



Health Policy and the Practice of Medicine

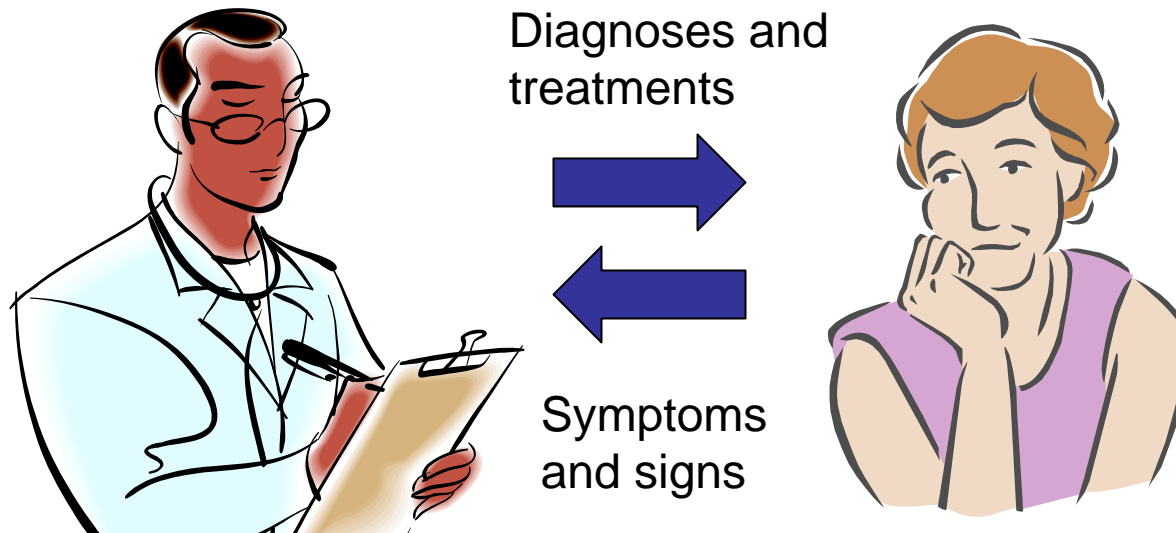
Jay Himmelstein, MD, MPH
UMass Medical School
Center for Health Policy and Research,
January 4, 2007

www.umassmed.edu/healthpolicy

Agenda

- Why health policy matters to the practice of medicine
- Emerging health policy issues aimed at controlling costs and improving quality
- Health care access: A case study - Massachusetts Health Reform
- Discussion

The Practice of Medicine



Much of MD training focuses on the patient-physician interaction in isolation...

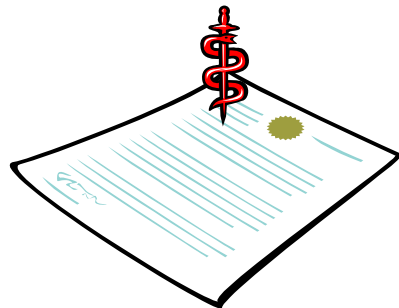
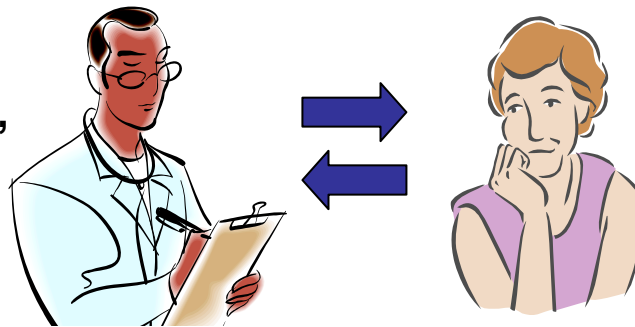
The Health Care “Marketplace”



Purchasers
(Employers, government,
& individuals)



Government
(Purchaser, regulator,
legislator)



Insurers
(Private plans, Medicaid,
Medicare, etc.)



Suppliers
(Pharmaceuticals, medical
equipment, and supplies)

Purchasers

- Purchasers supply funding to the health care system
 - Employers
 - Government
 - Individuals
- Purchaser interactions
 - Employers purchase health insurance
 - Government provides health insurance to employees and some beneficiary groups (poor, seniors, disabled, etc.)
 - Individuals purchase health insurance or pay directly for health services

For purchasers, health care is an expense. They want to know they are getting good quality at low cost

Insurers

- Insurers
 - Private plans
 - Managed care (HMO's, PPO's, etc)
 - Fee for service
 - Government
 - Medicare - a federal social health insurance program for the elderly and the disabled, insures over 40 million people.
 - Medicaid - a federally and state funded, state administered health insurance program for low income children, pregnant women, and disabled adults.

For insurers health care is an expense to be managed, hopefully without compromising access to, or the quality of, care.

Providers

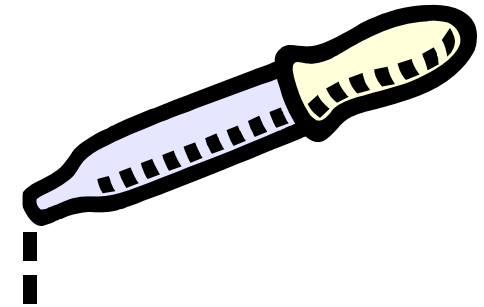
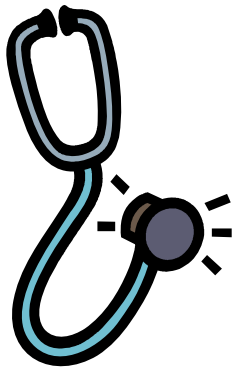
- Providers
 - Physicians
 - Nurses
 - Hospitals
 - Nursing Homes
 - Home Health Agencies
 - Pharmacies
 - Any provider of health care services



For providers health care ‘expenses’ are income. Providers have concerns about the adequacy and mechanism of payment for their services.

Suppliers

- Suppliers
 - Pharmaceutical manufacturers
 - Medical supply companies
 - Medical equipment companies

