

The Medical Arms Race Syndrome: *Where Will It Lead and Do We Want To Go There?*

August, 2006



*A summary report of the National Institute of
Health Policy's MARS Series Kick-off Meeting
July 13, 2006*

The National Institute of Health Policy

Advancing health policy dialogue in the Upper Midwest



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Introduction to the Medical Arms Race Syndrome (MARS)

The end of World War II in 1945 marked the start of an unprecedented expansion of higher education, scientific discovery, and efforts to bring the benefits of both to all Americans in the form of medical technology. Sixty years later we expect nothing less, even though the costs of that technology have priced many Americans, their employers and their governments, out of the market.

We expect that scientific discovery, professional skills expansion, medical technology innovation and the power of information technology will continue to effect positive changes in life expectancy and vastly improved quality of life in our later years. Infection and the impact of environmental toxins once consumed the best and brightest minds, but experts have now shifted their attention to prevention, longevity and living with chronic illness.

The Upper Midwest has experienced the benefits of medical science and technology investments, of innovative health professionals, practice, and payment systems, and pioneering efforts in advancing the science and development of information technology. We have never really understood, however, how to blend these benefits while at the same time diminishing their liabilities. Importantly, our localized attempts to do so have suffered from the disincentives built into national healthcare financing policy.

In the last three decades health services researchers and policy makers have sought to tie the expansion of medical science and technology to rising health care costs and access. We have shifted our emphasis from achieving the universal coverage that is prevalent in all other developed countries, to cost containment through third-party payers, cost shifting to individual consumers, and regulatory policy. Our public policy goals of universal access and coverage have collided with cost containment and affordability.

We have seen a diminution in physician and employer leadership for change, an expansion of the medical arms race in every community, and an over-reliance on national payment policy reform for our relief. Like the rest of this country, we are in danger of succumbing to what we have chosen to call “The Medical Arms Race Syndrome” or MARS.

“Technology is growing faster than the system’s capacity to maximize its value.”

-Dave Durenberger

As everyone knows, you cannot cure a disease you have not accurately diagnosed. When the disease affects a lot of people, the process of diagnosis, discovery, and therapy is likely to also be the best way to prevent it.

The National Institute of Health Policy (NIHP) convened a group of stakeholders in July at the University of St. Thomas to do just that: explore the complexities and possible cures for the Medical Arms Race Syndrome - a collection of disease symptoms that have gripped our health system.

Employers, device manufacturers, payers, elected officials, policy experts, consumer groups, hospitals administrators, and clinical providers joined Senator Dave Durenberger to launch the: *The Medical Arms Race Syndrome: Where Will It Lead and Do We Want to Go There?* The kick-off event initiated a two-year series to explore the policy opportunities and challenges imbedded in the medical arms race and their impact on the health system overall, and on medical facility expansion specifically.

This report serves as a brief overview of this nascent effort by the NIHP to give meaning to the Medical Arms Race Syndrome. This discussion is well-placed in the Upper Midwest as healthcare innovation, especially in medical technology development, is a hallmark of this region. We hope that this community can turn its healthcare genius to this complex challenge. We believe that our community, when equipped with enough knowledge to ask the right questions, can advocate for policy that will allow us to harness the healing power of innovation and produce a roadmap to high-value healthcare.



The Medical Arms Race Syndrome (MARS) Summary Report

The kick-off event was designed to provide participants with a cursory overview of the medical arms race and featured a broad range of perspectives about the prospects and pitfalls of technology development and diffusion.

Senator Durenberger opened the dialogue with several assumptions:

- Innovation is a value in health care;
- Appropriate use of technology depends on the education, information, motivation and experience of healthcare professionals and the information that is available to them;
- A functioning market that ensures value between producers and consumers does not exist in healthcare.

“If you accept that patients are portable, and information is infinitely portable,” said Senator Durenberger, “then you have to think about the future of health care delivery organizations in a completely different way. To produce useful results, this policy exploration will require your imagination and your willingness to abandon the status quo.”

