



**Closing Thoughts:  
The Role of Pay for Performance in  
the Future of American Healthcare**

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The following presentation is for mature audiences only.

It may contain sarcasm, irony, and facetious metaphors that you may find offensive. There may even be data to suggest that the American healthcare system is not the greatest thing since sliced bread. These remarks should not be construed as insults aimed at President Bush, the Government of Canada, the people of France, or Scottish farmers.

Viewer discretion is advised.

- The Context for P4P
- The Quest for Value
- Scenarios and Implications

## What We Expected in 1990

- Large Vertically-Integrated Systems
- Medical Groups based on interdisciplinary teams
- High Use of Nurse Practitioners and auxiliary health professionals
- Capitated reimbursement systems
- Practice Guidelines and conformity
- IT enabled decision support
- Greater emphasis on primary care over specialty care
- Thoughtful and scientifically defensible introduction of new technology
- Universal coverage
- Community rated, risk adjusted financing

## What We Got by 2006

- Horizontal Cartels
- Doctors still in onesies and twosies
- Teams and groups in only a few high performing environments that nobody wants to go to voluntarily (except Mayo)
- Hamster Care everywhere: Medicare, managed care and especially Medicaid
- Passive, aggressive resistance to measurement and management of quality
- AMR as a PET
- Expensive Technology excessively and aggressively applied to affluent and well-insured
- Rising uninsured
- Consumer payment, adverse selection, cream skimming and moral hazard

- The Quest for Value: Payers are waking up
- Transparency of Cost and Quality: We have turned the corner and are headed for the sunshine
- HIT: Everybody loves it, but who pays?
- Intelligent Consumer Engagement: Dumb Cost Shifting is not enough
- Pay For Performance: Follow the Money



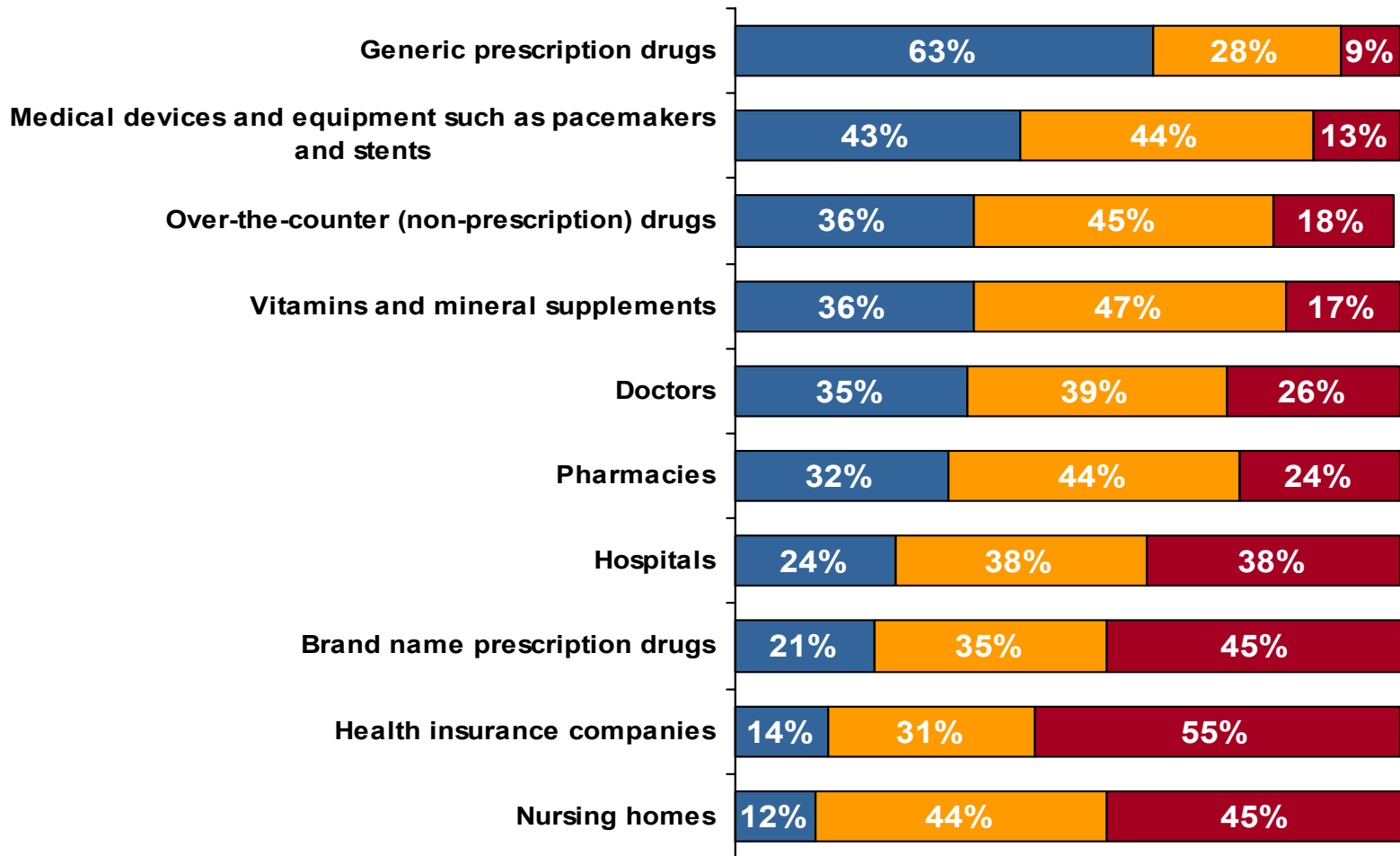
$$\text{Value} = \frac{(\text{Access} + \text{Quality})}{\text{Cost}}$$



# Healthcare Value: An Overview

- HC is failing to deliver value except for generics
- Consumer deflected healthcare improves the game for employers, hospitals (maybe) and esoterica providers, but is not good for drugs or primary care
- Pharma under the gun
- No organized backlash yet by the public, partly because the Democrats are clueless
- Building pressure of unaffordability, uninsured and underinsured, budget deficits, and lack of any new cost containment ideas means HC as a share of GDP will rise but a lot of unhappy campers
- Quality and safety a key concern among elites
- HIT, process redesign, and big business discipline only bright signs
- But the expectations of these maybe too high