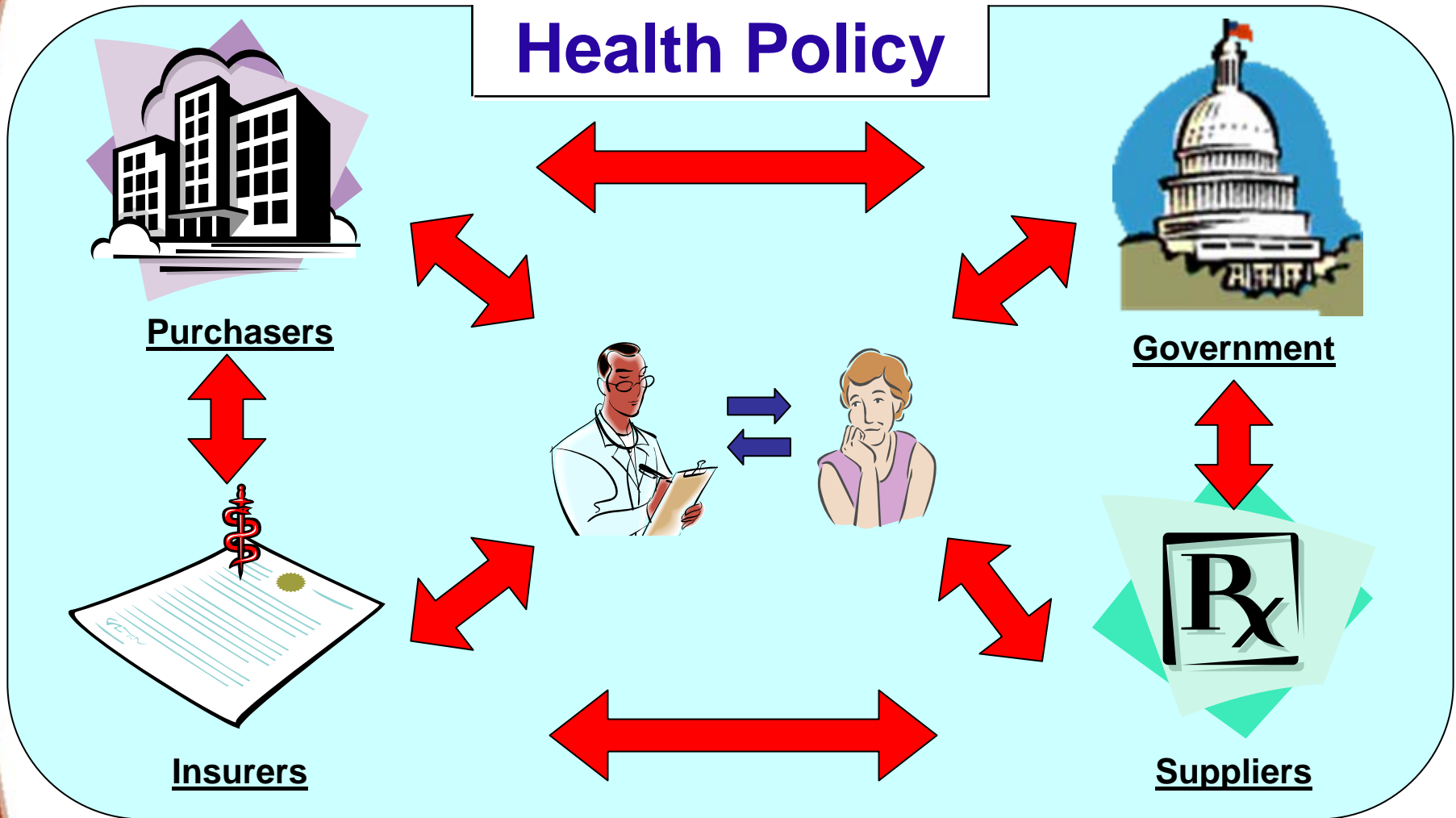


Most suppliers are for-profit entities who want to maximize revenues ($R = \text{Volume} \times \text{Price}$). They will resist attempts to control health care costs at their expense.

Government

- Government plays numerous roles in health care
 - Policy Maker
 - Legislative Branch makes laws that impact the health care system
 - Judicial Branch interprets laws and judges violations...
 - Market Regulator
 - Executive Branch runs health and human service agencies and regulates and licenses health care providers
 - Major Payer
 - Medicare, Medicaid, government employees, Veteran's health care, and tax subsidies account for well over 50% of health care spending!

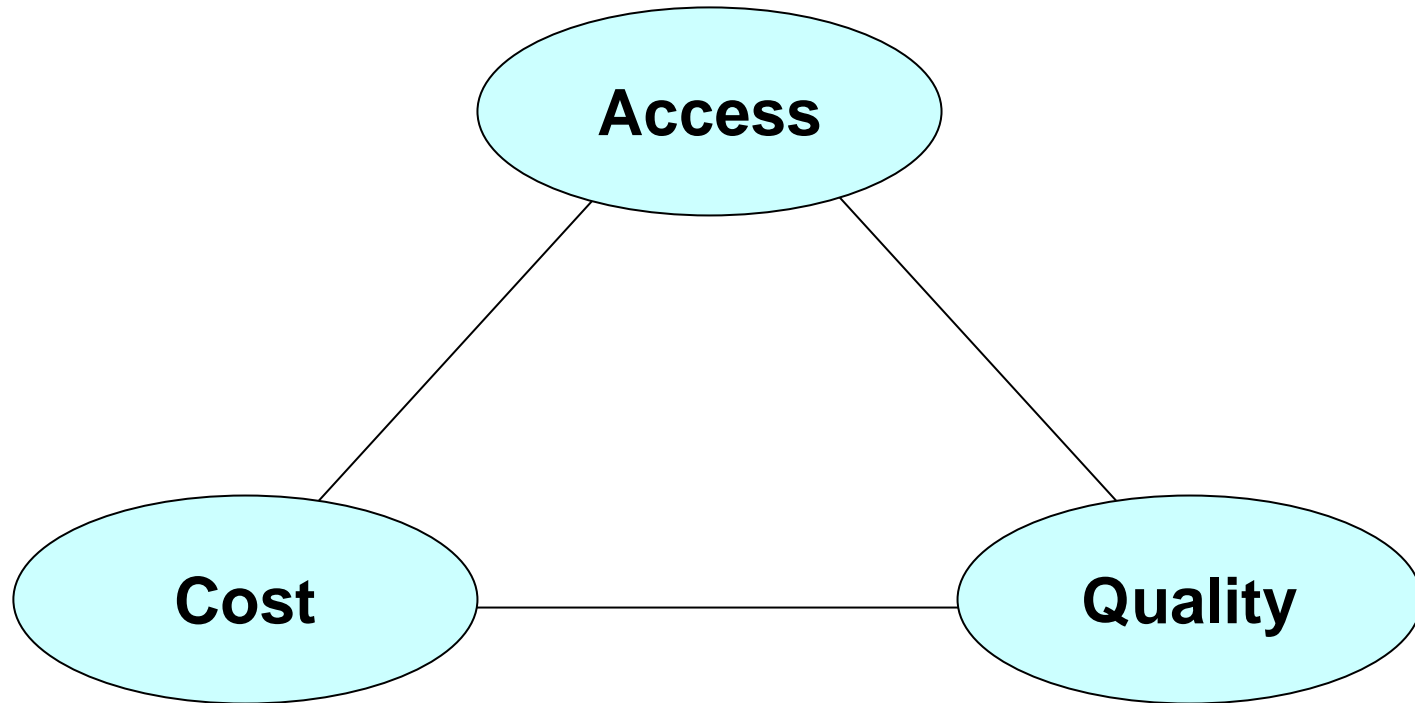
Health Policy



“Health policy making in the United States involves a complex web of decisions made by various institutions and political actors across a broad spectrum of public and private sectors.”

1) Patel, K. & Rushefsky, M.E. (1999). *Health Care Politics and Policy in America* (2nd Ed.). Armonk, New York: M.E. Sharpe, Inc.

Interrelated Health Policy Objectives



Much of the US health policy debate is focused on how best to expand access, control costs, and improve quality

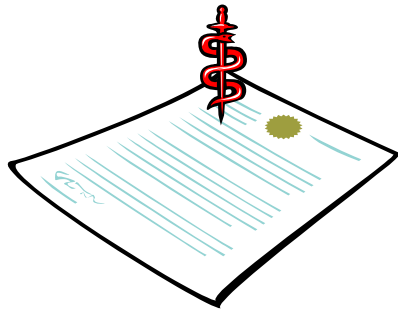
Why do governments get involved in health policy?

