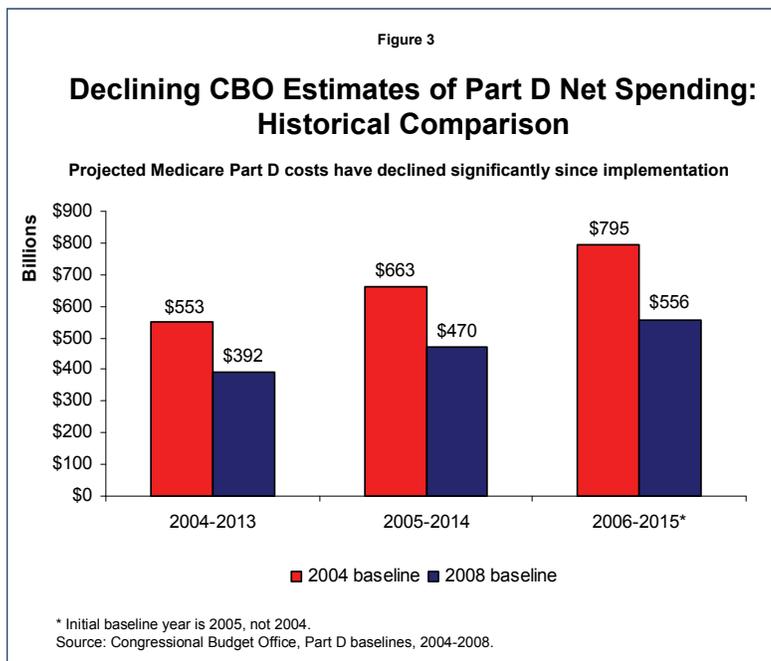
In these tiered-benefit plans, generic drugs are virtually free (only a few dollars per prescription), and “preferred” brand-name drugs cost a relatively modest flat amount (e.g., \$25 per prescription). For beneficiaries who switch to generics, this means a potential savings of much more than the traditional 25 percent. Similarly, data have shown that beneficiaries who switched from non-preferred to preferred brand-name drugs in categories like non-sedating antihistamines or oral drugs for diabetes also save much more than 25 percent of the cost. With these benefit designs, the use of generics and preferred brands has increased rapidly in Part D. These trends have been accompanied by relatively few beneficiary complaints and rising overall satisfaction levels, and the change in quantities of high- and low-cost drugs used (brand to generic and non-preferred to preferred brand) has been a major contributor to per-beneficiary costs that are much lower than originally projected at the program’s inception in 2006 (see Figure 3).<sup>21</sup>

Other “value-based insurance designs” are intended to provide the same kind of rewards for consumers who choose other types of care that meets their needs at a lower cost. For example, some plans are reducing or eliminating co-pays for drugs shown to be cost-effective in chronic disease management, leading to higher compliance.<sup>22</sup> Similarly, some health care providers, such as the Geisinger Health System, are now offering package prices for elective surgical procedures, accompanied by the publication of meaningful information on outcomes. As these benefit designs expand, providers that can reliably show better outcomes and lower overall costs could be “tier one” providers, with consumers paying little or no out-of-pocket costs when they choose these providers. Such plans could also cover other providers of similar services with worse outcomes and higher overall costs, but then beneficiaries would pay a larger share of the difference in costs than under traditional insurance design. With measures of quality of care that are compelling for consumers, the Part D experience suggests that such benefit reforms could have a large and rapid impact on consumer choices and thus quality and cost.

## Generating Meaningful Measures of Performance

To enable these policy reforms, reliable performance measures that provide relevant, meaningful information on the cost, quality and experience of care are essential. In recent years, a great deal of attention and investment has focused on developing consensus support for new measures. While the growing use of such measures has resulted in more information on the quality and cost of care provided by hospitals, physicians, and other providers, many of the measures have been developed at the provider- rather than at the person-level. Unless used as a basis for patient-level steps, this can reinforce fragmentation in the health care system and permits only a limited picture of overall health system performance for individuals. In addition, measures are used inconsistently across payers, plans, and regions. Reforms to promote the broader and more consistent use of well-validated, person-level performance measures are needed to achieve more significant improvements in overall cost, quality, and experience of care.

Even with reliable and meaningful measures of the quality and cost of care, our fragmented health care system is by and large not ready to take full accountability for outcomes and the overall costs of care. But, steps in this direction, accompanied by better support for care coordination, are feasible now.



