Sharpening the focus on health system reform

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Few will contest the assertion of Stuart Altman and his colleagues that nothing short of a national effort is needed to improve health care productivity, reduce costs, and level out the present inequities in the U.S. health care system. If there is a key to reform, it is a balanced national policy that does not single out one or two components as the catalysts for change. Voluntary cost reductions and the reimbursement-ratcheting pressures imposed on acute hospitals have not stemmed the tide of cost increases, even though some excellent cost containment has been and will yet be accomplished. However, three aspects of the problem of reform need to be seen in sharper focus: (1) all components of the health care system must be considered in relationship to each other; (2) Americans must decide what level of services they can afford; and (3) true reform can only arise from close involvement of community health care systems in any congressional or academic initiatives. In the following Perspective, I examine each of these points in greater detail.

The larger picture of health care delivery. Health care delivery in the United States must be considered as a total system in which a decrease in one area can lead to an increase in another. "Reform" applied to one part of the system typically shifts the problem to another part of the system—often at greater expense. For example, prenatal care costs little compared to neonatal intensive care, yet prenatal care is generally underemphasized in the U.S. health care system. More resources directed to prenatal care likely could alleviate many serious complications that result in costly neonatal intensive care.

The idea these authors express, that reform must consider the system as an interrelated whole, is fundamentally correct. A national reform must affect all contributors to rising health care costs, including all the...
institutions, organizations, and professionals that are involved in health care delivery. The appropriate focus here is on the payers, but public policymakers and consumers are not exempt from scrutiny. Certainly, continuing to single out the hospital as the “handle” to throttle back the whole system is absolutely wrong. Hospitals are under intense fiscal pressures, some are closing, and their bottom lines are diminishing.

**Desires of the American people.** What level of health care services does the American public want to purchase? This politically charged question will have to be answered forthrightly as a precondition to reform. Are Americans willing to accept the *de facto* rationing of a Canadian-type system? If not, are we willing to pay the higher price—in the form of insurance premiums, taxes, or shifted medical costs—necessary to support the level of care we desire?

A major issue that has not been dealt with effectively is the cost of new medicine and technology. The increased public demand for the latest medical techniques is running unabated, fueled by a competitive marketplace. Americans want to be allowed to spend any amount to regain their health. At the same time, large segments of the population—thirty-seven million people, according to recent estimates—need health insurance, yet they are effectively denied coverage because they cannot be underwritten profitably or economically. Given this, clearly some rationing of health care has already come to the United States.

In comparing the Canadian system to ours, some observers have argued that Canada does not achieve the same level of outcomes for similar inputs. Yet it is not clear whether we are doing too much or the Canadians, too little. Other socialized systems, to which ours is frequently compared, are not allowing runaway costs on high technology and lifesaving medicine for people in the last year of life, as we do. Nor do we have many of the rationing policies in effect in other countries: long waiting lists for medical care, patients excluded from the system due to old age, or medical intervention denied to newborns with life-threatening complications. Clearly, discussion at the national level must explicitly address these issues of public demand and need as a basis for reform.

**Reform at the community level.** The proving ground for reform must be the community—where health care is delivered—not Capitol Hill or academia. Neither government nor universities have adequate access to the daily, detailed clinical information that is the key to meaningful reform. Thus, it is difficult, if not impossible, for them to devise reforms at the national level that will be effective in communities across the country. Failing to focus on and involve community health systems in resolving the health cost crisis may lead to inappropriate solutions that miss the mark. Community health systems, however, can contribute
much to the improvement of quality and productivity—and appropriately so. If national resources are to be allocated to improving health care productivity, they can be used most effectively in helping local providers implement quality management.

At Intermountain Health Care, we have demonstrated that the right focus on quality can lead to appropriate cost reductions. But quality management depends on a detailed look at the process of care—a task performed most efficiently at the local provider level. Three conditions allow us to conduct the Quality, Utilization, and Efficiency (QUE) studies that are the basis of productivity improvement: (1) an integrated data system; (2) a well-defined geographic focus; and (3) central coordination.

To be effective, reform must focus on changing physician behavior; this, too, is most effectively accomplished locally. Physicians can do much to streamline the way medicine is practiced. For example, in the QUE studies conducted at Intermountain Health Care, physicians establish the “right” way to prescribe for various diagnoses and to perform procedures correctly the first time. Medical outcomes and productivity have improved even as costs have decreased.

Need for comprehensive reform. In conclusion, a national effort to reform the U.S. health care system is certainly necessary, and this effort must include a frank discussion of what the public wants and can afford. Such an effort will require not just cooperation among payers, providers, consumers, and policymakers but also a level of national resolve and broad-mindedness that is only rarely attained in national debate.

The real opportunity for productivity improvement and cost reduction lies in national involvement in local efforts to manage quality. Quality management programs, like the ones in progress at Intermountain Health Care and other hospital systems, are working; these could—with national support—be effectively applied at hospitals throughout the United States. According to some estimates, local quality management programs could reduce the nation’s annual health care bill by as much as 20 percent, if widely implemented.

The process of improving the productivity of the U.S. health care system will not be an easy—or a politically convenient—task, as long as Americans continue to demand immediate and unrestricted access to lifesaving medical care. But if we can derive any lesson from our experience of the past decade, it is that no individual component of our system is the key to efficient and cost-effective delivery.