The Role of Government and Market Regulation: Past, Present and Future

Government has been a constant presence in the medical arms race. Government supports innovation by subsidizing public universities’ expansion of bioscience efforts. Government, acting on behalf of the public, has spent generations funding invention in the name of excellence. Today, government also supports the technology industry as a way to support job creation and economic vitality.

Though the beneficiaries of government largess may have evolved over the years, one consistent focus of government has been monitoring and regulating facility expansion. As technology diffusion increases and a push for market competition in healthcare increases, it becomes increasingly difficult for elected officials to fulfill that duty.



Representative Tom Huntley cautioned against depending too heavily on the legislative process for steering the medical arms race. “The legislature makes good decisions on big healthcare policy issues,” he said, “but when it comes to details about which hospital wins

Expert Panelists

Duane Benson

Former State Senator, Co-chair, Citizens League Medical Facilities Committee

Peter Gove

Former St. Jude executive, Co-chair, Citizens League Medical Facilities Committee

Mark Harrison

CFO, Allina Hospitals and Clinics

Ken Heithoff, MD

Chairman, Center for Diagnostic Imaging

Allen Horn, MD

President, CentraCare Clinic

Thomas Huntley

Minnesota House of Representatives (D-07A)

Scott Lietz

Director of Health Policy, MN Department of Health

Michael Morrow

Senior VP of Business Development and Network Management, BCBSMN

Michael Scandrett

Health Policy Director, Hallelund Health Consulting

which bid, or which facility should be allowed to expand where, that's where we break down and are not as effective." A decision-making process should be made with good data, and analysis becomes bogged down in the special interests of the many stakeholders who will win or lose.

As the MARS continues, so, too, will consumer demand for cures to "all that ails them." Where to locate the next new hospital, what services does a specific community really need, and who will pay for it are not decisions that can be made through the traditional political process.



Former State Senator, **Duane Benson**, and former St. Jude Medical executive, **Peter Gove**, fresh from the [Citizens League \(CL\) Medical Facilities Study](#), emphasized that a "functioning market needs ample producers interacting with knowledgeable buyers." That was the crux of the CL findings and a theme of the recommendations the group proposed in its final report. "Certificate of Need has not been effective," said Mr. Benson. "Providing the community and individual consumers with more information will allow this market to send signals to the producers that we are, or are not, ready for more—more hospitals, more outpatient facilities, more MRIs.

The Citizens League study was funded by BCBS of Minnesota following Blue Cross's own analysis of dollars dedicated to hospital, inpatient facility expansion in Minnesota. The finding indicated that 56 out of 148 Minnesota hospitals since 2002 have planned or are conducting new building or expansion projects, with a price tag approaching \$1.37 billion. The study contends that such expansion is driving healthcare costs. The CL effort was intended to draw out the policy issues imbedded in this wave of expansion.

The CL study is just one example of a number of efforts over the past several years to better understand the following:

- How technology diffusion and the subsequent facility expansion impacts rising healthcare costs;
- What gaps in information exist for decision makers; and,
- Finding a better approach to a currently broken decision-making process.



Michael Scandrett offered an historic overview of the role of state government in the technology evolution and subsequent capacity expansion. See *Figure 1* for a timeline.

"The sky has actually been falling since the 1970s," said Mr. Scandrett. "That's not to say this isn't urgent, but it isn't new." Among the tools that government has tried to impose were major capital expenditure reporting, regional coordinating boards, an

"Whether we want to head in a regulatory direction, or a market direction, in either case we need more information. The MARS is an opportunity to decide if its regulation or a free market that we seek, and the NIHP is a proper venue for the discussion."

– Peter Gove

"The ongoing tension between individual interests and group interests continue to drive the medical arms race and there has been little success in using policy, politics or facts to overcome that tension."

