

**Citizens' Health Care Working Group
Salt Lake City, UT
Public Hearing
Friday, July 22, 2005**

Attendees

Members

Randy Johnson, Chair
Catherine McLaughlin, Vice Chair
Frank Baumeister, M.D.
Dorothy Bazos
Montye Conlan
Richard Frank
Therese Hughes
Brent James, M.D.
Patricia Maryland
Aaron Shirley, M.D.
Deborah Stehr
Christine Wright

Representing the Secretary, HHS

Michael O'Grady

Staff

George Grob, Executive Director
Andy Rock
Caroline Taplin
Jill Bernstein
Jessica Federer
Rebecca Price
Paige Smyth

Randy Johnson, Chair, opened the public hearing at 8:30 a.m. and reviewed the agenda.

Presentation:

David Walker, Comptroller General of the United States
(See also Power Point Presentation)

There is a myopic tendency in Washington to focus only on the five-year, short-term budget and a tendency to look at issues (Medicare, Social Security, etc.) in isolation

without understanding what the collateral impacts of decisions in one area are on other areas.

Over the past forty years, federal spending on defense has fallen from 40 to only 20 percent of the federal budget. That money went to Social Security, Medicare and Medicaid. Today, Medicare and Medicaid represent the fastest growing section of the budget and this is unsustainable. Allowing the budget to be on autopilot as it is now is imprudent and unsustainable. The gross domestic product (GDP) is growing slower than health expenditures. Deficits are increasing. The financial condition of the government is worse than advertised, and ultimately we're going to have to make some tough choices.

The method we use to estimate our upcoming federal financial condition has four erroneous assumptions; it assumes that:

- No new laws will be passed;
- Domestic spending will grow no faster than overall inflation;
- All tax laws will sunset as scheduled in current law; and that
- The alternative minimum tax will not be fixed.

None of these assumptions is realistic so the projections are not very meaningful.

What is more likely is that discretionary spending will grow faster than the rate the economy is growing and that all tax cuts will be made permanent. If these occur, the federal government is at risk of default in the 2040's; we have a large and growing structural deficit.

By three months ago, the total liabilities of unfunded obligations of the United States (financial commitments for future payments for Medicare; Social Security; and military and civilian pensions; health, etc) was \$46,000,000,000,000 (\$46 trillion). \$30 trillion of that was for Medicare; Social Security was only about \$4 trillion. That's \$150,000 for every man, woman, and child in America today or \$370,000 for every full-time worker.

The numbers just don't work. We are on an unsustainable fiscal path. Economic growth can help but it isn't going to solve our problem. Ultimately and inevitably the government is going to have to do three things:

- Reform entitlement programs (Social Security, Medicare, and Medicaid), this is absolutely essential;
- Reengineer both discretionary and mandatory spending; and
- Revise tax policy to comport with funding needs.

We need to begin this sooner rather than later; we have gone from being the greatest creditor nation in the world to the greatest debtor nation in the world. We're adding debt at record rates; in the second, realistic scenario, above, interest on debt was the fastest growing cost. Our biggest problem is the budget deficit, the savings deficit; these are bigger threats to the United States than any other country or terrorist group.

One of the big drivers of this debt and the deficits is health care costs. Growth in Medicaid spending affects both the federal and state governments. Medicaid is the fastest growing expense for states and their second largest expenditure. Growing health care costs also affects employers and adversely affects their competitiveness overseas.

Health care is a subset of a broader challenge: economic security during working years and retirement. People need adequate retirement income including affordable health care and long-term care. Especially important is considering the appropriate division of responsibilities between the different players:

- government
- employers
- individuals
- family
- community

We spend about 15% of our economy on health care. This includes the cost of Medicare prescription drugs and, to put this in perspective, health care spending is \$8.1 trillion. The entire debt of the United States since its founding as a republic is only \$7.4 trillion. Only Germany and France spend as high as 10% of their economies on health care; all other countries are much less.

Health care is also the largest tax preference (or “tax expenditure,” the estimate of the cost of the lost revenues due to the fact that individual never pay income tax on the value of employer provided and paid health care, irrespective of how lucrative the policy is and irrespective of how much money they make or how much money they have) in the Internal Revenue Code. This annual tax preference reduces taxes by \$102 billion annually.

If you add to this the fact that we don’t pay taxes on the Social Security and Medicare deductions from payroll, the total tax expenditure is about \$150 billion. It is the fastest growing tax preference expenditure and it is off the radar screen. The W-2 form has nothing on it about this. Unless you have catastrophic expenditures, there’s nothing on the tax return about health care. Yet these total costs and expenditures are the fastest growing fiscal problem today.

Until recently, most of the cost increases have been borne by governments and employers, not individuals. That’s going to have to change and it’s starting to change. Costs are starting to be shifted to individuals. The status quo is not sustainable. The direct effect is that prices are going up for everyone; the indirect implications are: fewer employment opportunities, off-shoring, more part-time employment, and slower wage growth. Also, something rarely thought of is that revenue growth for governments is slowed because there is a broader part of the tax base that isn’t taxed.

