

Reducing Costs while Improving the U.S. Health Care System

The Health Care Reform Pyramid

January 2009

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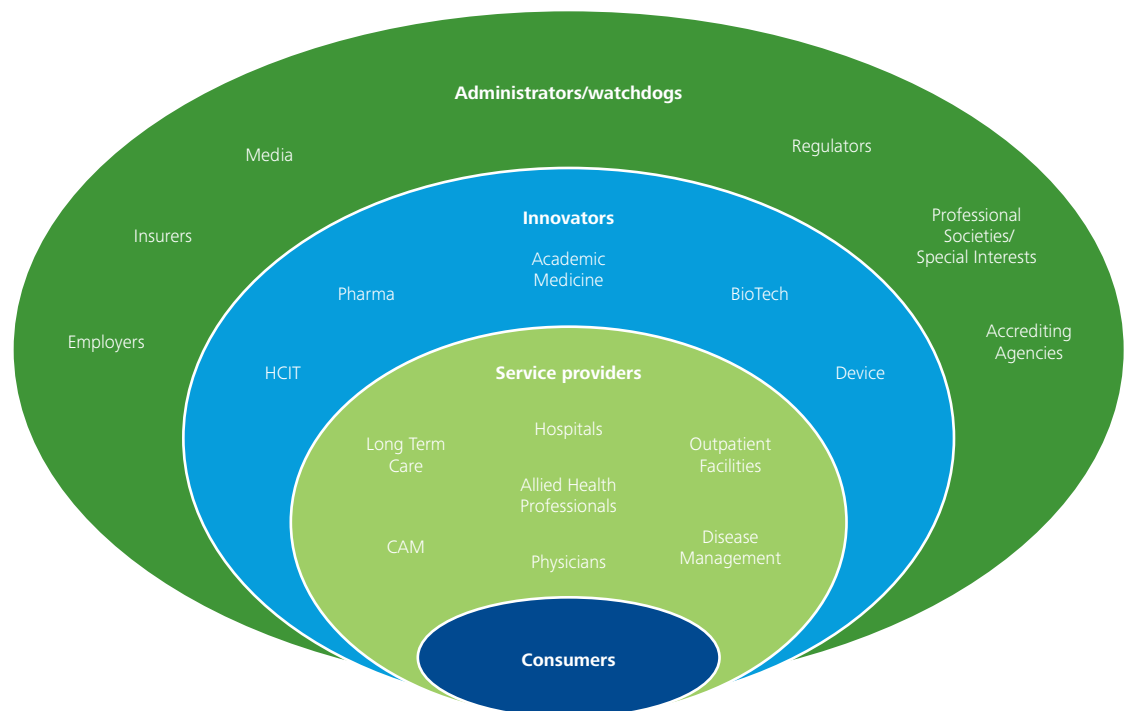
Background

For the past 30 years, U.S. health care costs have grown by at least 2 percent more than the nation's overall Gross Domestic Product (GDP). In 2008, health care cost increases will top 7.9 percent, with disproportionately adverse impacts on states as they grapple with explosive Medicaid costs, large employers who bear the burden for other employers who don't provide health benefits, and individuals who can no longer afford needed care. Further, the U.S. system's quality of care seems unrelated to its costs, as evidenced by estimates of 100 thousand deaths annually due to errors and adults receiving recommended care only 55 percent of the time. The U.S. is the world leader in health care spending but trails most

westernized systems in patient satisfaction, preventive health care and population-based mortality and morbidity results. And, as is widely known, more than 46 million Americans lack basic health insurance; 25 million more are underinsured.

Costs, access and quality are the three primary issues facing the \$2.2 trillion U.S. health care system. It is widely understood that costs must be addressed if quality and access issues are to be solved. Reforming the system to address costs without compromising quality is possible, but not without major changes to a system that is fragmented and complex (Figure 1).

Figure 1. Context: The U.S. health system is big, complex, fragmented, expensive



The Health Care Reform Pyramid

In recent history, health care reform efforts have fallen short as a result of two forces: The economics of the status quo make change an uphill battle for reformers, and end users – consumers – have not demanded major changes.

The system’s economics fuel its growth and sometimes retard reform efforts that might otherwise slow the cost spiral. Incentives encourage more physician visits, diagnostic tests, and medical procedures. Coordination of care across sites and organizations is not promoted nor are incentives adequate in preventive and chronic care management. Intramural conflicts among stakeholders keep tensions and distrust high – plans versus providers, specialists versus primary care, for-profit versus not-for-profit, and so on. Often, the tensions are well-intended protectionism of a view or role; sometimes they’re rooted in grabs for power or monetary gain. Whatever the reasons, momentum to maintain the status quo is generally stronger than the will to change. As a result, incremental changes are the norm.