- Presumption in capitalist economies is that private markets best determine the production and consumption of goods and services
- Government generally intrudes only when private markets fail to achieve desired public objectives
- Unfortunately, the health sector is especially prone to poorly functioning markets, e.g.
 - “Buyers and Sellers” don’t have sufficient information to make informed decisions
 - Barriers to sellers entering the market, e.g. provider training, hospital safety
 - Consequences of poor quality products and services
 - Inadequate resources for poor to ‘buy’ essential services

Access is a problem for over 46 million Americans



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(Employers, governments, & individuals)



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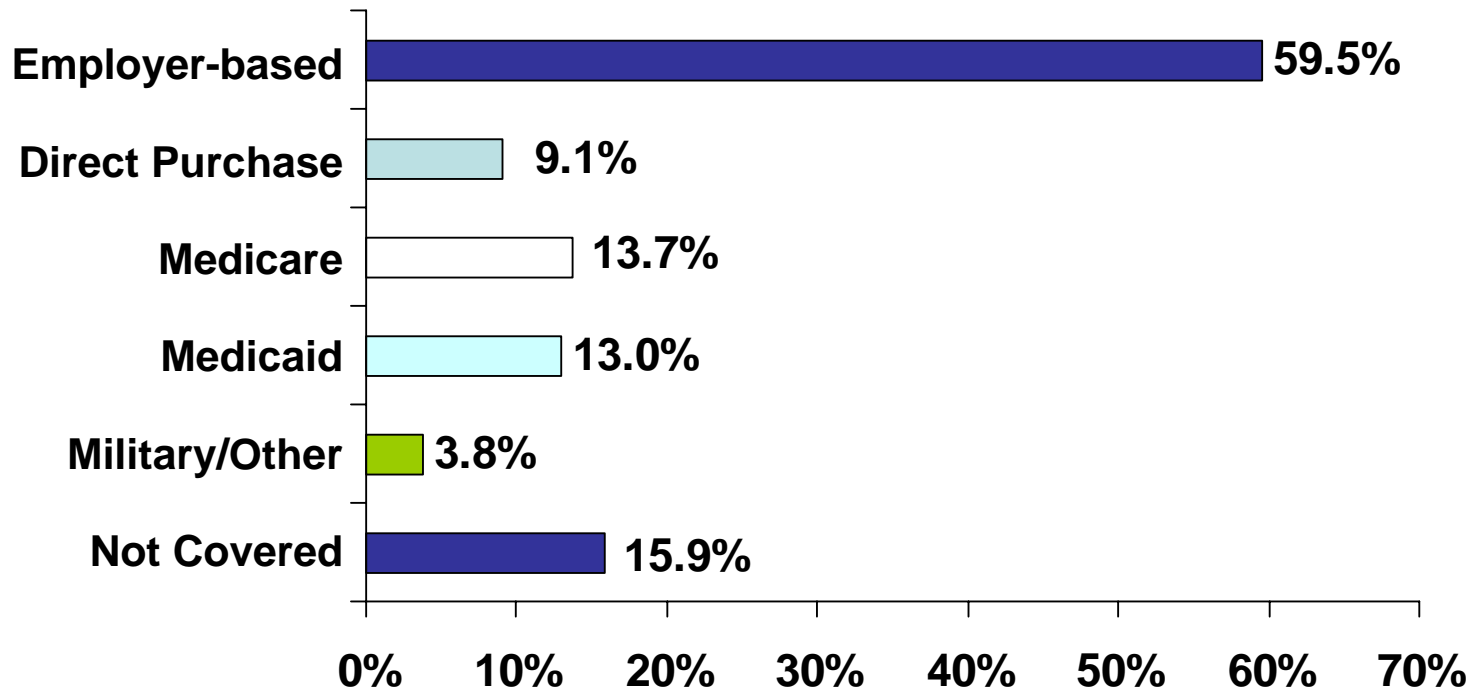


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(Purchaser, regulator, legislator)



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(Pharmaceuticals, medical equipment, and supplies)

Health Insurance Coverage of the U.S. Population, 2005



Total = 294 million

Note: The estimates by type of coverage are not mutually exclusive; people can be covered by more than one type of health insurance during the year.

Source: U.S. Census Bureau, Current Population Survey, 2005 Annual Social and Economic Supplement.

Employment- Based Health Insurance Coverage

- Unlike most other industrialized nations, US policy has encouraged and subsidized the workplace as a primary means for managing access to health insurance.
- The number of firms offering health insurance coverage, and the number of workers accepting the coverage is declining as the cost of coverage increases.
- Smaller employers and those with predominantly low wage workers are unlikely to offer health insurance.