In the long term, for any system, such as the health care system, to work, three elements are needed:

- Incentives for people to do the right thing,

- Transparency to provide reasonable insurance that people will do the right thing because somebody is looking, and
- Accountability mechanisms if people do the wrong thing.

We don't have any one of these three in adequate measure in health care and that's why we have some of the problems we do.

One of the things we've never asked is what are the basic and essential services for which there is a broad based need for and national interest in making sure that every American, irrespective of their age, location, etc, has access to. I don't know what those basic and essential services are, but examples would be:

- Inoculations against infectious diseases,
- Certain types of wellness procedures,
- Protection against financial ruin due to unexpected catastrophic illness where you're not using heroic measures, and
- Guaranteed access to health care at group rates.

But, that doesn't address who pays for these services. We've never been asked that; we've never answered these questions; and, as happens all too frequently in government, you start out with something and just add onto it without getting back to the basics and asking, first, "What makes sense?" Medicare today is basically what Blue Cross/Blue Shield was in 1965. But, we cannot sustain the status quo; we need to start asking these basic questions.

The second question is, "What's the appropriate allocation of responsibility for financing health care between government, employers, and individuals?" Arguably, if there's a broad-based societal need, then government has more of a role to assure this is achieved and maybe it has a role in the financing.

But, if it's beyond the broad-based need, beyond the basic and essential services, then you have to look for other options. You'll have to look for employers and individuals to provide what are considered "wants" rather than "needs." And, what types of incentives are needed in the health care systems to help providers make prudent medical decisions and help consumers make more informed decisions.

There are several areas where we need to seek ways to improve the systems:

- Too much of the budget is on autopilot; we need some threshold levels of spending that, when exceeded would trigger action by the Congress. I would hope that the Working Group would include some recommendations about what such a trigger should be.
- Tax preferences seriously need to be reconsidered. Should the \$150 billion per year preferences be scaled back? What should be done with the revenues this would generate?
- How can an insurance market be created/encouraged that provides both adequate risk sharing pools and that offers alternative levels of coverage from which individuals can choose.

- How can information systems be structured to provide more reliable and timely data to monitor costs, quality, and system integrity? Right now, with all we spend on health care, typically data on care provided is at least two years old.
- What efforts should be made to help control health care spending and assure quality by focusing on a case management approach for people with chronic conditions?
- How can the federal government leverage its purchasing power? Should the VA model be applied more broadly or is another approach to be preferred?
- What can be done to better control prescription drug costs; what about selected reimportation from certain countries?
- Should early retirees be allowed to purchase coverage for “basic and essential services”? Basic and essential care is not today’s Medicare and Medicaid. Basic and essential care would be a bridge to the future and would also be a way to help deal with some of the uninsured right now.
- What, if anything, should be done with Medicare’s eligibility age? The largest untapped under-utilized resource in the United States is citizens over 65; they need to be encouraged to work longer to help provide revenues and expenditures. The eligibility age set for Social Security and Medicare benefits made sense in 1935 and in 1965 but they don’t make sense today. (The first date for Social Security—age 65--was based on the age set for retirement in the 1870’s by Otto von Bismarck; at the time, the average life expectancy was 55; he was a brilliant politician, the retirement age for benefits made sense both as liberal policy and yet was fiscally conservative.) In 1935 when 65 was picked for Social Security, the average life expectancy was about 65. When 65 was picked for Medicare in 1965, life expectancy was higher; it’s even higher now. The Working Group should rethink this.
- We need to reconsider international agreements regarding information sharing and R&D. Work we do benefits the world but we pay the price for it disproportionately. We ought to consider burden sharing as is done during our international negotiations with other countries over national defense.
- What can and should be done to help promote standards of practice where uniformity would be desirable; and government shouldn’t be doing this. How can we take the money we’re spending and better target it?

To summarize: we have a large and growing challenge; there are no easy answers; tough choices are going to have to be made; and time is working against us. We ought to take a modern Hippocratic Oath to “do no harm.” By that, I mean, we shouldn’t dig the hole deeper; we need to figure out how to use what we have now more wisely because ultimately we are going to have to come to grips with that \$46 trillion gap.

We need to reform the entire health care system, remembering that it isn’t going to be a government-run system, and it’s going to be done in increments. The Citizens’ Health Care Working Group could provide the valuable help of first clearly showing where we are today, where we need to be in 20 years, and then develop a transition plan to help us get to where we need to be.

Discussion:

Randy Johnson – To what extent do you think Americans are ready to make a change?

Walker – They don't understand well enough; they haven't been given the facts. They need to have a large number of local public discourses to learn about this – a dialogue at the retail level. I believe that if they understood where we are and where we're going they'll be ready. We're not there yet; we need to help people understand we're on an imprudent and unsustainable path.

