

# The Road to Affordability

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# Causes of Spending Growth Are Many

- New technologies are introduced and not rationed based on effectiveness, let alone cost effectiveness
- Physicians, hospitals are paid to do more (sometimes with a lag in the hospital, but revenues track costs fairly well)
- Consumers have little or no incentive to resist the pitch for cutting edge devices, drugs, tests and no information on which ones are worthwhile
- Fragmentation of care causes redundancy, dropped handoffs, poor coordination for chronically ill

# Many Cost Drivers Also Contribute to Poor Quality

- Payment incentives
  - Fragmentation
  - Lack of infrastructure
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# Solutions Should Also be Manifold

- We need payment reform to promote high-value services and curb the tendency towards over use of expensive care by providers
- We need sensible cost sharing for patients
- We need payment and benefit designs that together support accountability
- Investment in public health for the long term

# Payment Reform

- As noted earlier pay for performance can work but realistically will generate modest improvement
- Moreover pay for performance can't fix all the payment-related ills in health care: e.g., it is unlikely to be suited to reduce over use
- Underlying payment (largely fee for service for ambulatory care and DRGs, per diems for hospital care) needs reform
- Alternatives include:
  - Case rates for primary care with prospective accountability and performance incentives
  - Episode based payment: global longitudinal
  - Shared savings models

# Public Health and Culture Change for Patients and Physicians

- Payment and benefit design changes are efforts to row upstream
- Changing the current requires:
  - Investing in public health broadly conceived -- campaigns against tobacco, obesity
  - Convincing people that more high-tech services does not mean better quality
  - Making everyone, including physicians, accept stewardship for the system

# How We Encourage Shared Accountability?

- We need payers to demand better outcomes, lower costs and to make changes to payment etc. that will create the business case
- But no one payer has an incentive to do this – reaction from providers, lack of will on part of employers, consumers
- Can the Commonwealth lead, facilitate, or even regulate to coordinate policies?

# Going Beyond Model Providers

- Geisinger, Bellin, Ascension have leadership vision, resources, and other fairy dust
- They are transforming care despite the lack of business case (note that some productive efficiencies pay for themselves, but often they are not the easiest way to increase profit)
- If there is a collective will by payers to support high performing health systems, how do these policies reach the rest of the delivery system? Should we encourage integration?

# Lessons from Coverage Reform

- It took a collective willingness to compromise to pass health reform – and a looming deadline
- What will motivate providers, payers, and consumers to be willing to give up something to gain affordability?