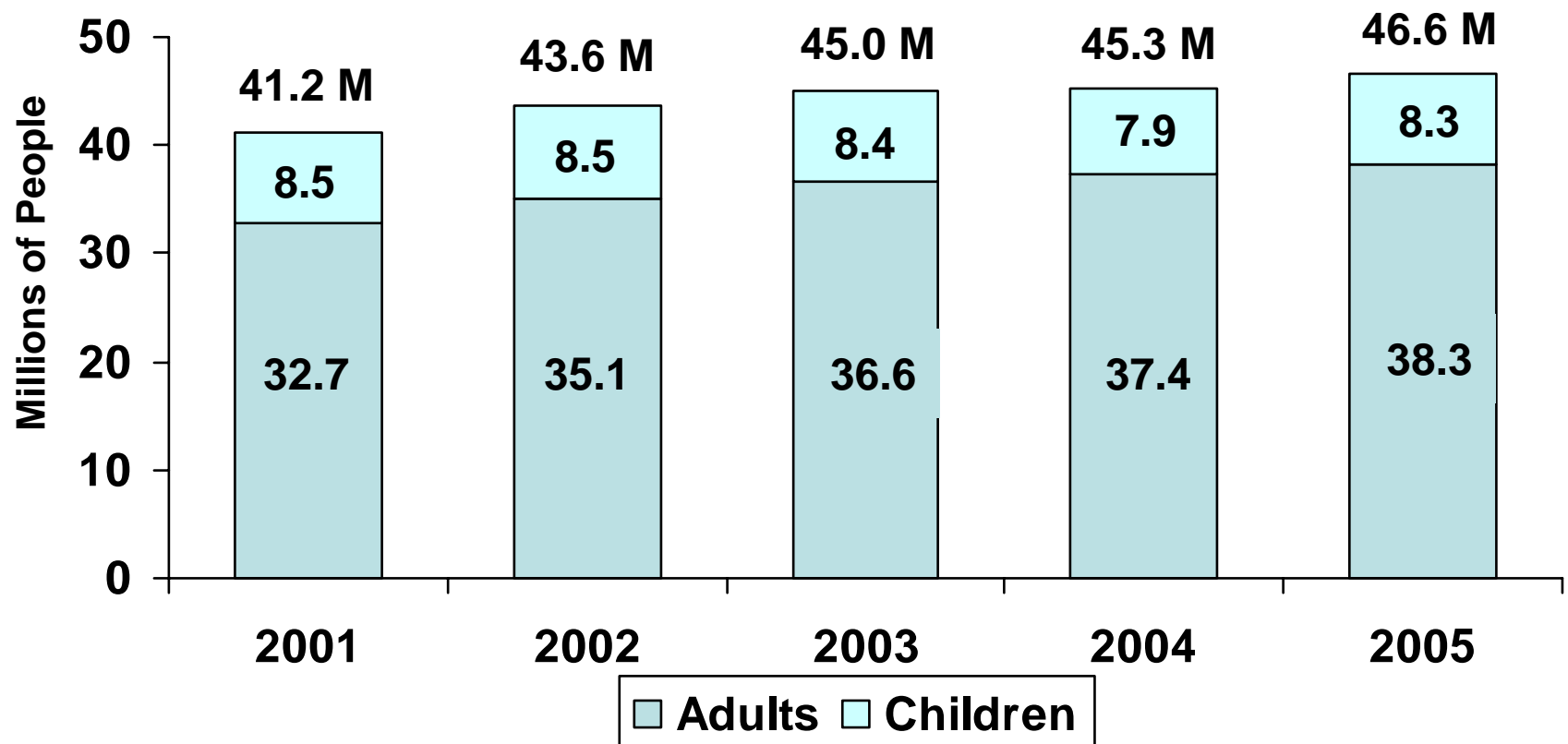
Medicare

- Medicare, a federal social health insurance program for the elderly and the disabled, insures over 30 million people.
 - Part A - Hospital Insurance - funded by employment based taxes.
 - Part B - Outpatient Insurance - funded by taxes (75%) and contributions (25%)
 - Part C – Medicare Advantage that provides for the delivery of Medicare benefits through private health plans (previously called “Medicare+ Choice”)
 - Part D – New Medicare prescription drug coverage
- Long term financing in danger --> increasing cost containment pressures.
- Medicare does not pay for long-term nursing home care

Medicaid

- Medicaid is the major state-federal health insurance safety net program providing health coverage for the poor and disabled
 - 1 in 4 children, and 1 in 8 adults receive coverage through Medicaid. (more than 30 million nationally)
 - More than 1/2 of all nursing home care is paid by Medicaid (over 70% in Massachusetts)
- Medicaid programs across the country are under stress as a result of increasing health care costs and declining state revenues.

Number of Uninsured Children and Adults, 2001 - 2005



SOURCE: U.S. Census Bureau, Current Population Survey, 2005 Annual Social and Economic Supplement.

The Uninsured

- Currently more than 46 million Americans are uninsured, almost 18% of the under 65 population.
- Most uninsured adults in this country have full time jobs, but work for small, generally low wage firms who do not offer insurance through work.
- Research demonstrates that the uninsured:
 - use fewer preventive and screening services;
 - are sicker when diagnosed;
 - receive fewer therapeutic services;
 - have poorer health outcomes (higher mortality and disability rates); and
 - have lower annual earnings because of poorer health.

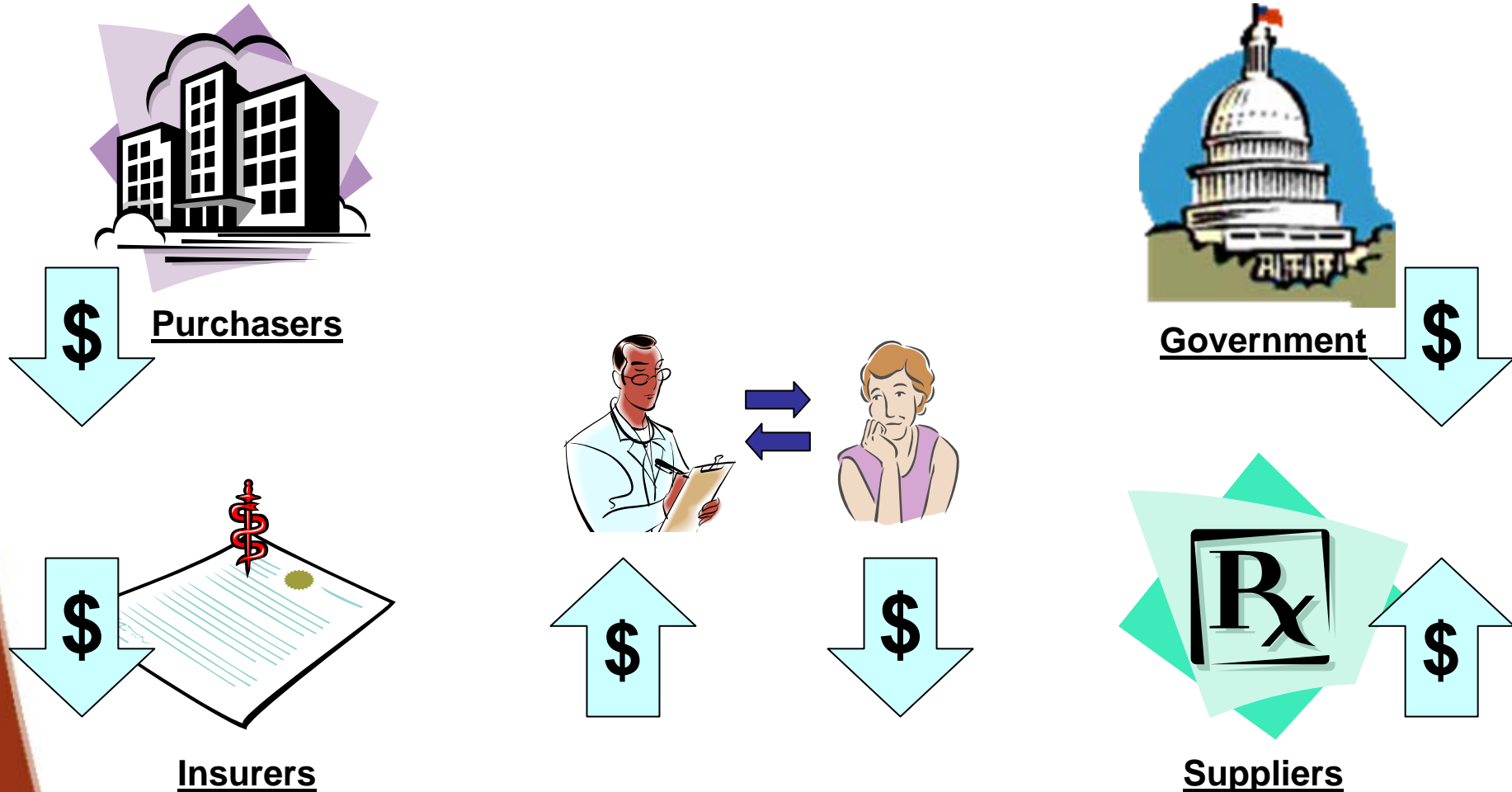
In 2005, 618,000 Massachusetts residents, or 9.8% of the population were uninsured compared to 16% nationally.

SOURCE: Hadley, Jack. "Sicker and Poorer – The Consequences of Being Uninsured: A Review of the Research on the Relationship between Health Insurance, Medical Care Use, Health, Work, and Income," *Medical Care Research and Review* (60:2), June 2003.