Randy Johnson – Do you know of other efforts other than the Working Group's to inform the public?

Walker – Yes, there are a lot of groups who are getting started on this. It's similar to efforts made in 1998. There is a consortium forming that will conduct town hall meetings; it's a broad coalition that will engage in a year or two of effort to jump-start the effort. This will be precursor to broad based change.

Pat Maryland – Has there been any thought from Medicare's perspective regarding how to link performance with reimbursement and associate them with clinical outcomes?

Walker – It is at the preliminary stages. It would be useful if this Citizens' Working Group focused on whether or not you think there's merit in this concept. Also, who's going to make it happen? It's going to have to be a collaborative effort between government, providers and other interested parties. I think there's great conceptual merit to it.

Aaron Shirley – Is there data on the degree to which the uninsured are contributing to escalating costs, such as individuals' premium increases?

Walker – There is cost shifting; in addition to costs of the uninsured shifting to the insured this way, there is also a growing amount of cost shifting when the non-indigent insured are not covered for some types of services, such as dental, they will have to pay super retail prices rather than the group rates the insured pay for those services.

Richard Frank – I'm intrigued by the tax deductibility issue and the argument regarding alignment of incentives. Were these incentives to be modified, it would need to be done so as not to increase the uninsured problem by making insurance unaffordable. What's your advice?

Walker – The two biggest tax preferences provided for health care are the deduction for employers and the exclusion for employees reflected in reduced payroll taxes. Government and private sector employers are sensitive to costs so I wouldn't change their deductions. While it might be easier politically, it would act as a disincentive for employers to provide health care coverage. To sensitize individuals to the true costs of health care, I would modify the personal exclusion for health care. So the question is whether all or part of the excluded payments should be made taxable in order to begin

to sensitize people to true costs. Such changes would need to be combined with providing individuals greater choice regarding how much of their direct or indirect income to dedicate to health care.

Richard Frank – How would you do this? Would you set thresholds on income or the value of insurance and then change the deductibility above that?

Walker – There are a lot of different options. First, we need to define “basic and essential services.” I believe these are services for which there is a broad-based societal interest in assuring that they are provided to everyone. Health coverage in excess of that level could be included in taxable income. This would begin changing mindsets and generate revenues for other laudable purposes.

Frank Baumeister – The current attitude toward national fiscal realities reminds me of the story of the two golfers who see a green mushroom cloud rising behind them. One says to the other, “go ahead and putt, it’s two minutes before the shock wave hits.”

Walker – We will either deal with the fiscal challenges that are confronting us rationally or we risk default, hyper inflation, or having to find draconian ways to cut expenditures and raise taxes. My belief is we will take reasonable steps to address these things. My concern is that we need to get started sooner than later. Last week OMB announced that the deficit will be “only” \$333 billion this year; but \$333 billion is really already over \$500 billion, because we are spending Social Security funds. Our long term imbalance is getting worse every day. We can’t solve the problem until we face the fact that there is a problem—until we agree we need to solve it. When you’re in a hole the first thing you have to do is to stop digging it any deeper; we’ve got to do that. In seeking to address the economic issues facing us, we need to take a portfolio approach and include entitlement spending and tax policy as well.

Catherine McLaughlin – “Basic and essential” implies prevention. But when we think about insuring against risk we don’t necessarily include prevention. How are you thinking about health insurance? Is what is needed a combination of prepaid care or just high cost insurance?

Walker – A combination is needed to address the threat of financial ruin from catastrophic illness. When I say basic and essential, I’m thinking about this from the perspective of both the individual and society. For instance, it is in society’s interest to make sure people get inoculations.

Catherine McLaughlin – It is appealing to have a level over which health spending becomes taxable, but does that mean we need to rethink insurance? It’s not really insurance coverage in that case; you are establishing a standard that we decide is appropriate. You get into the issue of what we think is appropriate.

Walker – I’m not talking about forcing people to do something they don’t want to do. Maybe it is the role of government to assure basic and essential services. If you want to

scale back or better target the tax preference, if you agree some basic and essential set of services is appropriate, then you can make spending above that level subject to taxation. What we have today is not going to get the job done.

Health Care Quality

Panel

Donald Berwick, MD, MPP,
President and CEO, Institute for Healthcare Improvement (by phone)

The information I'm presenting comes from the Institute of Medicine (IOM) 2001 report, "Crossing the Quality Chasm," a complicated, wonky document even for professionals. I wrote a Primer on the Health Quality Report for "Health Affairs." The IOM is the medical branch of the National Academy of Science (NAS). The NAS was established by Abraham Lincoln in 1863. IOM works on commission from Congress usually. The quality report was initiated by the IOM itself due to work in the 1990s on these issues. The roundtable on quality (that included Bob Galvin, the Chairman of Motorola) found enormous problems with quality of health care in the United States.

Between the health care we have and that we could have there is a chasm. There are six dimensions for improving quality: safety, effectiveness, patient centered care, timeliness, efficiency and equity.