## Concrete Steps Toward Reform

**M**ost health care reform proposals under consideration can become transitional steps to reach the goal of accountability and support for high-value care at the person level. Examples of current and proposed initiatives that hold particular promise include the following:

- Proposed new federal payments for adopting health IT could be tied to using health IT to contribute to patient-level quality of care measures, and to exchange information needed in the management of chronic diseases, such as through clinical registries.
- New support for “medical homes” could be tied, over time, to at least partial accountability for primary care providers to achieve reductions in costs and improvements in outcomes for their primary care patients.
- “Episode” payments, accompanied by episode-based quality of care measures, could encourage better coordination of care and cost reductions – for example, a single, bundled payment for acute and post-acute care for a hospitalization.
- “Shared savings” initiatives, currently in promising Medicare demonstration programs, could be expanded – along with expanded reporting on quality and cost impacts to assure that these steps do not have anti-competitive effects.
- “Comparative effectiveness” research initiatives should focus not just on head-to-head comparisons of treatments, but on comparisons of payment and benefit reform policies, such as many of those discussed above. This would determine which ones achieve better outcomes and lower costs for the affected populations – and address the main causes of cost variation across areas.
- Medicare could be given greater authority to join multi-stakeholder initiatives to promote accountability for quality and costs. Such initiatives –

including those underway in North Carolina, Indianapolis, Vermont, and other areas of the country – are currently comprised of private insurers, Medicaid, state employee programs, and other payers. They are less likely to succeed when Medicare payments in the region do not support reforms in care that improve outcomes and lower costs.

Many careful actuaries and analysts have thus far been reluctant to conclude that these kinds of “incremental” steps can lead to significant savings. However, with a requirement of accountability for improving overall quality and reducing overall costs, these payment reforms are less likely to add to health care spending. Moreover, as these programs expand, better evidence would help identify the most effective specific policies for supporting better quality and lower costs.

In the meantime, some further steps can build in savings in the short term. Legislation earlier this year to support e-prescribing in Medicare was scored by CBO as saving money even with bonus payments in the short term, because penalties were imposed in later years. Also, a bundled payment for a hospitalization that included any readmissions could offer a higher base payment, in conjunction with reduced payments for readmissions over time (that more than offset the higher base payment), building in the expectation that higher up-front payments and tracking quality of care would lead to reductions in readmissions over time.

Clearly, as CBO has suggested, we need more experience with financing reforms that lead to fundamental changes in the environment for medical practice. But, the only way to do that is to link coverage reforms with delivery reforms that promote better quality at a lower cost, as described here.

## Engaging the Public

**E**ffective reform of the health care system is unlikely to happen without the engagement and support of the public around the need not just to expand coverage, but also to reform health care policies to improve quality and provide better support for changes in health care delivery that increase the value of care. There is already substantial consensus among health-policy experts that true reform must focus on these types of priorities. More than four out of five (85 percent) experts surveyed, for instance, agree that fundamental provider payment reforms that provide incentives for high-quality and efficient care will be the most effective strategy for improving the health care system.<sup>23</sup> But policymakers' belief in the importance of these reforms does not assure success, especially if immediate public concerns are oriented in a different direction.

### Health Care Reform as a Priority

Although lagging significantly behind the economy as the highest concern for Americans, health care reform was among the top priorities cited in surveys conducted just prior to the election.

- While the share of those naming the economy as their top concern was considerably larger (62 percent) than those citing health care (12 percent), these anxieties are clearly linked as “pocketbook issues.”<sup>24</sup>
- Among registered voters in October 2008, 62 percent agree that, given the economic challenges facing the country, it is “more important than ever to take on health reform.”<sup>25</sup>
- As for the degree of reform envisioned by the public, 46 percent feel the need for major changes in the U.S. health care system, while another 24 percent believe that a complete overhaul is necessary.<sup>26</sup>

This overall sense of urgency does not necessarily translate into broad support for specific reforms, and is accompanied by considerable wariness among many Americans about reforms that would actually affect them personally. While there is overwhelming support for health care reform in general, there is considerably less consensus with respect to the specific problems driving the need for reform and how to address them. Although numerous public-opinion polls about health care have been conducted, the challenge of finding common ground among competing perspectives and priorities is further complicated by significant gaps in the survey literature. These gaps are highlighted by what we do know from recent surveys on the major dimensions of the health care.

### Health Care Costs

Overall, Americans feel that cost is the most important health care problem facing the country today, with cost defined not as total health care spending, but as the out-of-pocket expenses incurred by individuals and families for their coverage and care.