# Health Care Products & Services Rated on “Value For Money”

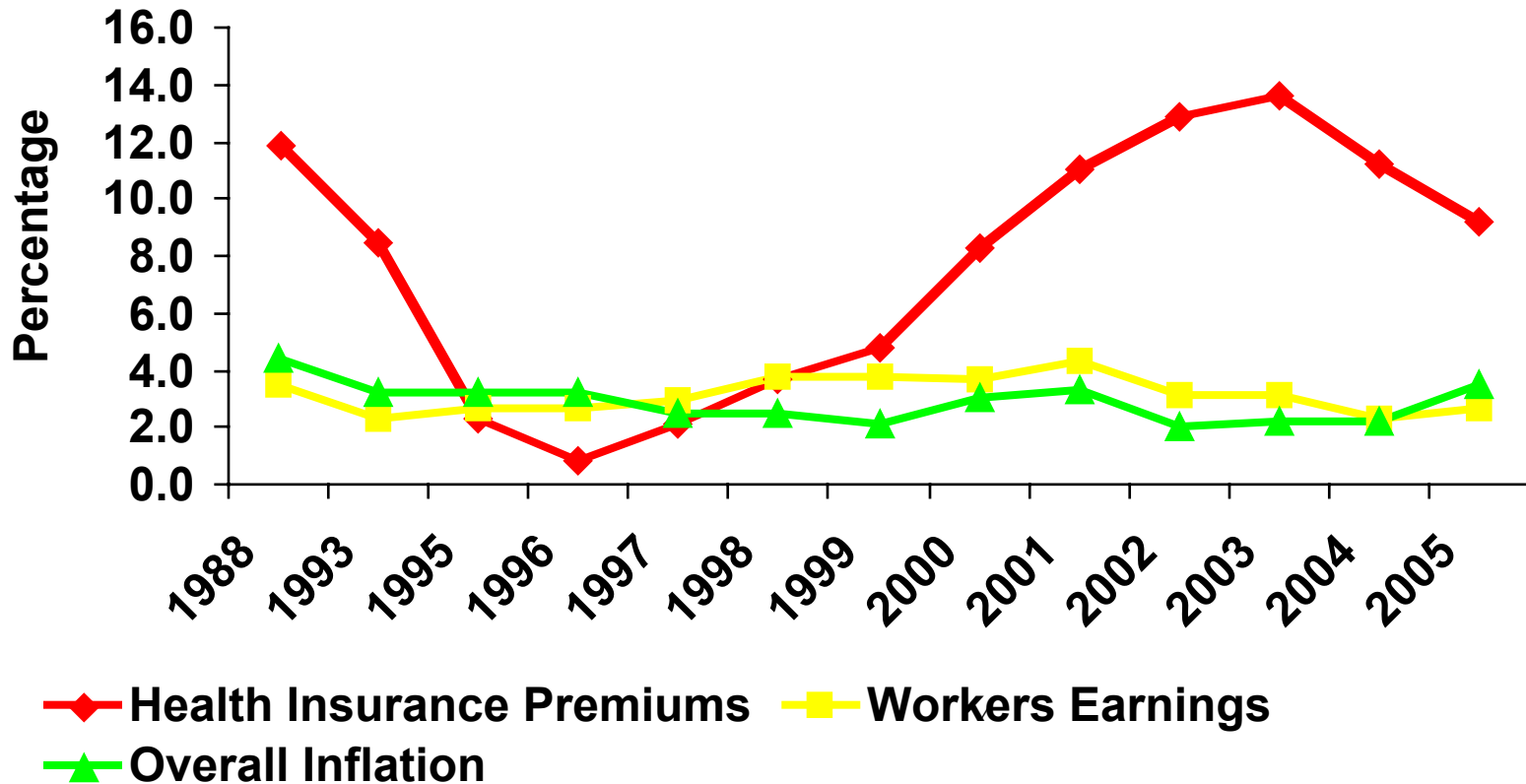


■ Very Good or Fairly Good Value ■ Not Sure/Average Value ■ Somewhat or Very Poor Value





# Premium Increases Compared to Other Indicators, 1988-2005

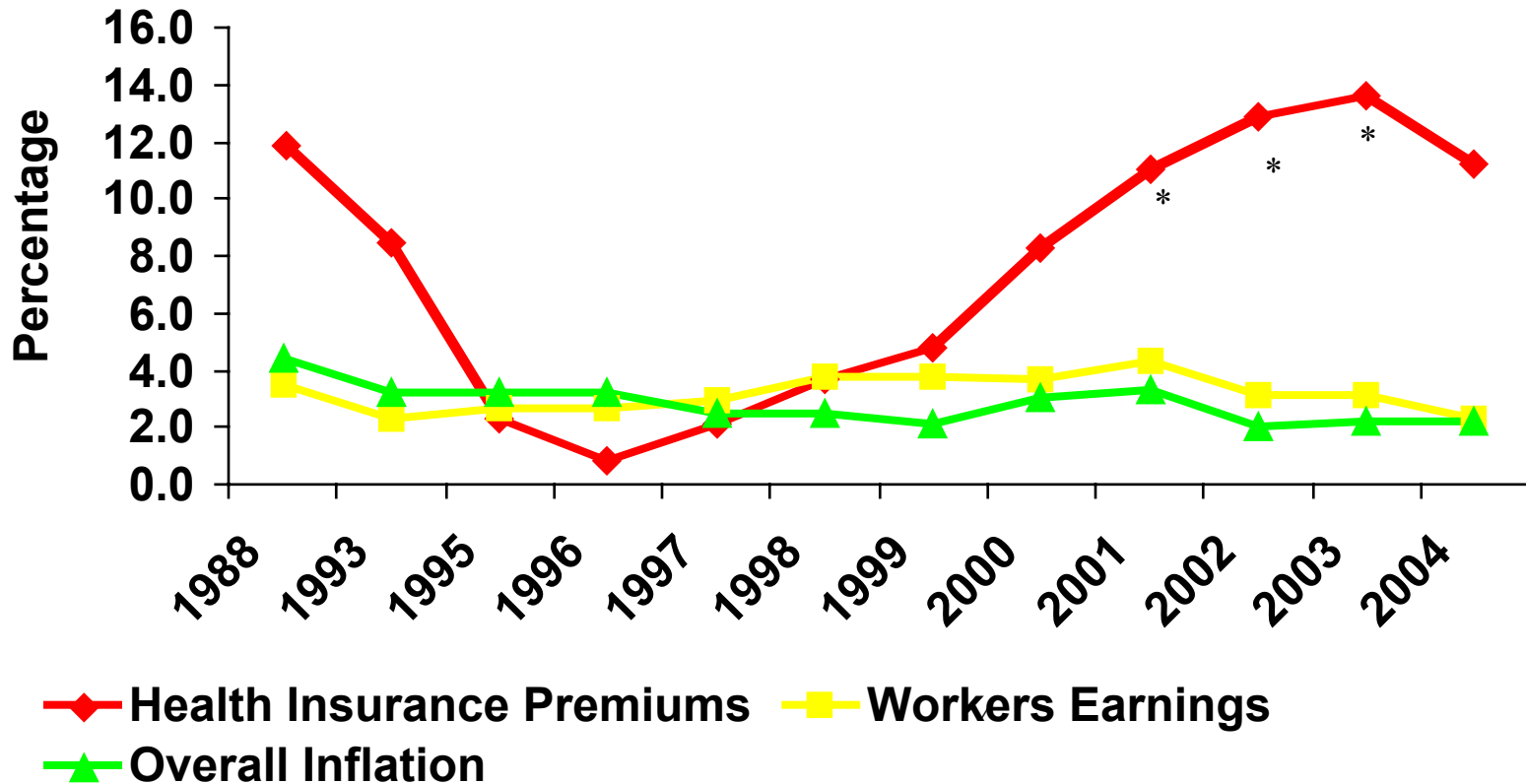


Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999, 2000; KPMG Survey of Employer-Sponsored Health Benefits: 1988, 1993, 1996, 1998; Bureau of Labor Statistics, 2000.

\* Estimate is statistically different from the previous year for years 1997-1998, 1998-1999, 1999-2000. No tests were done on years prior to 1997 or for Workers Earnings or Overall Inflation.

- Healthcare premiums up 73% since 2000, workers earnings up only 15%
- Premiums are now \$10,800 for a family
  - \$8,167 paid by Employer (76%)
  - \$2,713 paid by Employee (24%)
- Premiums are now \$4,024 for a single
  - \$3,143 paid by Employer (81%)
  - \$610 by employee (19%)
- 20% of Employers offering HDHP
  - 2.3% (1.6 million) enrolled HDHP+HRA
  - 1.2% (810K) enrolled HDHP+HSA