- **Safety** – means preventing harm to patients; the systems are too complex, they let us down even when the professionals and technicians are the best.
- **Effectiveness** – means receiving care that works; there is big difference between what we know is possible and what happens to patients; patients only receive about half the care they need; overuse is also lack of effectiveness; receiving services that can't help them also occurs.
- **Patient centeredness** – is a big area and the most subversive or most radical; this doesn't mean that making patients pay more out of their own pockets will improve care; that won't work and we're the only western country that has any interest in this way of approaching it. Rather, patient centered care seeks to let patients' values, our values, control care, lets the patient make the choices; enables patients to take care of themselves; this is not passing the buck, but rather is an effort to make care better. We've learned that patient centered care leads to better outcomes and reduced costs of care. Patient centered care involves transparency; patients should have all the information they want. We need to begin to think of the patient record as belonging to the patient and making it available without restriction, cost or delay. Not making the patient record available impedes care. We mistakenly regard productivity as doctors seeing patients or procedures being done not as skill being built in the patient.
- **Timeliness** – is the realization that delay is waste and adds to cost; sometimes delay is instrumental and provides more information to the patient; other times, such as waiting for doctors' services or laboratory results, the patient may be waiting in the corridor on a stretcher, an obvious reduction in the level of quality.

This is lower quality; the timeliness goal says that delay itself is bad, apart from the outcomes.

- **Efficiency** – emphasizes the utility of investments; we're wasting approximately 40% of the money currently being spent on health care; we could be putting those resources to much better use, investing in better, more effective health care or even roads, education, or the arts. There is much waste because of the way we have built the health care system. Jack Wennberg and I have seen this in our visits to other countries, Scandinavia, for instance, where they spend 50 to 60 percent less and have just as good outcomes as we.
- **Equity** – is the central challenge we face; if I was rewriting the "Chasm" report, I'd put equity at the top of the list; race is the single clearest indicator of how long a person will live; it trumps all the other predictors. It's the most embarrassing and unacceptable defect in our health care system; we need to understand that it constitutes an essential health quality problem and as a nation I think we ought to consider it Problem Number 1.

The six quality indicators are the "what" we need in health care. Next, the Chasm report addresses the question of "how?"

The Chasm report rejects the idea that the best option is to simply try harder; and that implies that using incentives to get the health care workforce to work better isn't going to work. Health professionals are, for the most part working as hard as they can every day. We can align payment better; but it's not an incentive problem but rather a structure problem. The Chasm report proposes ten principles for the system.

They aren't easy to understand, but they cluster around three areas:

- Knowledge-based care – we have science, data, patient voices and measurement tools, but we don't use them; we don't aggregate information and make sure that every professional has all the knowledge they need; we don't have electronic patient records, we're using 19th century systems.
- Patient-centered care – this means putting the patient in the driver's seat, as discussed above.
- Cooperation – most of the defects in care can be traced to lack of cooperation; people don't transition well, we don't have good team-based care; we pay for fragments rather than a whole. Some of what we mean here was contained in the basis for the idea of managed care, viewing care from the patient's point of view, managing the patient's journey through the entire care process. We rejected managed care because of some of the flaws, but the principle of cooperation is needed, the importance of integrating the care continuum, not focusing only on the individual encounters.

We have to build team-based care, both at the personal level and at the institutional level, because when what you pay for care has enforced barriers between hospitals and outpatient settings, between hospitals and nursing homes, between home health care and institutional settings, we don't move knowledge or information around effectively because we pay for fragments instead of for the whole.

I don't think we'll fix things until there is a will to address these issues. There is an interest in overall costs of care but not on fundamental addressing quality. We need to focus on assuring that people are treated more safely, better and in a more dignified way. We need public policy that focuses on having a better health care system just like we focus on having a safer homeland. It's too fragmented. We're spending 40 percent more than any western democracy but we don't get any better outcomes. There's the money in the current system to deal with the gaps. We don't configure resources well. We're spending more than we need to get care we need. We have too much of some things. We do not need to spend more on health care to get a better system; as a technical matter, we have enough money in the system that realigning our spending consistent with value would result in sufficient funds to fill the gaps, including assuring the need to insure the 40 some million uninsured. Whether the political will is there and whether the Citizens' Health Care Working Group can address this is another matter. But, on purely scientific grounds, we don't need to spend more to get better care.

Discussion:

Montye Conlan – Thank you for your remarks about empowering the patient. As a chronically ill patient, I've learned a lot about my disease and have empowered myself. Sometimes I feel that my physicians feel defensive and a little threatened by that. It seems that we need to find ways to empower the physicians and other health professionals as well.

Berwick – I agree. You've acquired a lot of information; the entire system needs to honor this principal. We've trained professionals to tell the patient rather than aid the patient to take care of themselves. Studies have found that when doctors ask the patient "how can I help you," the patient starts talking and, on average, the doctor interrupts the patient within 17 seconds.