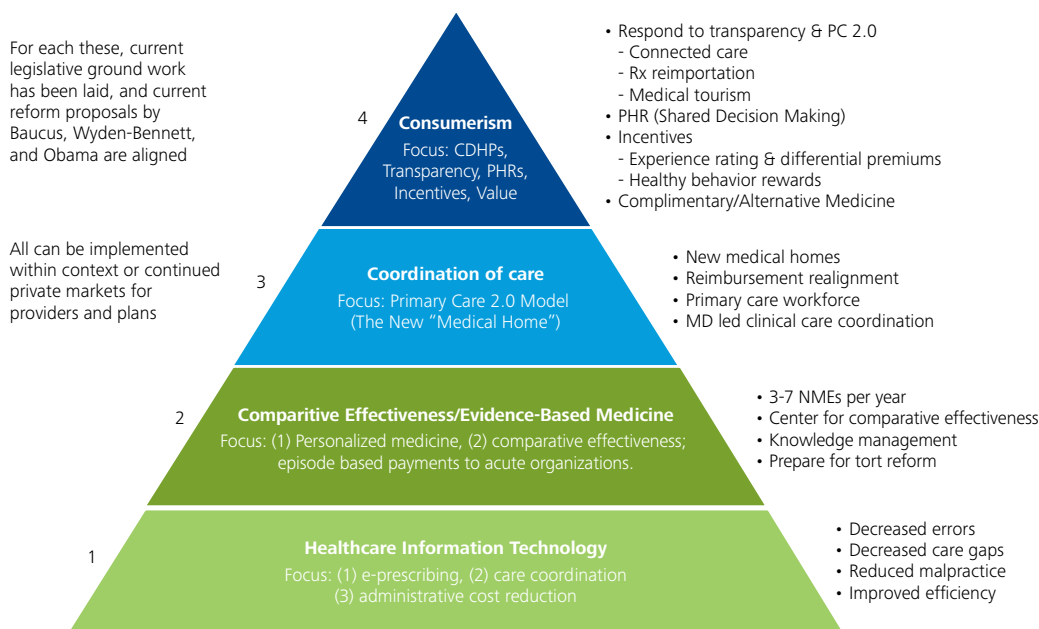
Consumers bear some responsibility, as well. While satisfaction with the U.S. system is not high, consensus

around needed change is not apparent. Consumers like health care when they can get it the way they want it – someone else pays, and they bear no responsibility for unhealthy behaviors or outcomes. “Quality of care” to most bears closer resemblance to waiting times and convenience than error-avoidance, accuracy of diagnosis and appropriateness of interventions. And consumers spend more time selecting cars than choosing physicians and hospitals, where outcomes and safety vary widely.

The issue of health care reform is not about bad people; it is about a flawed system in which the results reflect perfectly the incentives upon which it is built. Health care reform is about systemic change. It is not about a single program that benefits one stakeholder at the expense of others. It cuts across every sector, every role and, indeed, every household.

We believe that four interdependent areas of focus provide a solid foundation for systemic reform. The pyramid (Figure 2) reflects the essential relationships among these areas. Taken together, over a 10 year period, the result is a \$530 billion reduction in spending while improving quality.

Figure 2. Four programmatic areas bend the curve to reduce cost and improve care



Four Areas of Focus: Key Considerations

Each of the four areas of focus includes several programmatic efforts that are consistent with the direction of current federal policy initiatives, so transcendence to the new administration seems likely. The domains are interdependent and should be viewed as a whole. Excluding any of their component programs will limit potential savings and systemic impact.

- **Healthcare Information Technology (HCIT)** is the foundational focus; it is comprised of e-prescribing, technology-enabled care coordination, and administrative cost efficiencies. E-prescribing saves money and improves safety by addressing adverse drug events. It facilitates sharing of patient information across sites of care, reducing redundant paperwork and unnecessary tests. The application of HCIT to which the Obama administration has pledged \$50 billion over five years has the potential to achieve net-present-value (NPV) savings as high as \$90 billion over 10 years.
- Building on the HCIT foundation, the **Comparative Effectiveness** focus may be implemented as a means to shift incentives from doing more things to doing right things that are evidence-based and cost-effective. An important feature of this domain is continued investment in funding three to seven new personalized therapeutics/companion diagnostics annually. The advantages of personalized medicine in tandem with comparative effectiveness and HCIT could achieve NPV savings as high as \$140 billion over 10 years.
- Building on the HCIT and Comparative Effectiveness areas of focus, the **Coordination of Care** focus is Primary Care 2.0, a new approach to delivering and paying for primary care health services to reduce demand for more expensive acute services and to improve population-based health outcomes. The net costs of Primary Care 2.0 are significant and front-end loaded. They are necessary, nonetheless. Primary Care 2.0 requires a NPV investment of up to \$140 billion over 10 years, but it is crucial to support the pyramid's dual goal of reduced cost and improved care.

- The fourth focus is **Consumerism**, enabled through the use of Personal Health Records (PHRs), heightened transparency and linkages to Primary Care 2.0 incentives and results. Nine of the 15 reasons for hospital admission involve the progression of chronic conditions that are not treated. The combination of Primary Care 2.0 plus incentives and technologies supportive of consumer engagement has the potential to dramatically reduce costs while improving health outcomes. Consumerism implemented in the context of the pyramid can achieve NPV savings as high as \$440 billion over 10 years.

Conclusions

The health care reform pyramid reflects systemic reforms to the U.S. health care system requiring efforts and investments in four interdependent areas of focus.

As a whole, over a 10 year period, it has the potential to achieve a \$530 billion reduction in spending while improving quality overall. The upfront investments over three years are \$220 billion, with net savings realized beginning in year six. Thereafter, compound annual growth rate (CAGR) health costs may decline to 4 percent if implementation of the plan proceeds without delay and with adequate investment. Taken together, the four areas set the stage for improved patient satisfaction, improved safety and efficacy of care, and reduced administrative costs.

The pyramid is a framework for considering health care reforms that are timely and necessary. Given the uncertainty of the economy and ever-increasing demands for health care services, stakeholders might consider this a model for creating a truly reformed system. In addition, by reducing its costs, policymakers are availed the opportunity to deploy precious resources to increase health care access for the uninsured and other worthwhile programs.

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