– Michael Scandrett

antitrust exception process, a health technology advisory committee, and the most famous, Certificate of Need. The government’s role hasn’t really changed over the past few decades and continues to be one of oversight and monitoring resulting in little policy that is sustainable.

Scott Leitz and his staff in the Health Policy Division of the Minnesota Department of Health are called upon routinely to collect and analyze data to support policy decisions. Hospital occupancy rates, demographic trends, and hospital expenditures by service line are among the hundreds of data points collected for the healthcare industry. For example, according to his research, in 2005 hospital capital expenditures totaled \$710m and cut across all service lines—without counting the Maple Grove Hospital or outpatient facilities. *See Figure 2 for the trend in spending.*

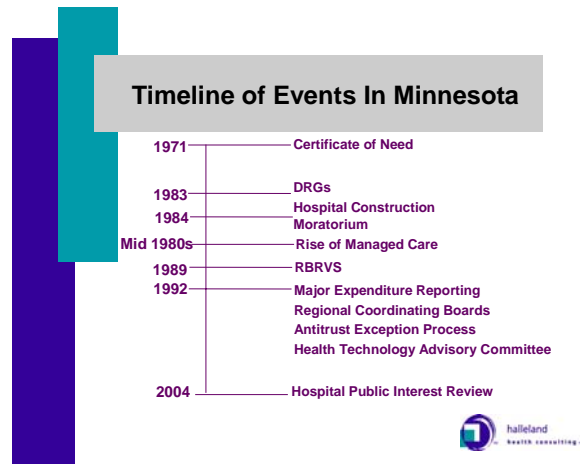


Figure 1: Historic overview

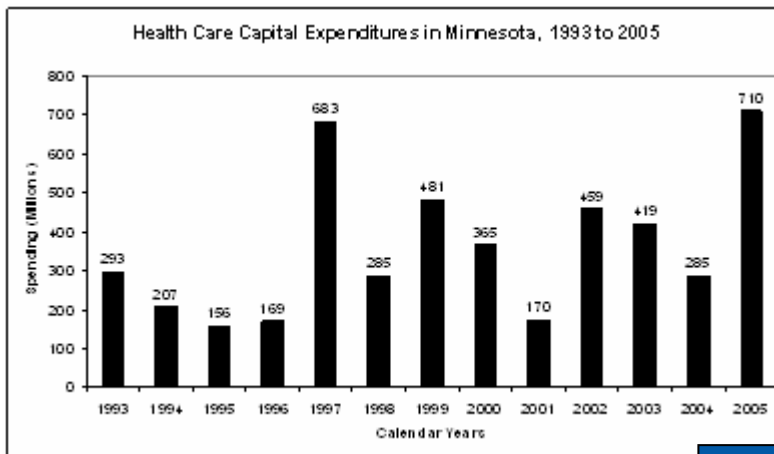


Figure 2: Trend in Spending

“We are not comfortable with unfettered competition in healthcare because perfect competition may result in efficiency, but it doesn’t necessarily lead to equity.”

- Scott Leitz

What is missing from the discussion, said Mr. Leitz, is the definition of need that reaches beyond basic demographic trends. What kind of health outcomes are we after, and what are the possibilities for how to get there? For some, need equates with convenience. For others, need means high-tech. And yet for others, it means a life-long relationship with the same provider, regardless of the facility.

Once need is defined, it is our responsibility—the community’s responsibility—to determine who delivers the response to that need and what that response should look like.

The Payers' Perspective

The role of the payer is complex, as explained by **Michael Morrow**. Treatment availability, issues of ownership, coverage eligibility, payment for new technologies, and demand for health information technology are among the issues facing the plans.

“Medical technology policy is a balancing act, at once nurturing innovation and at the same time assuring adequate controls. Such policies are best developed through collaboration with all stakeholders.”

- Michael Morrow

Market Competition

Ken Heitoff offered his perspective as a physician-entrepreneur who came to Minnesota 30 years ago because of this community's reputation for clinical excellence.