# Premium Increases Compared to Other Indicators, 1988-2004



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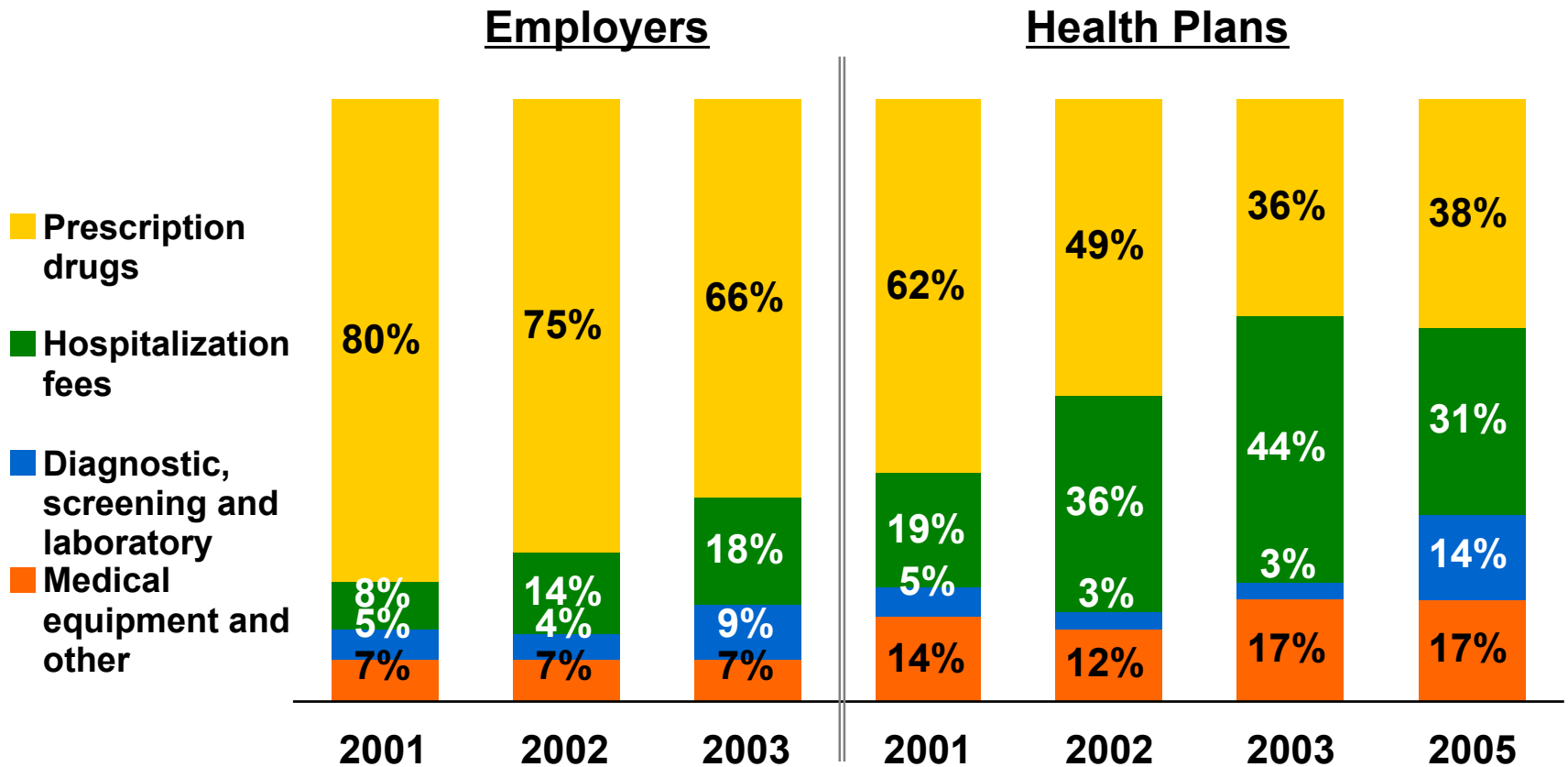
^ Sample included firms with 200 or more workers only.

# Health Care Costs and Consequences

- For the Uninsured: Rising from 45 million today to 56 million in 2013
- For the Working Poor: In 1970 health benefits cost 10% of the minimum wage, today it is 100%
- For the Median Household: Health benefits are 20% of median compensation will rise to 60% by 2020 if trends continue
- For Small Businesses: Only 60% of firms offer insurance in 2005 down from 69% in 2000
- For Big Business: Delphi goes bankrupt, Big Auto renegotiates because corporate healthcare costs surpasses the net profit of all business

# Drugs Still the Bad Guys but Hospital Costs and Ancillaries are Increasingly Seen as a Key Cost-Driver

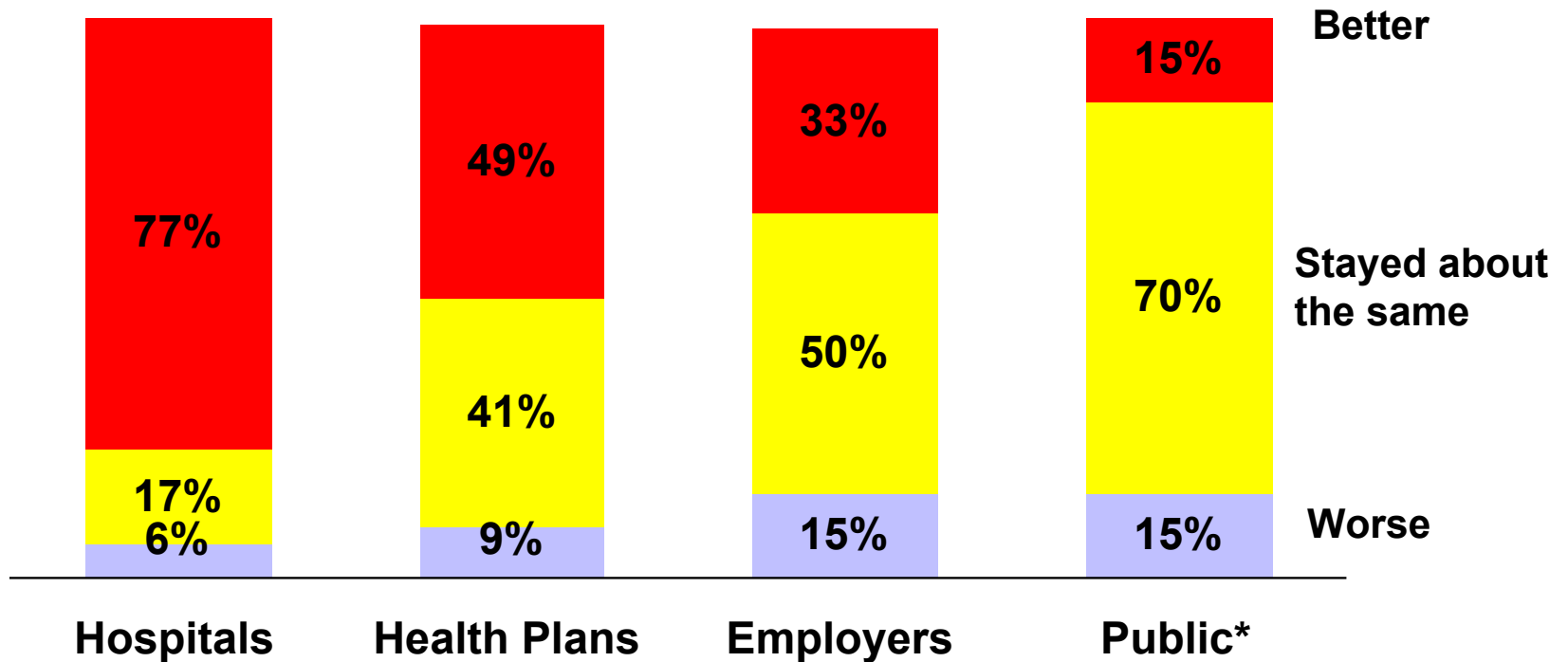
Which of the following cost has increased most during the past two to three years?



Source: Harris Interactive, Strategic Health Perspectives 2001-2005

# If Quality has Improved, the Public has not Noticed

**Has quality of care gotten better or worse in the past 5 years, or has it stayed about the same?**



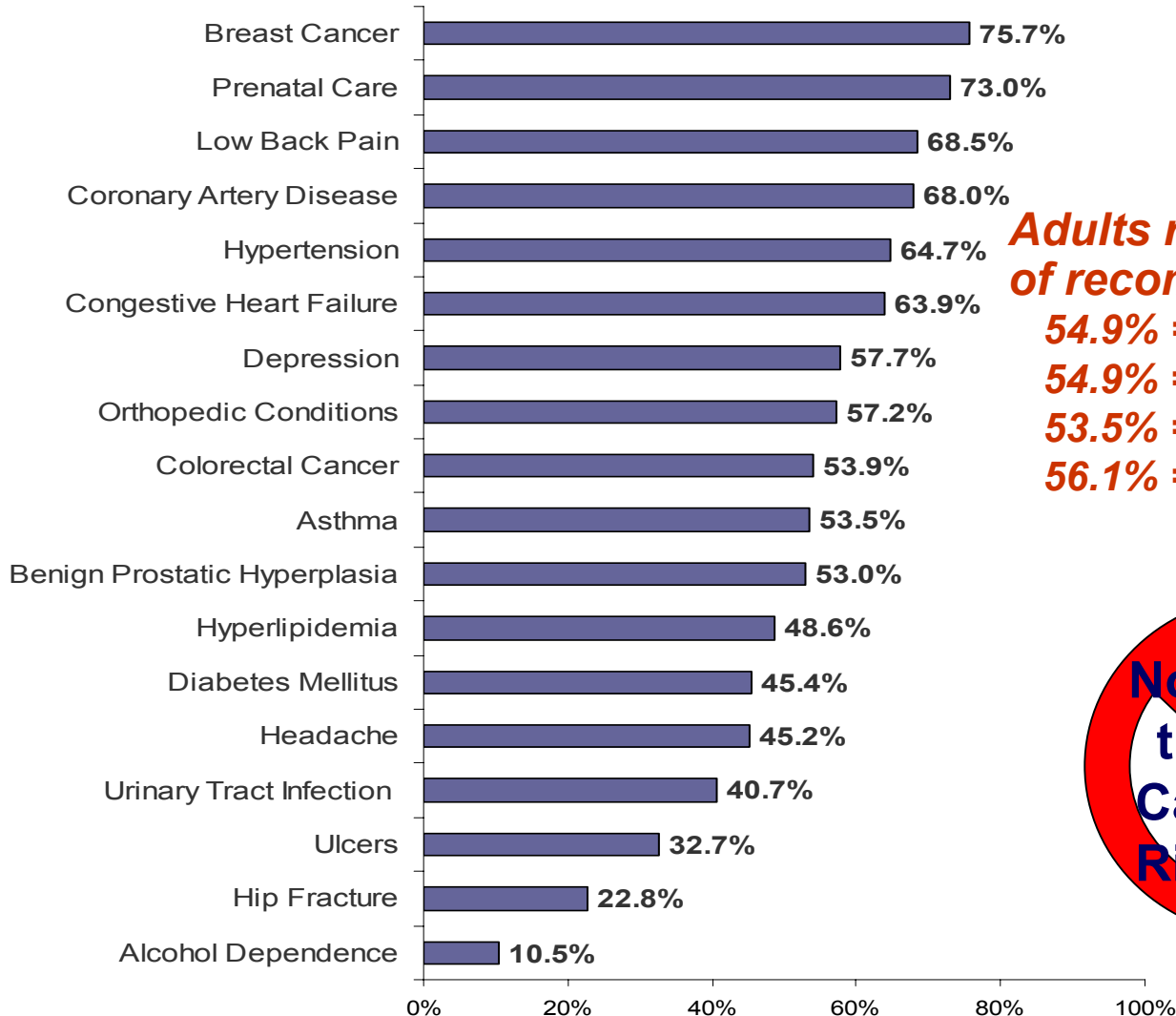
Source: Harris Interactive, Strategic Health Perspectives 2005