Patricia Maryland – How does new technology impact the escalating costs of health care? And, how shall we handle situations when a patient comes with specific preferences of care and the potentially exploding costs of new technology?

Berwick – Technology can help in several areas. Information being generated is overwhelming; we need intermediate ways to gather and package all the information and offer it up to doctors. I've read that a practitioner that read the results of a randomized trial every day would still be 10,000 years behind by the end of the year; that's how much new information we produce. Medical records are a mess; we almost need to toss them all out and redesign them with their purpose in mind so that they will be useful. On patient centeredness, access matters a lot. How can you get coaching and information when you need it? We haven't grappled with how to fully use technology to help us. In some ways, we're spending too much on information technology without enough thought how it will help the patient.

For a patient that demands a more expensive option, they are doing what they've been taught to do; we need respectful exchanges with them and there is no expectation that patients have that we haven't created. There is no evidence that patient centered care costs more; in fact costs fall. When patients are actively involved in decision-making, surgery rates fall; costs per surgery fall 23 percent; it looks like formula for decreasing costs.

Randy Johnson – What would be one or two recommendations you would make?

Berwick – First, set national goals for improvement of health care and ask the President and Congress to take responsibility for their achievement. We need in health care quality something like the clean air act with goals set and monitored at the national level with a congressional body to monitor the results.

Second, we need bold experimentation for the total system. Simple redesign may not big/bold enough. I'd urge allowing regions to suspend the rules for a 3-5 year period to allow for the emergence of new forms of care. We need relaxation of rules that cause fragmentation to encourage providers to come together to provide new forms of care. Although its reputation has been discredited, we've got to readmit the possibility of further experimentation with managed care. We need to rediscover the good form of managed care; integrated care systems that help patients get through care.

Third, we should become curious about other countries and the things that we aren't closing our eyes to what they are learning about these great systems. Generally when one suggests this, someone will say "But America is different; we're not Swedish." And I understand that but we ought to be curious about how 30 other democracies are able to outperform us at about 40% less cost. There are tremendous lessons worldwide.

Those would be ideas for starters and the most important is to improve health care quality and, certainly we should find a way to make health care coverage universal. It's long past the time we should have done that.

John Wennberg, MD, MPH, Dartmouth Medical School
(See Power Point presentation, "Unwarranted Variations in Health Care")

For additional in-depth information regarding Dr. Wennberg's work, see the [Dartmouth Atlas](#) site.

I want to provide an epidemiological framework for what Don Wennberg has said and focus on some new data that shows that everything we found true about variation between regions is also true within regions. Much of these variations are not on the radar for change yet. There is unwarranted variation that is not associated with illness rates or patient preferences; they reflect irrationalities in health care. Most of these unwarranted variations are resulting from the supply side, not the demand side.

In the United States, no matter where you look, we don't do enough effective care. The dots on slides in my Power Point presentation each represent one of the 306 regions we have divided the United States into for the purposes of health care variation analysis.

I'm going to begin with a review of what I call "unwarranted variation" by which I mean variation in treatment that is not accounted for by: differences in illness rates, patient preferences, or the results of evidence-based medicine. These differences are basically irrationalities in the system, mostly on the supply side, from the perspective of achieving efficient services.

We can divide care provided into three categories and remember that the cause and the remedy for the variation we find in each category will be different:

- Effective care – this is care for which we have evidence that it works, that there is proven effectiveness. Beta blockers are in this category. They don't involve a significant trade off so anyone with a specific need should receive them and a failure to provide them represents medical error, an error of omission. There are also medical errors of commission but I'm not dealing with those here. No matter where you look, in the United States, we don't do enough effective care. That's what several years of analysis of medical variation among regions have shown. And this is quite surprising because (a) it isn't very costly and (b) it works. For this category of care, the remedy is greater awareness among physicians of the most efficacious treatments, education, monitoring, and establishment of standards of care.
- Preference-sensitive (shared decision-making; informed patient choice) care – this is the category of care in which there are several relatively equivalent treatment options as regards efficacy; sometimes there is evidence on effectiveness and sometimes not. An example of this category is early stage breast cancer, for women. For these conditions, it would be appropriate for patients' preferences to prevail rather than the choices of physicians. But, this is not happening. All the practice variation we see indicates that it is the doctors' opinions that are dominating rather than the patients. Even for areas where the critical issues are really not medical but which may have significant implications for the patient: breast cancer, hip fracture. The care received shifts radically from community to community due to providers, not patient choices. The physician driven choices may not correlate with the supply of doctors, rather it appears to result from the different views doctors have. Different orthopedic surgeons tend to focus on different things. What does predict knee surgery? If we had a system in which patients were choosing their service with full knowledge, shared decision-making and patient choice, we don't know what the pattern of care would be. There has been a movement to create decision-aids using scenarios to help patients to become more involved. An example of shared decision-making and informed patient choice is BPH treatment. People who have surgery do have good results as far as urinary tract functioning; however, they are more likely to have adverse sexual functioning. So this is a good example where patient preference and informed participation in decision-making is important. After

shared decision-making, surgery rates dropped 40 percent in a region that was already among the lowest 25 percent in the country. A major impediment to greater patient involvement in their care is that doctors don't really believe that patients have a role in decision-making. Also, anytime you upset the equilibrium between service and supply there is an economic impact. Somehow we have to figure out what will happen due to adverse economic incentives.