Agenda

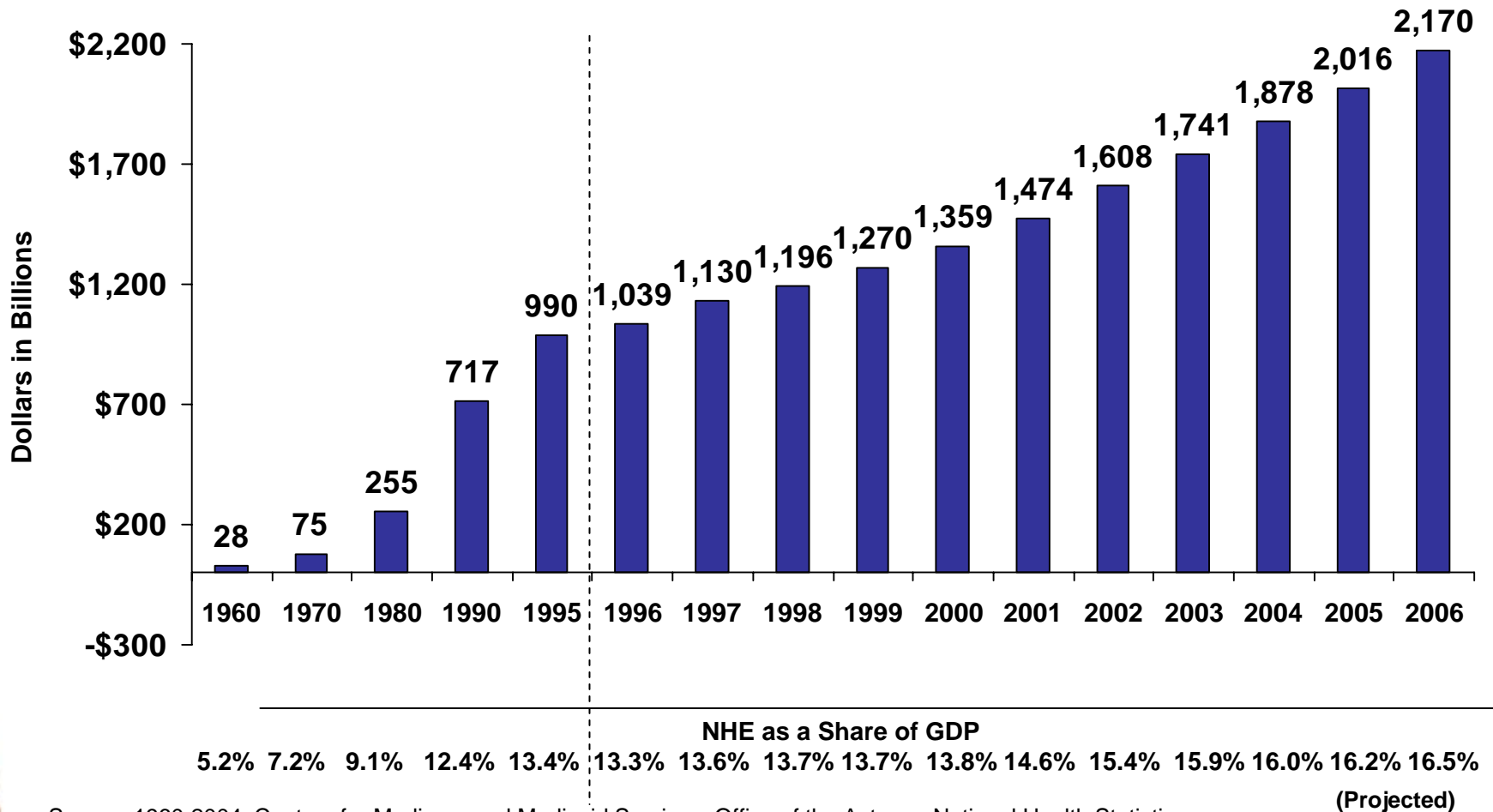
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Costs for Health Care in the U.S. Are Going Up, Up, and Up



Costs Are Going Up

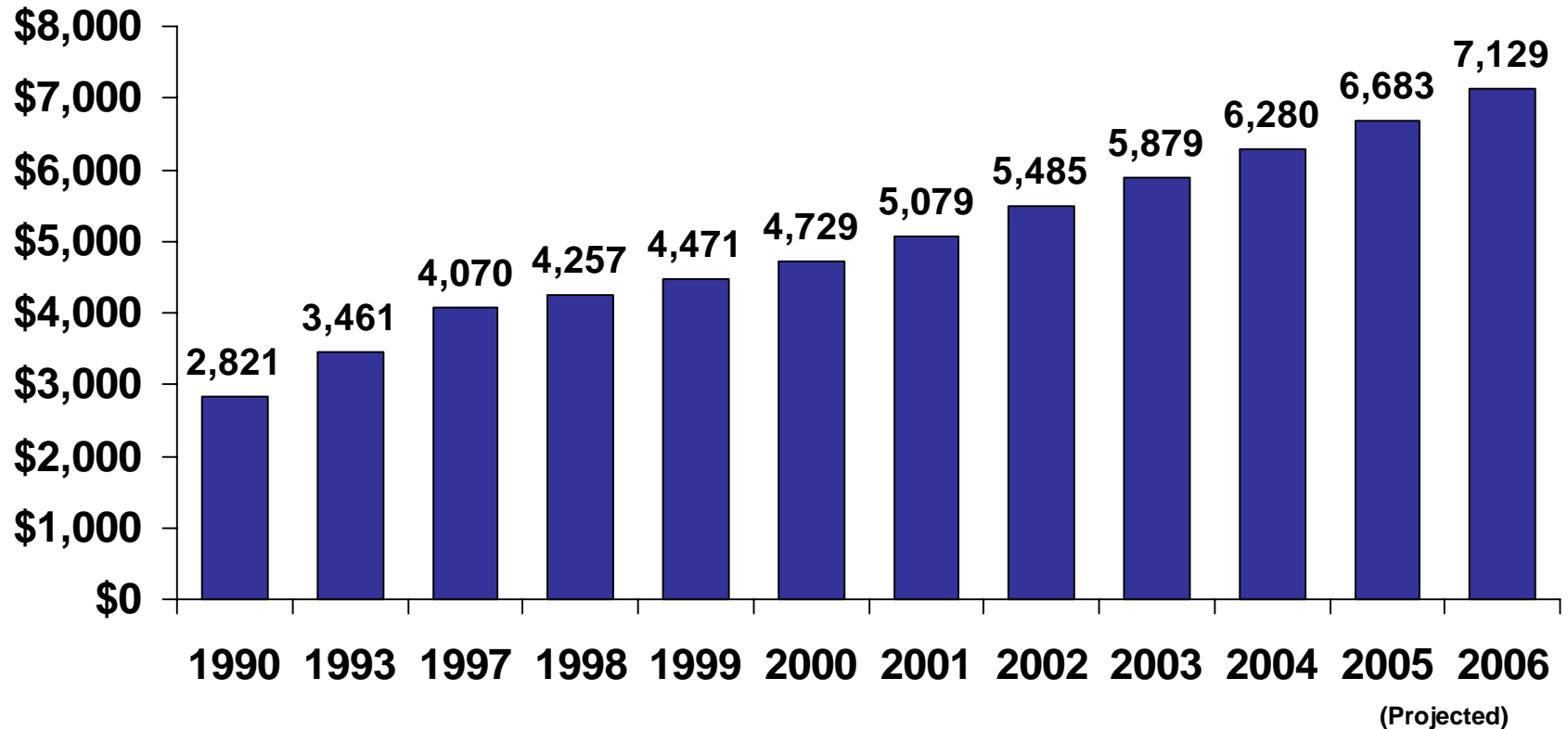
US National Health Expenditures and Their Share of Gross Domestic Product, 1960-2006



Source: 1960-2004: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, at <http://www.cms.gov/statistics/nhe/default.asp> (2004 National Health Care Expenditures Data Files for Downloading, file nhegdp03.zip). 2005-06: CMS projections.
<http://www.cms.hhs.gov/NationalHealthExpendData/downloads/proj2005.pdf>.