Note: Percentages do not add to 100 because "not sure" answers are not included.

\* Has the quality of medical care that you and your family receive gotten better or worse in the last 5 years, or has it stayed about the same?

# Quality Shortfalls: Getting it Right 50% of the Time

## Adherence to Quality Indicators



**Adults receive about half of recommended care**  
**54.9% = Overall care**  
**54.9% = Preventive care**  
**53.5% = Acute care**  
**56.1% = Chronic care**

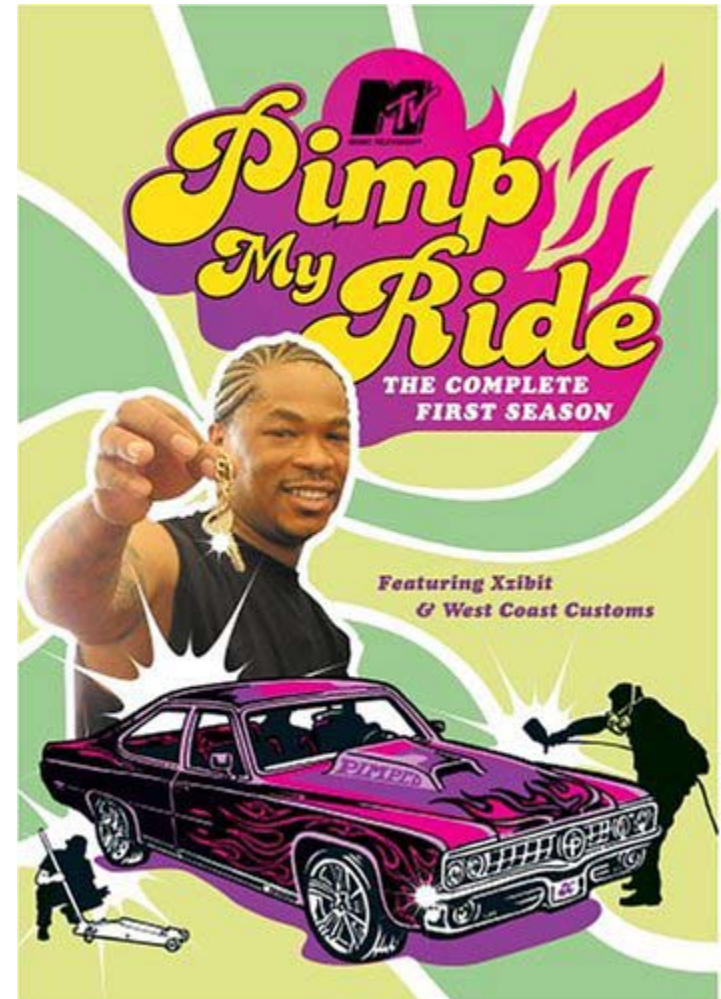


■ Percentage of Recommended Care Received

# The Battle for Quality: IOM versus “Pimp My Ride”

The IOM Vision of Quality:  
Charles Schwab meets  
Nordstrom meets the  
Mayo Clinic

The Prevailing Vision of  
Quality in American  
Healthcare:  
“Pimp My Ride”





# The Battle for Quality: IOM versus “Pimp My Ride”

- Really Bad Chassis
- Unbelievable amounts of high technology on a frame that is tired, old and ineffective
- Huge expense on buildings, machines, drugs, devices, and people at West Coast Custom Healthcare
- People who own the rides are very grateful because they don't have to pay for it in a high deductible catastrophic coverage world
- It all looks great, has a fantastic sound system, and nice seats but it will break down if you try and drive it anywhere



# Consumer Responsibility: Arguments For and Against

## For

- Consumers insulated from the cost of care
- If they had to pay they would use it less
- If they had to pay they would take more responsibility
- Consumers should have the right to choose
- When consumers choose and pay the market is working

## Against

- The 5/50 Problem
- One day in an American hospital and consumers exceed maximum deductible, so
- Catastrophic coverage is a green light for esoterica
- Does it save money overall?
- Poor people with chronic illnesses will be disproportionately affected

# Across the board, HDHP consumers have more compliance problems

## Treatment compliance problems

	All Privately Insured* %	All HDHP** %
Had a specific medical problem but did not visit a doctor	17	33
Took a medication less often than I should have	14	29
Did not fill a prescription	15	28
Did not receive a medical treatment or follow up recommended by a doctor	17	28
Did not get a physical or annual check-up	19	25
Took a lower dose of a prescription than my doctor recommended	15	19

\* Currently insured in employer-sponsored or self-purchased plan

\*\* Currently enrolled in high deductible health plan



# The Good, the Bad and the Ugly of Non-Compliance

- The Good: Unnecessary care is foregone
- The Bad: You don't take the Lipitor and it hurts in the long run
- The Ugly: You don't take the asthma medication you go to the ER