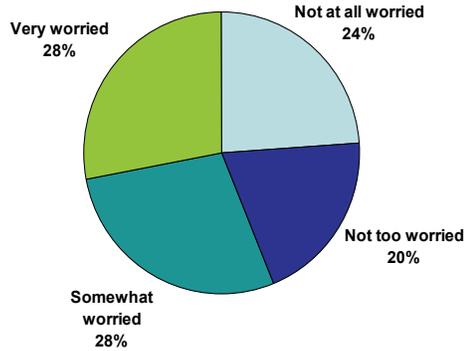
- More than half (56 percent) of all Americans are worried about being able to afford needed health care services (Figure 4).<sup>27</sup>
- As of October 2008, fully 50 percent cited ‘making health care and health insurance more affordable’ as the most important health care issue driving their choice for president, marking an increase of 13 percentage points since February 2008 alone.
- By contrast, only 6 percent cited ‘reducing the total amount the country spends on health care’ as their top health care priority.<sup>28</sup>

### Quality

Although strategies for improving the quality and efficiency of care are now featured prominently in

Figure 4  
**Concerns About the Affordability of Health Care**

"How worried are you about not being able to afford the health care services you think you need?"



Source: Blendon, Robert J., et al., "Voters and Health Reform in the 2008 Presidential Election," *NEJM* 359:19, November 6, 2008.

many reform proposals, quality is not generally perceived as a top priority.

- Only 11 percent of registered voters cited quality as the most important health care issue driving their choice for president,<sup>29</sup> and people overwhelmingly describe themselves as either 'somewhat satisfied' (34 percent) or 'very satisfied' (51 percent) with the quality of the care that they receive.<sup>30</sup>
- At the same time, significant majorities perceive at least some differences in quality across general practitioners (65 percent), hospitals (73 percent), and health plans (71 percent) in their area. A majority (53 percent) of Americans are at least somewhat worried about the quality of the care they receive getting worse over time.<sup>31</sup>

### Transparency and Consumer Empowerment

Despite emphasis in recent years on increasing transparency and empowering health care consumers, by and large, Americans do not have a lot of personal experience with quality data.

- As of August 2008, only 30 percent of health care consumers report having seen quality information on health plans, hospitals, or doctors, and this marked a decrease (from 36 percent) since 2006.<sup>32</sup>
- The share of those who have actually used quality information to make decisions about their own health care is even smaller. As of August 2008, only 9 percent of consumers had used such information to make a decision about a health plan, 7 percent had used it in selecting a hospital, and only 6 percent had used it to choose a doctor.<sup>33</sup>

These perspectives and the public's documented interest in access to information on quality and cost suggest a continuing unmet need for clear, consumer-friendly information that people can confidently use to get better care for less money.<sup>34,35</sup>

### Building Support for Reforms That Improve Care

Connecting with the public on the need for strategies that address quality and efficiency is essential to building confidence in and support for reforms that can improve health care delivery while actually lowering costs. Are there compelling ways to convey that more care is not necessarily better? Are there better ways to mobilize the concerns with Americans who are frequently not getting high-quality care, or those with a frail parent who spend a lot of time and effort

making sure that appointments, test results, or medications don't fall through the cracks among providers, and fighting with payers to get the care that they think they need?

One avenue is much more emphasis on specific, compelling information that is personally relevant. For example, saying that one-third of medical care isn't beneficial to patients is quite different than saying that, one out of three patients getting care very much like yours is not getting treatments that could significantly improve his or her health.

The technical complexity of health care issues, the public's reluctance to endorse policy changes that are perceived as risky, and the fact that the most effective solutions will have larger impacts over longer time periods all complicate the challenge of effective health care reform. However, as public education activities around other long-term, seemingly hard-to-influence issues like global warming have demonstrated in recent years, it is possible to achieve both greater support for reforms and widespread changes in personal behavior that make a growing difference over time. As with other important public issues, using the "bully pulpit" of political leaders and especially the president to highlight specific, concrete ways in which progress is possible can both raise awareness of and build new support for meaningful reform of the health care system.

## Achieving Real Health Care Reform

**H**ealth care reform that improves health care is needed more than ever, from the standpoint of both our health and our fiscal outlook. In part because of the huge economic challenges facing the country, the political opportunity for reform – while by no means easy – is also more promising than it has been in 15 years. Truly sustainable health care reform will require a different focus than that of past approaches, which have emphasized trying to find additional sources of funding to keep up with cost growth. We can no longer afford that approach. Instead, we need a health care reform strategy that puts improving health care delivery front and center, and that promotes the 21<sup>st</sup>-century promise of innovative, increasingly personalized, prevention-oriented health care.

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