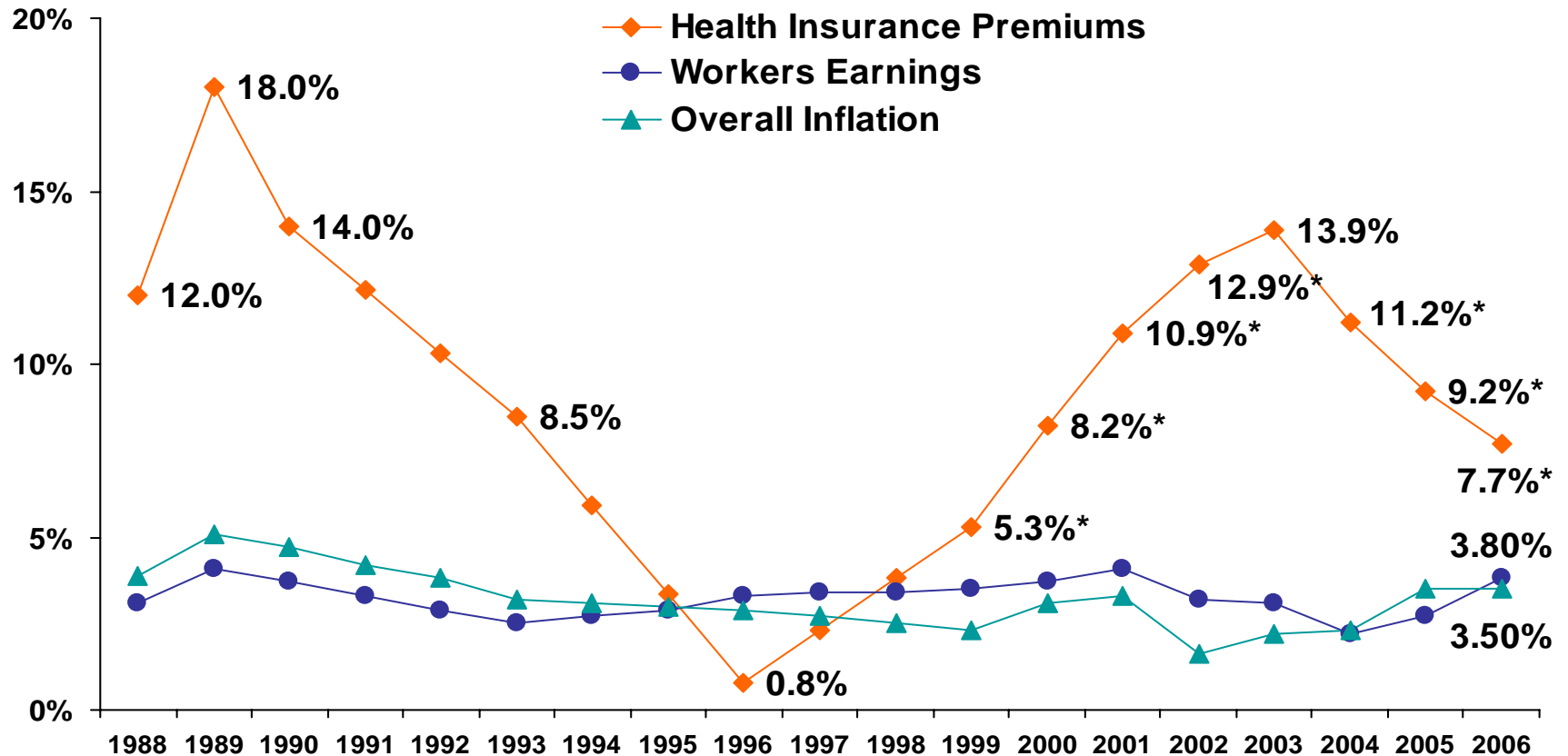
Costs Are Going Up

National Health Expenditures per Capita, 1990-2006



Source: 1990-2004: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, at <http://www.cms.gov/statistics/nhe/default.asp> (2004 National Health Care Expenditures Data Files for Downloading, file nhegdp03.zip). 2005-06: CMS projections. <http://www.cms.hhs.gov/NationalHealthExpendData/downloads/proj2005.pdf>

Increases in Health Insurance Premiums Compared to Other Indicators, 1988-2006



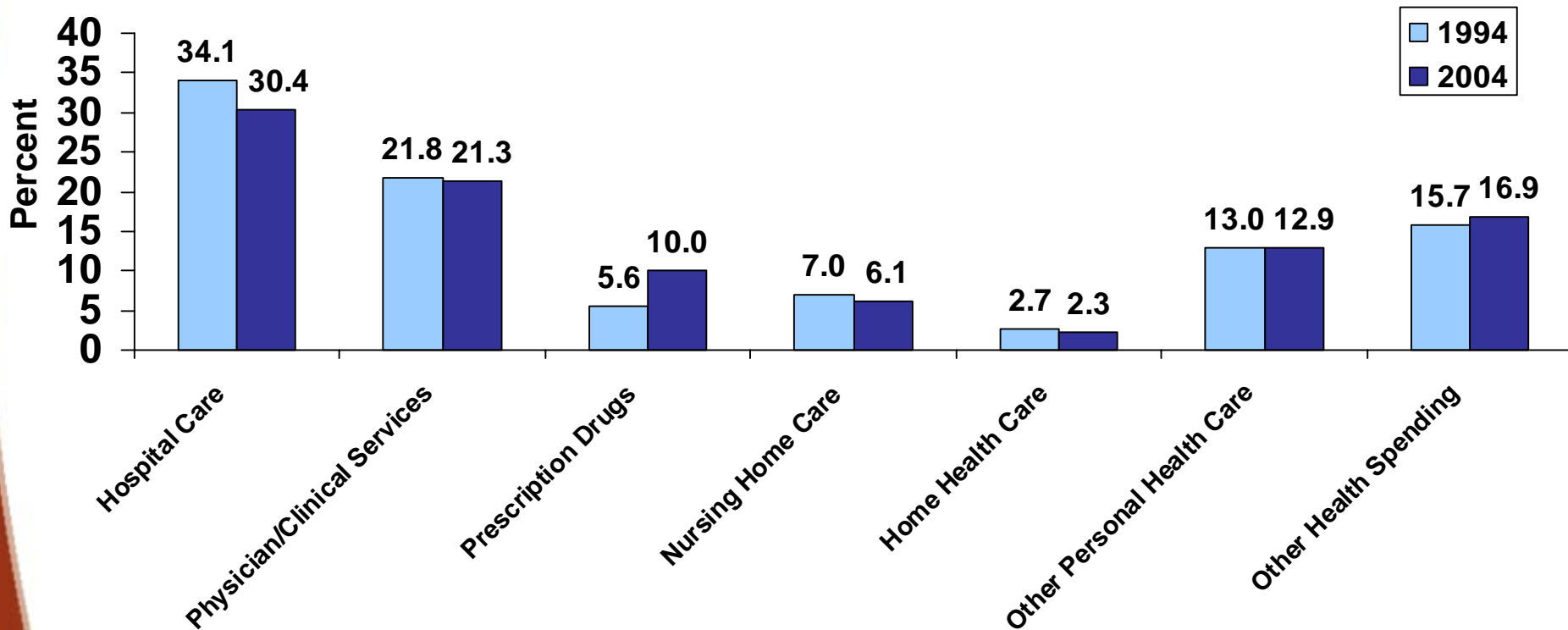
* Estimate is statistically different from the previous year shown at $p < 0.05$; $\pm p < 0.1$

Note: Data on premium increases reflect cost of premiums for a family of four.