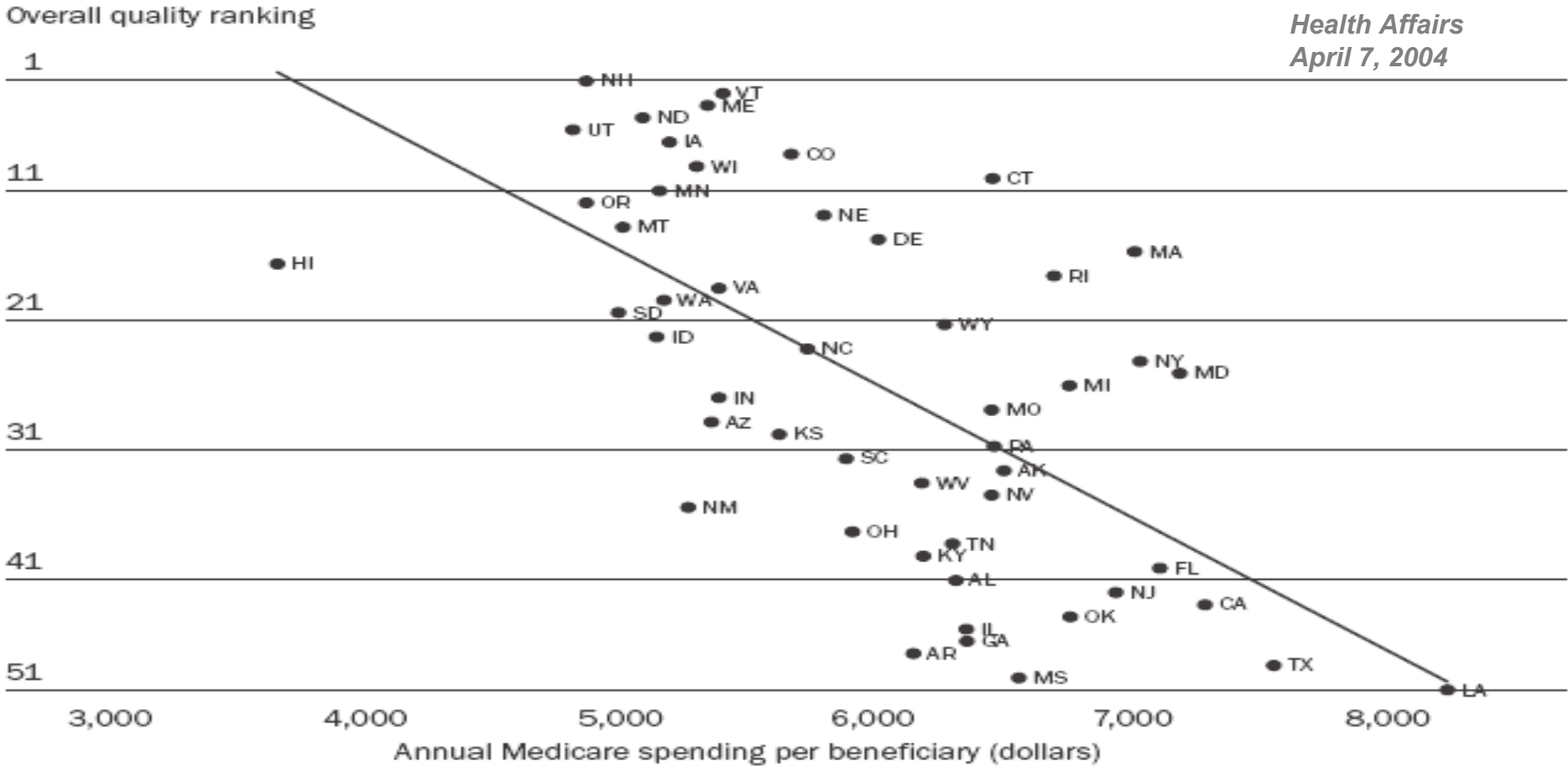


# Fat People meet Skinny Benefits



# Quality and Efficiency Vary Widely By State

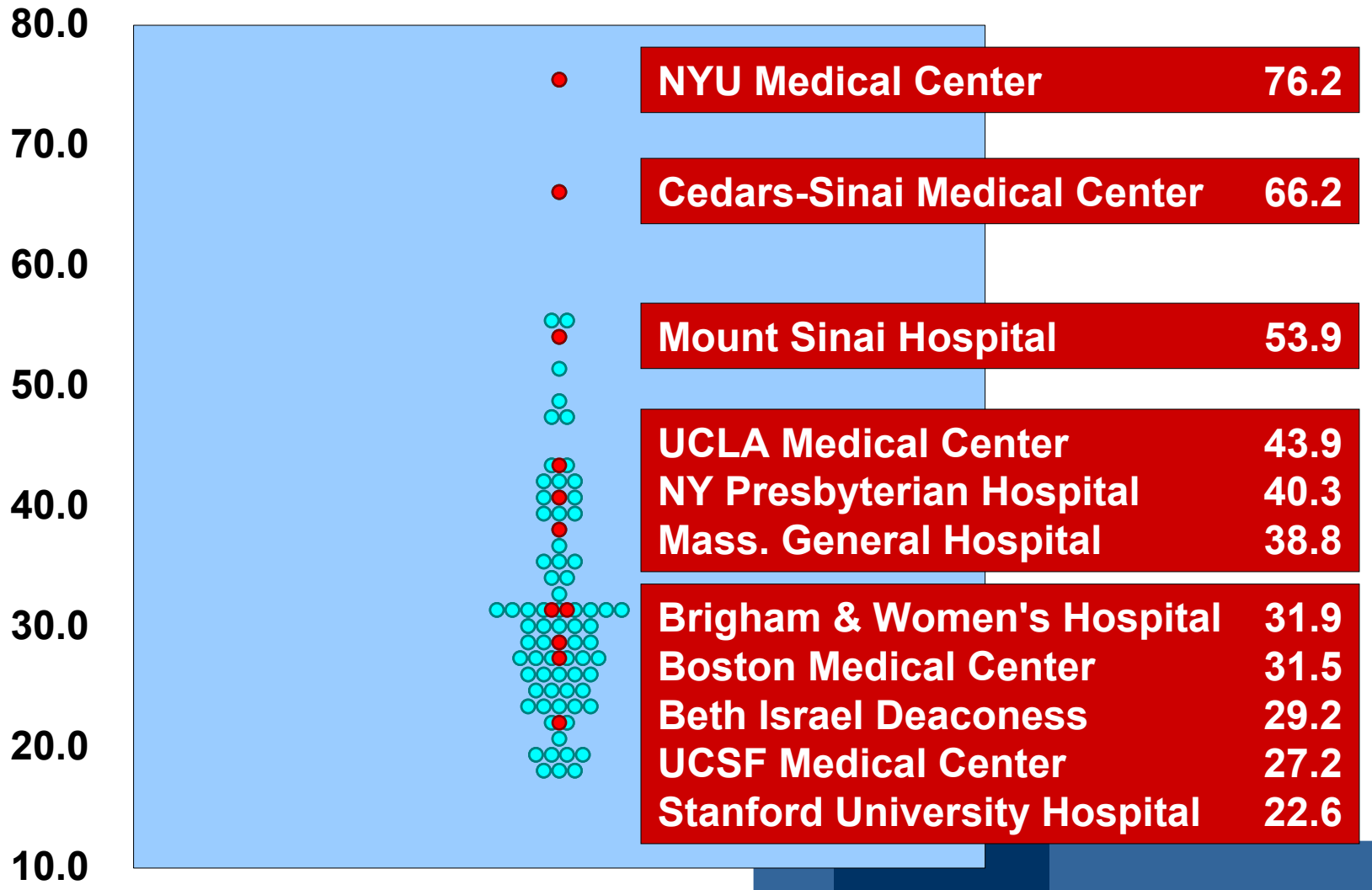
**EXHIBIT 1**  
**Relationship Between Quality And Medicare Spending, As Expressed By Overall Quality Ranking, 2000-2001**



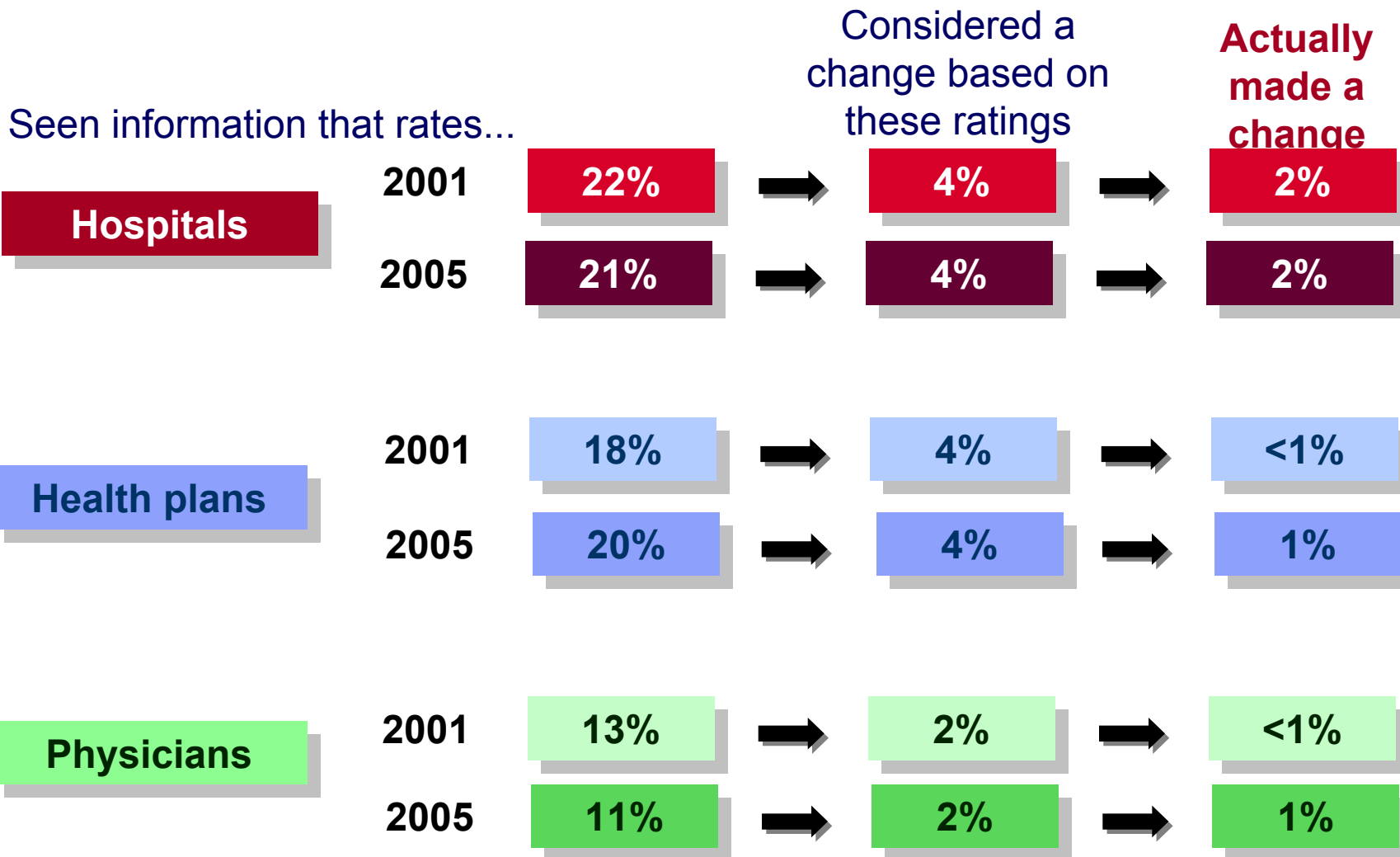
**SOURCES:** Medicare claims data; and S.F. Jencks et al., "Change in the Quality of Care Delivered to Medicare Beneficiaries, 1998-1999 to 2000-2001," *Journal of the American Medical Association* 289, no. 3 (2003): 305-312.  
**NOTE:** For quality ranking, smaller values equal higher quality.