- Supply sensitive care –I have this “defect” that I think the system ought to be rational. However, we assume too much that more is better. Doctors reschedule so offices are always full; but how frequently should care be provided? There is no evidence about how to determine optimum frequency. Is more better? What's the evidence that more care is better? If more is not better, then efficiency comes closer to the low cost regions rather than to regions that have done a better job of constraining supply and better management of care. The low rate regions tend to be places that are dominated by integrated medical services, such as the spill over from Kaiser. Low rate group practices, including the Mayo Clinic; Portland, Oregon; and Dartmouth are pockets of efficiency that if widely adopted would significantly address the care needs for the expanding number of patients. The problem is how to recover money; a major problem is the excess of specialists and over-building of facilities. The high rate regions, with lots of visits, lots of hospitalizations, had 2-5 % higher mortality. Successful studies that have shown the effect of supply have been carried out in HMO environments because the distorting effect of cost is reduced. Adding medical error contributes to the higher rates. I believe that the United States is on the descending rate of the benefit curve from over use of care (e.g., using more is less). Reducing the overuse of supply sensitive care and active chronic disease management are needed. In a study of the days individuals spent in the hospital during the last six months of life in 77 academic medical centers, it was found that the biggest influence on how much care was provided, how many days individuals spent in hospital, and how many physician visits were provided depended on where you go, which you were treated. In other words, “it's the volume, stupid.” We've seen also that there is an inverse relation between the number of medical professionals involved in care and care outcomes.

We have over-invested in specialists in acute care hospitals. Having a financing system that protects hospitals that want to do the right thing may be worth examining. Because the implication would be that fewer days of care would be provided. In other studies, we could show no relation in California between, cost and outcomes. We should ask providers to do more: to eliminate under service of effective care and reduce medical mistakes.

Discussion:

Aaron Shirley – Could you comment on variation based on race or pay source?

Wennberg – We've been examining the fact that blacks may receive more care; it may be in part that outpatient care is less available. But the regional location explains more than race and sex characteristics even though there are some procedures for which blacks get more and others for which they receive less.

Frank Baumeister – Do you think the differences in wealth and therefore availability of other options is the reason for some of the high and low rates of hospitalizations and intensity of medical interventions during the last months of life?

Wennberg – That would imply rationality and I don't see that operating across the regions. We don't see these types of trade offs; people that have more nursing home beds don't have less hospital care. Both LA and NY suffer from plethora of hospital beds. In Boston, there are three academic medical centers; when one did something the others followed. If you want a place without unnecessary care your best bet are places with group practices, integrated medical care systems. But achieving this across the country is not easy; it's based on culture, attitudes. Portland is a benchmark example; if the rest of the country looked like Portland, we wouldn't be having care and cost problems.

Health Information Technology Panel

Stanley Huff

(See Power Point Slide Presentation)

People have limitations so you have to make choices on whether to be a generalist or specialist. The complexity of modern medicine exceeds the inherent limitations of the unaided mind. People are not perfect information processors and cannot be relied upon. We're in the position where we need a "thermometer" for medicine (i.e., a mechanism to help determine and measure care). The HELP System allows Intermountain Health Care (IHC) to do integrated patient care.

As care activities are entered into the system, errors are detected: dose checking; drug-food interactions, drug-drug interactions, duplicate therapy, allergy effects, cost effectiveness analysis built into the automated system. The HELP System has more complex protocols incorporated into the automated system also: basically procedures and services that need to be provided that the system provides reminders to the health care providers that these services are needed. The risk, effectiveness, and cost factors are all included in the system and presented to the clinician who can then select the most beneficial and cost efficient option. The system incorporates the results of evidence-based knowledge and has allowed IHC to improve the provision of appropriate types of care.

In the new HELP2 system, additional protocols for better health care are being implemented. Information is made available to physicians along with the care system. Through the "info" button in the software program, medical information and advice will

be provided. Evidence indicates that physician behavior is influenced and better care is provided. Poor treatment is discontinued and more appropriate treatments increased.

Standards are important.