Source: KFF/HRET Survey of Employer-Sponsored Health Benefits (ESHB): 1999-2006; KPMG Survey of ESHB:1993, 1996; HIAA: 1988-1990; BLS, CPI (U.S. City Average of Annual Inflation (April to April), 1988-2006; BLS, Seasonally Adjusted Data from Current Employment Statistics Survey (April to April), 1988-2006.

Where Does the Money Go?

Distribution of National Health Expenditures by Type of Service, 1994 and 2004



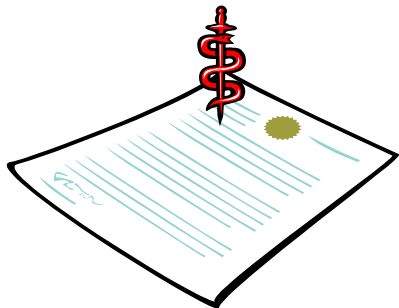
Notes: Percentages may not total 100% due to rounding. Other Personal Health Care includes, for example, dental and other professional health services, durable medical equipment, etc. Other Health Spending includes, for example, administration and net cost of private health insurance, public health activity, research, and construction, etc.

Source: Kaiser Family Foundation calculations using data from Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, at <http://www.cms.hhs.gov/NationalHealthExpendData> (see Historical; National Health Expenditures by type of service and source of funds, CY 1960-2004; file nhe04.zip)

Does our health care system produce the best quality?



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(Employers, governments, & individuals)



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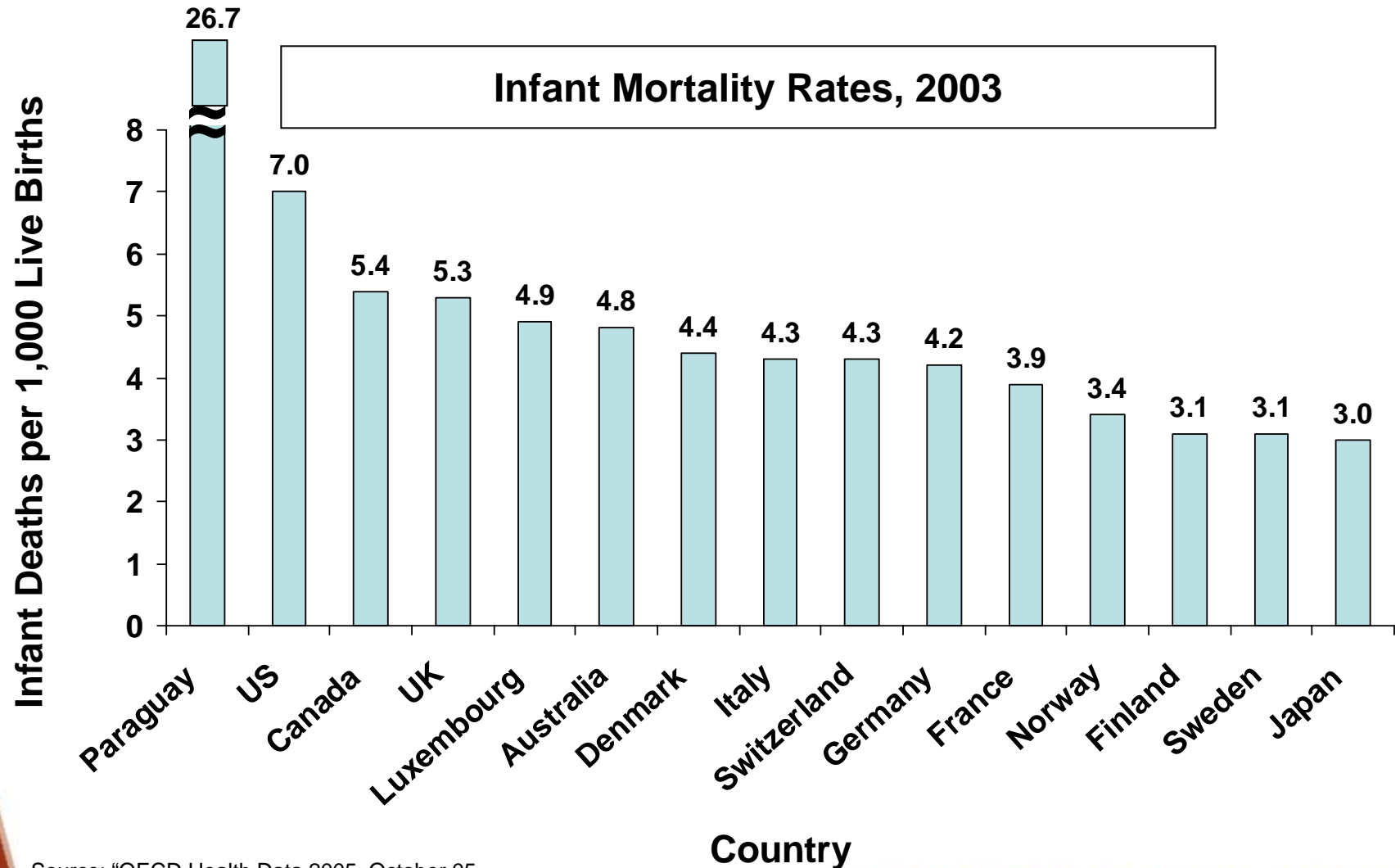


Government
(Purchaser, regulator, legislator)



Suppliers
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Is the US System the Best, or just the Most Expensive?



Source: "OECD Health Data 2005, October 05

Defining Quality of Care

- Quality of care is the degree to which **health services** for individual and populations increase the likelihood of desired **health outcomes** and are consistent with **current professional knowledge**

--Institute of Medicine, USA

Clinical Quality Challenges

- Overuse or unnecessary or ineffective care
 - Antibiotics
 - Imaging Services
 - ‘Elective’ surgical procedures
- Under-use of effective care
 - Primary Prevention (e.g. condoms, immunization)
 - Secondary Prevention (e.g. screening for disease)
- Misuse: Safety and Medical Errors
 - Drug Errors – e.g. wrong drug, wrong dose, wrong patient
 - Communication errors: Patient to Doctor, Doctor to Patient, communication handoffs between health professionals

Why hasn't health care seen the quality and value improvements that have been achieved in other industries?