# Supply-Sensitive Care Can Be Measured for Specific Providers

Physician Visits During the Last Six Months of Life



# Consumer Use of Quality Ratings Remains Low

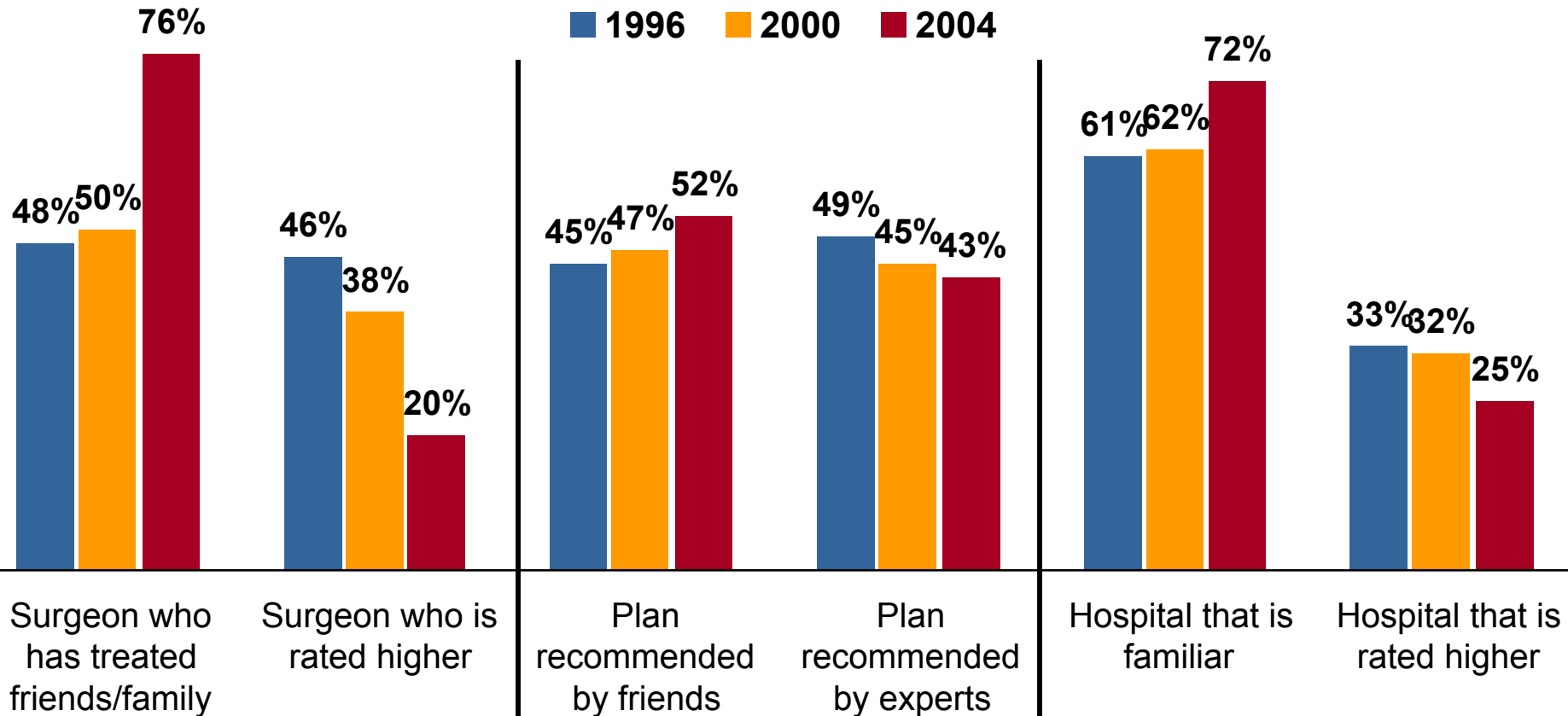


Source: Harris Interactive, Strategic Health Perspectives 2001-2005



# Consumers: Quality Ratings Are Less Important Than Word of Mouth

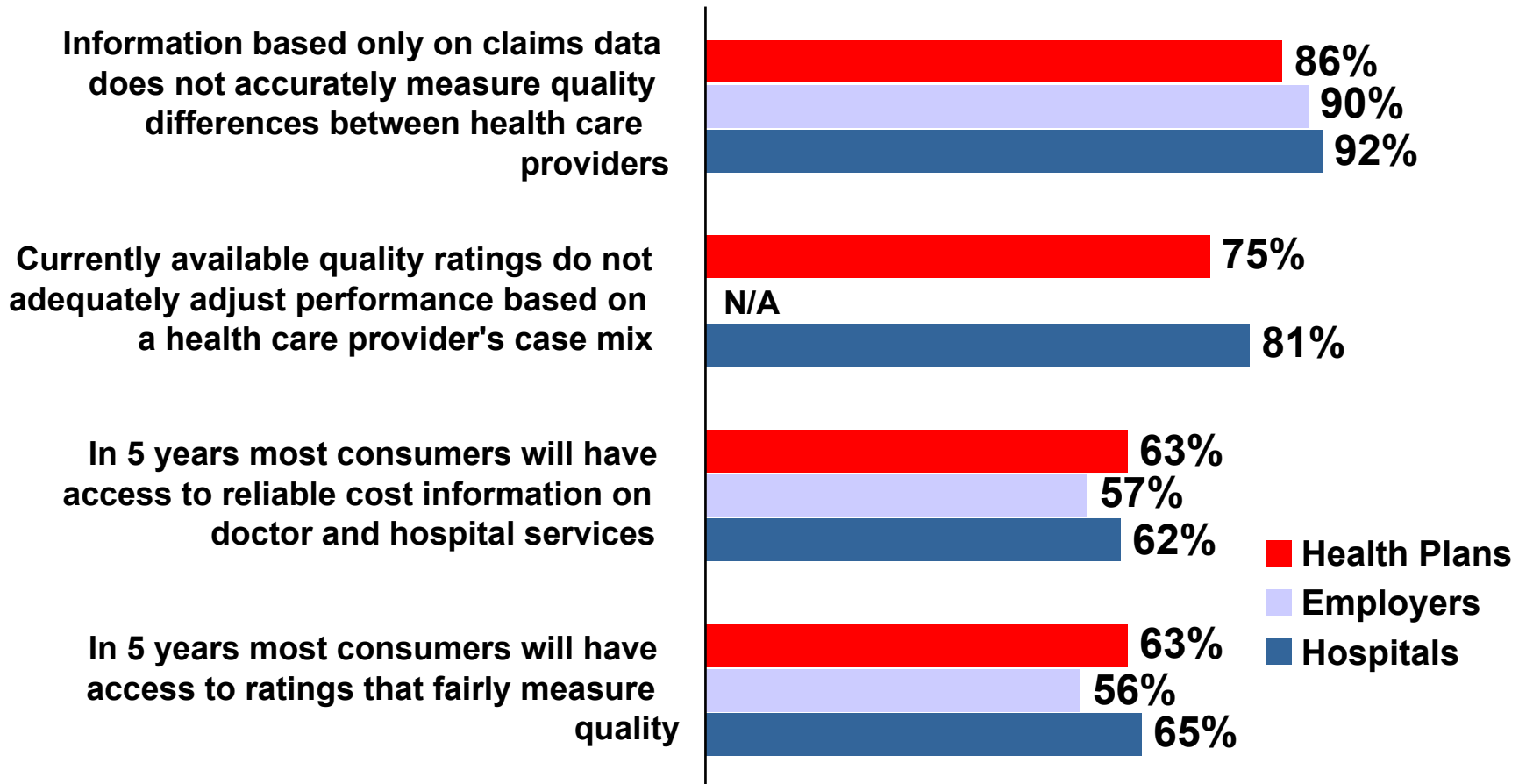
Percent of Americans who say they would prefer a...