Eric Pan

Center for Information Technology Leadership, CITL, Boston Mass

Internist, Partners Health Care System (No slides)

I'll discuss the potential cost savings associated with the use of health information technology; this involves the exchange of medical information between health providers. The application of health information technology is central to improving health care delivery. We could save \$44 billion annually in health care by reducing unneeded tests and unnecessary care. There are important advantages of improved exchange between health care providers. Electronic exchange of medical information between different settings is practically nonexistent currently. If we standardized exchange of clinical and administrative information, it would save \$7.8 billion each year in addition to the savings from digitizing information. This can only be achieved if the providers/facilities upgrade their internal systems. These potential savings are conservative. Interconnected systems would assist in improving care, bioterrorism monitoring, etc. Our health information technology (HIT) study showed that standardized exchange is quicker and more reliable. Without standardized systems, we lose major amounts of money nationally. All components: hospitals, laboratories, clinicians, etc, would benefit from standardizing data interchange.

Scott Williams

Vice-President for Health Affairs, HealthInsight, the Quality Improvement Organization (QIO) for Utah and Nevada and

Project Director, Utah Health Information Network Clinical Gateway

Health Information Technology

(See Power Point Slide Presentation)

I've been a pediatrician and provider in public health and have been limited by the lack of timely, accurate, and reliable data. Surveillance for bioterrorism can be inhibited by the lack of information if it requires a week to get laboratory information back. The four key issues that are important on data availability are transparency, leadership, alignment of financing incentives, and improved technology. There are several issues important to health information technology (HIT) that now starting with value—who benefits and who pays for it?

HIT can be viewed in three components:

- Electronic medical record, paperless office and personal health record;
- Health information exchange; and
- Clinical support for decision-making.

Currently Utah Health Information Network (UHN) transmits 17 million claims per year. What made UHN succeed: having a champion, value accruing to all participants, community ownership, being standards-driven, and using data subject to a governance process. Currently only 17 percent of physicians offices have electronic medical records. The value for physicians is that they benefit by lower costs but they are not clear this is true since it is not immediately obvious where the savings result. Providers don't yet believe they will benefit cost wise. It is hard to deal with large numbers; the average community hospital would accrue about \$1.3 million savings a year after setting up the system.

There is a fair amount of spending that isn't contributing to better health outcomes. The computerized physician order entry system is the source of potential \$44 billion savings.

The important potential role of the Federal government is to improve coordination among federal health providers.

Discussion:

Randy Johnson – The National Quality Forum was created by Congress. Do you see the government establishing a quality standards body that would maintain and keep the data?

Huff – There is a committee for systemic interoperability, under David Brailer (This committee was authorized in the Medicare Modernization Act). There were two requests for proposal issued asking for groups to bid to create an authoritative standards adoption agency; responses have just been received. It would be a nongovernment body regulating government bodies (would set standards for federal agencies). It doesn't obligate private systems. The thinking is that once government has set standards there is no good reason the private market would not follow and adopt those standards.

Williams – The Utah Health Information Network model doesn't have one centralized data place; we think it is important that the local sources of data maintain and control the data. We're not recommending any regional or national storage facility. We believe it would cause concern among the public and it isn't necessary for the systems to work. The Network doesn't hold the data but merely facilitates its transmission among the participants.

Brent James – To reiterate, there is a potential \$77 billion in savings nationally, in addition to the savings the local health institutions will realize.

Eric Pan – The \$77 billion is associated with reducing costs for inefficiencies for saving and handling data; \$30 billion savings can be achieved from reductions in inefficiencies in clinical facilities. This is lower bound – we believe it is a conservative number.

Patricia Maryland – Here at Intermountain Health Care, have you been able to use your information systems to better manage patient care and moderate inappropriate use of emergency departments by patients?

Huff – Yes; anywhere a patient receives care, the entire data laboratory and pathology reports are available so that we can identify and address inappropriate care and gaming of the system; unnecessary or duplicative visits become obvious immediately.

Michael O'Grady – There's a lot of skepticism about potential savings. If there isn't agreement both in the public and the private sector regarding a good approach on achieving standards, however arrived at, then there is some risk that a desirable approach may not persist – and then apparent savings may turn into costs. In addition, there is the question about getting agreement by both the public and the private sector to join in any efforts to establish standards that are both voluntary and that both parties will engage with.

Brent James – I just want to point out that all these presentations we've just heard are of a piece – the potential cost associated with this activity is 40 percent of the entire health care dollar.

Employer/Employee Initiatives

Peter Lee, Pacific Business Group on Health
David Blitzstein, United Food and Commercial Workers
International Union
Elizabeth Gilbertson, Hotel Employees and Restaurant
Employees International Union Welfare Fund

(For Presentations, See Power Point Slides)

Discussion:

Randy Johnson – Do you all agree about the need for profiling of providers and the value of the Centers for Medicare and Medicaid Services (CMS) making its data available?

Blitzstein – Yes and I want to emphasize need for wide discussion and availability of information about the health care system, including our members.

Lee – I strongly support using Medicare data in enabling valid use of good information to determine the differences in quality of care and costs occurring.