“Reforming the healthcare system has failed because attempts have been based on the wrong diagnosis of the problem. With competition at the wrong level, all participants: consumers, providers, employers and insurer, have acted counterproductively. The CT scanner and the MRI are unequivocally the greatest medical advance in the last 50 years and all we hear about is cost. We have to stop talking only about cost and start talking about value. It is the only way to unlock the great innovation that medical technology affords us.”

- Ken Heitoff

He challenged the audience to imagine what is possible under a value-based system where everybody competes in terms of what is best for the patient, and competes at the level of specific diseases and conditions.

Challenges for Hospitals and Providers

The non-profit hospital CFO has a tough job. At once, he or she is expected to maintain a healthy level of capital, but not so much as to raise eyebrows about tax exemption. CFOs like **Mark Harrison**, formerly at Allina, must ensure that the hospital remains competitive but continues to deliver services that might not be financially attractive—services that the community needs and a full-service hospital is expected to deliver. Mr. Harrison pointed to several challenges hospitals face.



The Twin Cities **healthcare infrastructure is aging**, with substantial need for facility replacements and upgrades. An aging and growing population will require not only updated, but different kinds of services and technology, thus different kinds of healthcare facilities. Absent changes in care patterns—said Mr. Harrison—the Twin Cities will run out of hospital capacity.

Technology is also enabling an increasing amount of **care to move out of the hospital and into outpatient settings and physician offices**. As a result, hospitals are under substantial margin pressure to make up for lost inpatient revenue.

Consumers have expectations that the hospital in their community will deliver a broad range of services—some **services that are money losers**. So when

hospitals look at the service mix, they focus on revenue producers as a way to **cross subsidize** and as an antidote to going out of business. These revenue producers are often tied to technology. Further, hospitals sharing the same market often turn to technological advances as a way to **distinguish themselves from the competition**. The result is often redundant capital investment within a given community. The race is on.

“We have to ask: when does this innovation become too expensive for society? Are we willing to justify any and all innovation? Demand for the newest technologies is driving costs. Consumers and providers should know that some older technologies can still do a pretty good job.”

- Mark Harrison

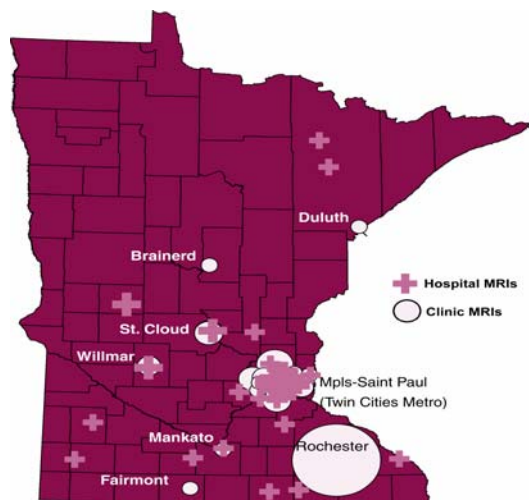
In closing, Mr. Harrison also highlighted the **complexities of the hospital supply chain** and described the vertical chain of production in a hospital setting. Along that chain, everyone is involved in producing healthcare as an end product and all of the producers are competing for a share of total profitability.

Though hospitals have been driving down prices for recurrent spending, 18% of Allina’s costs are for new spending. It is a response to the innovation strategy employed by the device companies. Most of the profitability for device companies is generated in the first 1-2 years. Thus there is a motivation to promote and diffuse new devices.