Source: Kaiser Family Foundation / Agency for Healthcare Research and Quality / Harvard School of Public Health *National Survey on Consumers' Experiences with Patient Safety and Quality Information*, November 2004 (Conducted July 7 – September 5, 2004).

# Quality Information is Currently Inadequate, But Just Wait Five Years

Percentage of that agree with each statement



Source: Harris Interactive, Strategic Health Perspectives 2005



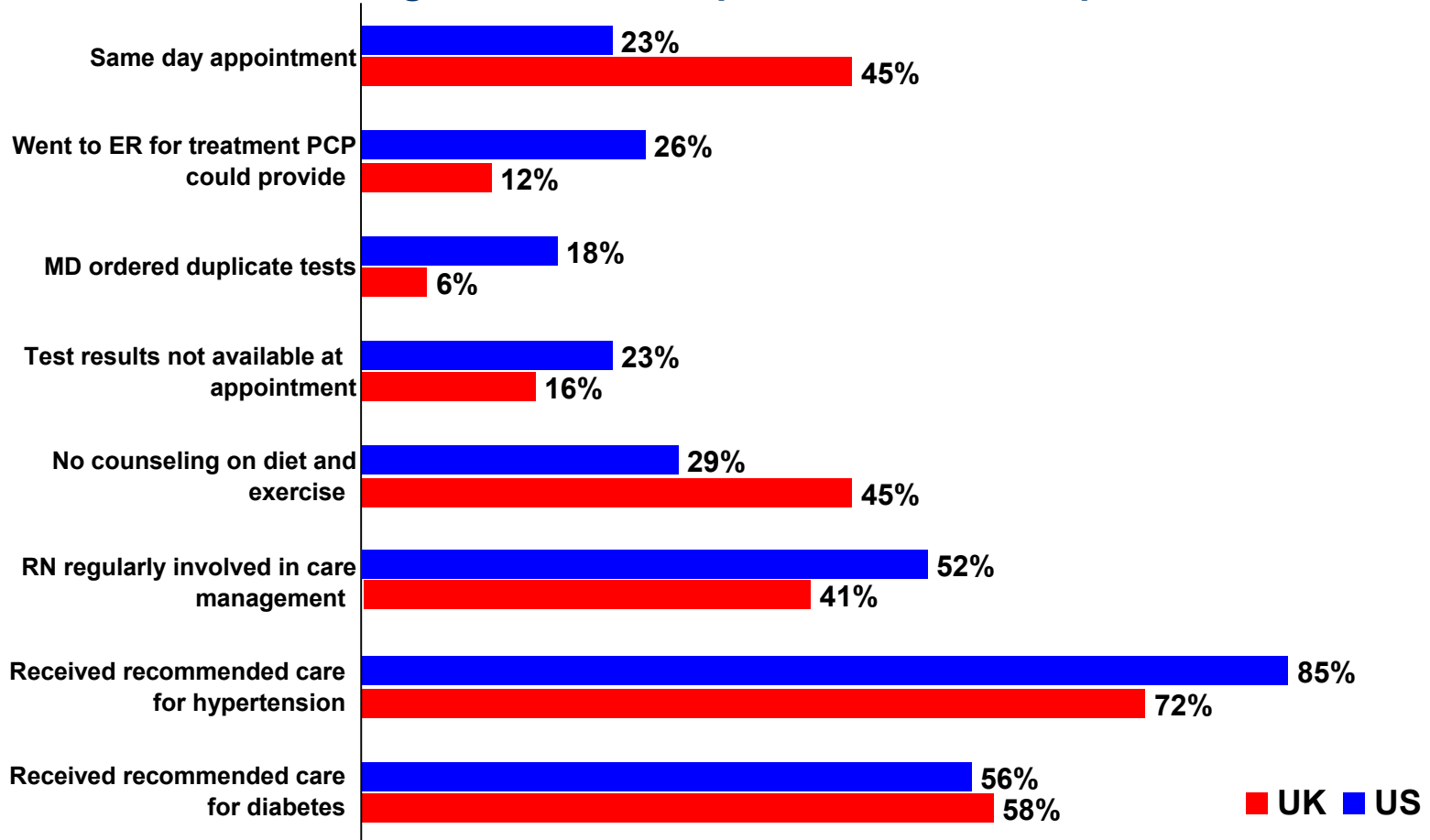
- Doctor's Office Quality Trial – CMS
- Quality Purchasing Initiative – Leapfrog Group
- Quality and Outcomes Framework – UK General Practitioners' Contract, established 2004

# A Closer Look at the UK's Quality and Outcomes Framework

- Voluntary program with potential to increase practice income by 20 percent
- “New money” rather than redistribution of old funding
- 147 quality indicators across four domains:
  - **Clinical indicators** representing 10 common medical conditions (coronary heart disease, stroke and transient ischemic attack, hypertension, diabetes, COPD, epilepsy, hypothyroidism, cancer, mental health and asthma)
  - **Organization indicators** of medical records and information, communication with patients, education and staff training, practice management and medication management
  - **Patient experience** indicators using recommended standardized surveys and consultation length
  - **Additional service area** indicators including cervical cancer screening, Child birth surveillance, maternity and contraceptive services
- Additional holistic payment points:
  - **Holistic care** payments reward overall achievement in clinical domain
  - **Quality practice** payments reward overall achievement across all four domains
  - **Access** bonus rewards sustained achievement against a target of 48 hour access to health care professionals