- Payment policy
 - Historically, providers get paid for 'productivity' – visits, hospital days – not quality or outcomes
 - Insurance, while making expensive health care more affordable, removes restraint on 'demand' for health care
- There is a need to create a stronger business case and motivation for the health care system to change

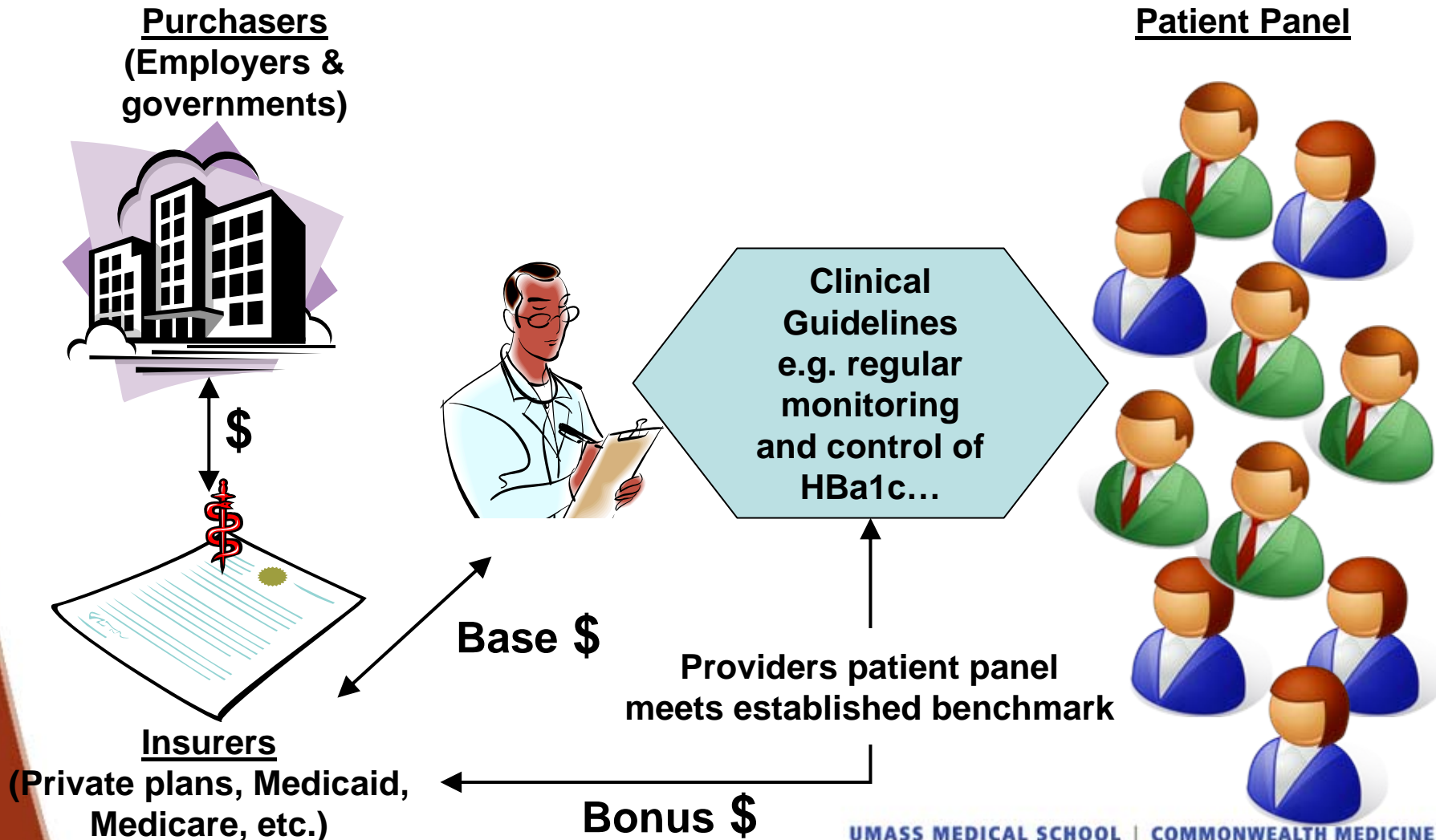
Some Emerging Strategies for Improving Quality and Controlling Costs

- “Pay for Performance”
- “Consumer” focused strategies to control costs and improve quality

“Pay-For-Performance (P4P)”

- New approach to quality improvement
 - Relies on economic incentives (prospective) rather than punitive approach (retrospective)
- How Pay-for-Performance works
 - Health plans and other insurers reward providers with bonus payments for meeting specific quality and/or efficiency goals (process, outcome, patient satisfaction, etc.)
- Examples:
 - In Massachusetts, insurers are now paying a “bonuses” to physician groups and hospitals for meeting specific quality measures.
 - In Great Britain, up to 30% of physician salary is dependent on performance for over 140 quality indicators

Example of P4P in office practice...



“Consumer” focused strategies to control costs and improve quality

- Rationale: cost growth will continue until appropriate limits are placed on consumer demand.
- Approach: Use economic measures to increase consumer sensitivity to costs and involvement in decision making
- Examples:
 - Increasing consumer awareness of cost and quality (‘transparency’, publishing quality measures)
 - Increasing consumer “financial responsibility” and “cost sensitivity” through high-deductible health plans

Health Care “Transparency”

- Rationale:
 - Making quality information public will allow consumers to choose higher quality providers and pressure to improve
- Approach: Websites aimed at consumers and providers
 - Massachusetts State Government
 - Hospital Quality and Cost Information
 - [Hip Fracture Mortality](#)
 - Private Efforts
 - The [Leapfrog Group](#)
 - E.g. [Hospital survey results Worcester Massachusetts](#)
 - Massachusetts Health Care Quality Partners
 - reports on [clinical quality in primary care](#)

High Deductible Health Plans and “Consumer-Directed” Health Care

- Rationale:
 - Control costs and improve quality by increasing consumer awareness and providing incentives for consumers to consider costs when making health care decisions
- Approaches:
 - Create relatively low cost health plans through use of caps and high deductibles – for example, the UMass Student Health Plan, or possibly some of the new plans that will be offered by the Massachusetts Connector
 - “Consumer-Directed” High Deductible Health Plans

UMMS Student Health Insurance Basics

- Annual Cost: \$3,176 for individual
- Outpatient benefits: maximum of \$20,000 per sickness/accident
- Surgical Benefits: maximum of \$20,000 per surgery.
- Prescription Benefits maximum of \$7,500.
- Aggregate Maximum: \$250,000

Consumer Directed Health Plans

- Definition:
 - Health plan with a high deductible (e.g. over \$1000 for individual) accompanied by a consumer-controlled 'health savings account' (HSA).
 - Example: see [PerfectHealth Platinum HSA](#)
- Higher cost-sharing in consumer directed health plans:
 - Leads to lower premiums, but
 - Is likely to deter use of beneficial (preventive, diagnostic, treatment) as well as unnecessary services (see Rand Health Insurance Study)
 - Impact on health outcomes unclear
- Social policy concerns
 - As high deductible health plans attract healthier people, prices for more traditional insurance will rise because they will be left with disproportionate share of sicker enrollees

High Deductible Health Plans: Medical Practice and Quality Issues

- These policies should be designed to minimize financial barriers to effective and needed care (especially for low income populations)
 - Plans should provide full coverage for effective preventive care and medications for chronic conditions (e.g. HBP and diabetes)
 - Modify product designs so that low income patients have less exposure to financial risk
- Providers have increased responsibility (and potentially conflicting economic pressures) to develop systems for keeping track of populations with chronic disease to insure that they receive needed care and adhere to treatment regimens

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Summary/Discussion

- Health policies external to the physician patient relationship may have a significant impact on the practice of medicine
- During your careers, you can expect increasing focus on controlling the costs, and improving the quality and value of medical care.
- Your careers may be more effective, and more satisfying, if you aware of the impact of health policy on your practice, and can learn to advocate for policies that will improve patient outcomes.