Brent James – Current systems cannot rank accurately. Medical outcomes statistics have almost zero impact on choices. Stories were more important than statistics to patients and have more impact – as indicated by Wennberg's studies. Recent findings

are that quality of the patient-provider relationships are the overriding factor and a good word from an old consulting physician carries much weight so we need to figure out how to encourage relationships with unbiased sources.

Lee – We need systems that adjust validly for risk. The issue about administrative data is how to get good enough data so that it's better than driving blind. What about use? Consumers aren't using risk adjusted data because they aren't given a useful tool that allows them to use the data effectively. The primary consumers of provider information are the doctors themselves; they don't want to be at the bottom of their "class."

Gilbertson – These tools aren't optimal. There is a very clear cost to uninsurance. If it increases, and we have less access it is toxic to health. We must do the best we can using the available tools as best we can; that way the market for the tools will improve.

Michael O'Grady – As we try to go to scale outside of California, to rural areas, small physician practice groups, as we go east where there are fewer group practices, I can see health information technology effective with a large group. But what about small practices? When you see success, how to you scale it up?

Lee – The Bridges to Excellence model is about the small practice. Today we need to require use of information technology but in 10 years we should reward actual performance of better quality.

Michael O'Grady – The Federal government has an interest in sharing Medicare data. The privacy act limits this and may need to be changed to use more data, but the administration wants to use and share as much of the data is possible.

Blitzstein – I think Health Insurance Protection and Portability Act (HIPPA) was an example of over-regulation. Now we have to put a series of Chinese walls and we've created a whole new employment industry and have to spend money on things we don't need to spend money on.

Richard Frank – My mother's dentist has an Apple II computer; each month, when my mother visits her dentist, she fills out a card and she gets it in the mail as a reminder; on the other hand, my personal physician has electronic medical records but can't manage to achieve that same level of basic service. What incentives do we need here?

Lee – Information technology is merely a means to an end.

Montye Conlan – Regarding the personal health advocate. Do participants make use of them; who are they; and what do they do?

Blitzstein – Health advocates are a growing group of individuals with various backgrounds; some are nurses who work with the patients. They can be very effective and it's something that people like. These people take on responsibility for assuring that the patient gets information they need.

Lee – They are meant to be a gate opener rather than a gate keeper.

Randy Johnson – We'd like to acknowledge Senator Hatch has entered the room (Senator greets the members of the Working Group individually).

Senator, we want to thank you for introducing this legislation and recognize your important role in Utah.

Senator Hatch – When Senator Wyden and I decided to do this we decided it could work with good people like you. You are discussing some very important issues of health care. Everywhere I go I find that some of the most important issues people are addressing regard health care, getting care, having insurance, and being able to afford it. It's one of the fastest rising costs in our lives and even if people could afford it, it may not be available. I'm pleased to have Brent James on this group; he's without peer in his field. I'd say the same about you. Senator Wyden and I are in agreement over this.

Don't pay attention to us though; we want you to listen to the people around the country. Developing drugs is very costly and companies can't afford to do it with illnesses affecting very few people. We came up with the orphan drug bill; it only cost \$14 million; today there are over 300 such drugs that have been developed; sometimes it turns out that they have additional values, benefits for other circumstances. The Hatch-Waxman bill is saving money. By thinking about these things you can find incentives to make things work using market mechanisms. We provided for patent termination and the FDA revitalization act. We had FDA staff located in around 50 areas; so supervisors spent time traveling. The bill consolidates the agency onto a single main campus. There have been dozens of Hatch bills on health that work and save money. You want to find ways to get cost efficiency and medically efficient care. The State Children's' Health Insurance Program (SCHIP) bill became the glue to pass the first balanced budget in 40 years by blending the SCHIP that the Republicans didn't want and the balanced budget that the democrats didn't like, so they achieved a bipartisan bill. You need to do what is right sometimes, saving money sometimes, compassion and taking care of people sometimes. You need to get information and think it through. Then we'll try to get it through. If it's too far right or left, it won't succeed.

But let's forget left and right and do what's necessary. We have too many uninsured; businesses are going under and dropping coverage. We have large drug firms that do most of the development of new drugs; we have generic companies that want access to the drugs for sales.

I'm looking to you to help us understand what is needed and help address problems at both the Federal and State levels. We need to come up with solutions that address both access and cost concerns; not either/or.

Montye Conlan – I want to thank you; I inject a daily drug that was developed under the orphan drug act.

Senator Hatch – We may come up with some more cures too. We're working on a stem-cell bill to expand research using cord blood that will help. Embryonic stem cell research is further off. I've always said that being pro life means caring for the living as well. If we brought up embryonic cell research by it self, we'd have too many objections.

Patricia Maryland – Thanks you for coming and helping us end the day on a note of hope.

Catherine McLaughlin – Most of us haven't been involved in the political process before and the process of making laws. We know it is a political issue and we'd like to have your advice again in the future.

Senator Hatch – It has to be practical, can't just be esoteric. God bless all of you and thank all of you.

The Chair adjourned the hearing at 3:20 p.m.