# The UK's Quality and Outcomes Framework; Initial Results

## Practices achieving a mean of 91.3 percent of the total points available<sup>1</sup>

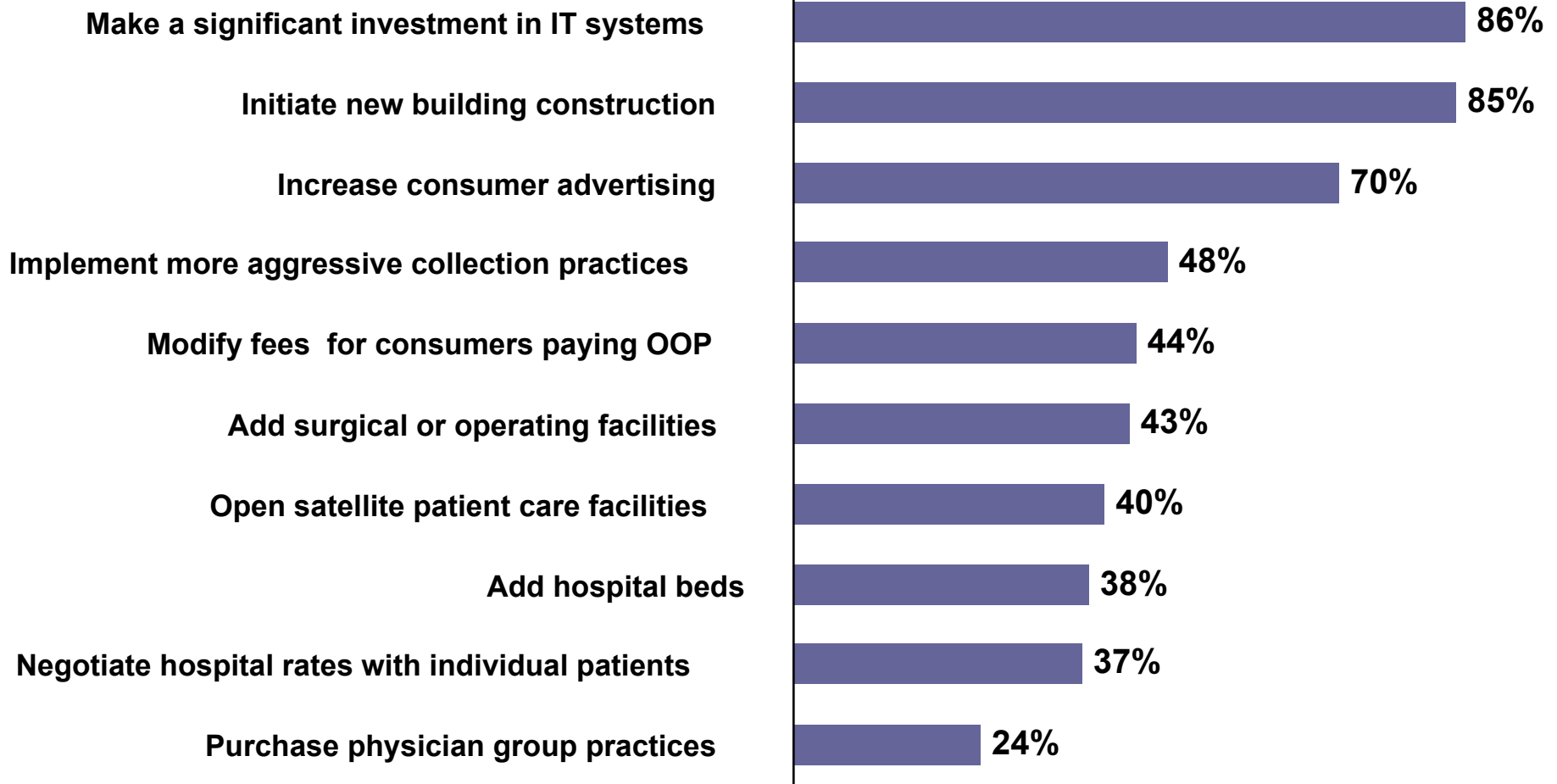


Sources: 1) Using Financial Incentives to Promote Quality Improvement:: The UK Experience, M. Marshall, Head of Division of Primary Care and Professor of General Practice, University of Manchester, United Kingdom

2) The Commonwealth Fund 2005 Survey of Sicker Adults in Six Countries, November 2005

# Large Majorities Expect to Make Investments in Information Technology and New Construction in the Short-Term

## Planned hospital actions in the next 2 to 5 years



- Potential for improving safety and quality
- Long term costs saving
  - Shorter lengths of stay
  - Reduced duplication
  - Better DSM
- Basis for transformation of clinical processes
- Better compliance by patients, physicians, caregivers in practice standards
- Interoperability across continuum
  - So when your turned away from the ER at least they had your record

# HIT: Momentum is Building but....

- HIT is good thing don't get me wrong
- EMR is a PET
- It won't save money quickly
- Expectations are too high, but .....

  - You gotta spend to save
  - You create a platform for improvement
  - We do not have another idea
  - Strong bi-partisan support conceptually ..... Show me the money

- The power of simple disease registries: what can you achieve on 3x5 cards and a telephone
- Will we really do the hard process redesign and culture work?
- Interoperability is critical issue across the continuum of care, institutions and communities
- What about the vast rabble of American doctors?
- Who is going to do all this work?





# Four Scenarios for US Health Care 2005-2015

	Individual	Government
Minor Delivery System Reform	<b>Tiers R'Us</b> 50%	<b>Bigger Government by Request</b> 20%
Major Delivery System Reform	<b>Disruptive Innovation</b> 10%	<b>National Rational Healthcare</b> 20%





# Scenario 1: Tiers R' Us: Impact on Healthcare System

- Pharmaceuticals
  - More consumer behavior: trading down twice as often as trading up
  - Innovation is celebrated by the wealthy and the covered
  - Biotech is aimed at lifestyle improvement and well being not just rare dread diseases
- Providers
  - Well-heeled, well situated, well run providers continue to thrive and distance themselves from the pack on quality, safety, and service (one third) aided by P4P
  - Basket cases that deal with the poor and the lower middle class
  - A health system for the top third
- Health IT
  - Providers use HIT as strategic competitive weapon not community resource
  - Enormous consolidation in Health IT as too many vendors chase too few profitable accounts
  - New high end entrants in Customized Genomic Medicine: Cerner meets Celera

## Scenario 2: Bigger Government by Request

- Baby Boom Backlash against cost-shifting
  - Democrats run on shoring up and expanding Medicare for middle aged and elderly
  - Government regulates healthcare even more
  - Slowing innovation, reducing provider payment, and limiting profiteering
- 
- Probability over 10 years: 20%



# Scenario 2: Bigger Government by Request: Impact on the Healthcare System

- Pharmaceuticals
  - Medicare Part D becomes a Regulated Utility
  - Prices are set by government for Medicare and Medicaid drugs
  - Lower R&D spending
  - Advertising and promotion practices regulated and restrained
  - Innovations slows
  
- Providers
  - Hospitals are secure but under-funded for major capital initiatives
  - Top tier institutions make it on philanthropy and differentiated care for the affluent elite
  - Only cost-reducing technologies are rewarded
  - P4P: You gotta perform to avoid a pay cut
  
- Health IT
  - RHIOs are standardized and regulated but not given enough resources
  - Electronic Health Record is mandated but not funded
  - Process redesign is necessitated by tight budget controls

## Scenario 3: Disruptive Innovation

- Cheapo plans proliferate (high deductibles and retail primary care) forcing cheaper delivery models to emerge
  - New disruptive competitors emerge at a lower price point e.g. Revolution Health, Wal-Mart, Kaiser Lite
  - Almost as good, and a lot cheaper
- 
- Probability over 10 years: 10%

# Scenario 3: Disruptive Innovation Impact on the Healthcare System

- Pharmaceuticals
  - Established generics are embraced as best value therapy by providers, payers and consumers alike
  - Enormous global competition drives prices down
  - Innovation is rare and only for the rich (e.g. 50% co-insurance on biologicals)
  
- Providers
  - Outpatient alternatives grow from Minute Clinics to outpatient surgery chains to federally funded safety net community clinics
  - Hospitals are either struggling as government (under)funded geriatric ICUs or thriving as body repair shops for affluent baby-boomers
  - Primary Care becomes the ultimate P4P: it's all retail
  
- Health IT
  - Regional Health Information Organizations RHIOs are open standards
  - The standard Electronic Health Record is Microsoft Outlook with Macros



## Scenario 4: National Rational Healthcare

- Mandatory universal individual insurance is passed
  - National policy commitment to restructure healthcare financing and delivery
  - True managed health care
  - Focus on public health and prevention
- 
- Probability over ten years: 20%





# Scenario 4: National Rational Healthcare Impact on the Healthcare System

- Pharmaceuticals
  - Reference-pricing and cost-effectiveness criteria for new technology
  - True clinical innovation is rewarded
  - Side by Side clinical trials for new product launches
  - National Technology Assessment System continuously monitors technologies in use
- Providers
  - Chronic Care management done right: innovation in community based chronic care
  - New reimbursement systems “Daughter of Capitation” force market leaders into fundamental clinical system redesign
  - Acute care is evidence-based and standardized
  - Innovation concentrated in designated centers of excellence
  - P4P means better payment and earns the provider the right to serve
- Health IT
  - RHIOs are interoperable and standardized and at the core of new chronic care paradigm
  - HIT is funded through special national health infrastructure tax

## Common Themes

- High end patients and providers will always do well
- Generics will grow in almost any scenario
- True cost reducing technologies will always have appeal
- True clinical breakthroughs that are radically better than existing modalities and therapies will always be rewarded
- Healthcare is a superior good and will take a larger share of national wealth
- But who pays for what and how will be central difficult questions for business, government, and households around the world forever
- It's all about Information and Incentives

- No matter what, we will need better value measures and more transparency of measures
- Value based purchasing and P4P will become more prevalent and have a powerful influence on providers and vendors
- Consumers will become more engaged in value decisions but we cannot rely on them absolutely
- The systems of healthcare need to be continuously improved to deliver greater value
- Will require clinical skills, process skills, use of cutting edge technology and big-time capabilities
- Most of all, it will require leadership

- P4P is powerful because it affects provider incentives
- P4P can build on the broader positive trends
- But.....
  - We must make the incentives big enough to matter
  - We must build the infrastructure to measure, manage, and referee the system
  - We must be vigilant that P4P does not amplify disparities
  - We need to implement and sustain the trend not just wander off in pursuit of the next big fad