Allen Horn brought the morning session to a close with *“Eight Myths about the Medical Arms Race as Viewed by a Small Town Doc:”*

- **Myth #1:** Competition improves the quality of care.
Reality: It improves market share not health care.
- **Myth # 2:** Competition always reduces costs.
Reality: Competition increases overall healthcare costs through duplication of facilities and technologies.
- **Myth #3:** Doctors in small towns are slow to adopt new technology.
Reality: Small town docs want new technology as fast as the other guys.
- **Myth #4:** New technology equals better medical care.
Reality: Physicians are susceptible to market influences and new technology acquisition is sometimes made for the wrong reasons.
- **Myth #5:** Doctors don’t care about keeping up with the Joneses.
Reality: We want to do better than the Joneses and technology allows us to compete with others for market share and reputation.
- **Myth #6:** Consumer demand doesn’t impact the adoption of innovations.
Reality: Physicians have a genetic propensity to do everything they possibly can to meet their patients’ needs.
- **Myth #7:** The salesperson is your friend.
Reality: They only tell you part of the story – safety and efficacy but not cost-effectiveness.
- **Myth #8:** The medical arms race involves only technology and innovation.
Reality: There is a race to build an army of healthcare workers, especially in subspecialties and for ancillary services.

Figure 3 shows new MRI acquisitions in Minnesota since 1993. This map speaks volumes to Dr. Horn's Myth #5 regarding rural providers and their patients want for easy access to technology. But who will pay for it?



The Stakeholders Define the Issues

Readers will find that the problem statements were easy to come by. The challenge is to come up with the answers, or at least a different way to think through the problems that have been challenging us for so many years.

We are not yet ready to define the goals for the NIHP MARS series. As a first step, it will be critical to decide what is different about the series. What unique outcomes can we expect to produce, and for whom, and how do we avoid launching another debate on health system reform without doing an effective root cause analysis on one of the system's most challenging elements—the value of innovation.

Following the presentations, workgroups tackled some challenging topics and produced a list of issues to consider.

Some common themes are highlighted in the attached Appendix. They point to a fledgling consensus on where the MARS series should first turn its attention. Though the workgroups were given specific questions to consider, many discussions morphed into far-ranging exchanges of ideas.

The discussion will continue through the next several months. If the feedback continues to be positive, the MARS series will carry us to a national conference to explore the health care facility of the future—or “Where is My Nearest Hospital?”

As a starting point, participants suggested they were not equipped to talk about the macro system issues without more background on market and hospital economics. To that end, we have scheduled the next session in the MARS Series for **September 29, 2006**. **Paul Ginsburg, PhD**, President of the Center for Studying Health System Change, will join us for a web-based seminar to discuss the economics of the healthcare system. Participants will have the opportunity to dialogue with the Dr. Ginsburg and Steve Parente from the University of Minnesota, who will moderate the discussion. More details will follow.

“The technology industry has evolved from what was once an industry devoted to finding cures to one that is now also focused on economic vitality, investor returns, and competitive advantage. At some point, it seems, the search for medical miracles has gotten lost in the economics.”

- Dave Durenberger

Conclusion

A search of the literature reveals a vast universe of varying perspectives on what contributes to the Medical Arms Race Syndrome, and what to do about it.

There are those like David Cutler, an economist at Harvard University who says: “Even if you could take all the waste out of the healthcare system, the spending would still go up because we have a technology-intensive system that will continue and it is delivering a lot of benefits in terms of longer, healthier lives.”

Ultimately, this discussion will be about whether medical spending is too high and wasteful, or valuable and affordable. Is the free market approach, government intervention and control, or a marriage of the two the best option? Is medical technology to become the next commodity available for purchase on your lunch hour? Who will drive that trend? And what if the trend is untenable to some? Is it possible to dam up or even reverse the flow of this rushing torrent of innovation, invention and economic vitality? And would we want to in the name of a more egalitarian approach to access and affordability for all Americans?

If you are interested in becoming involved as the NIHP is planning the MARS series and/or the National Conference, please contact Rachelle Kotrba at rlkotrba@stthomas.edu or 651-962-4635.



Appendix A: Workgroup Summaries

| Workgroup | Medical Technology |
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| Quotes of Note: | <ul style="list-style-type: none"> ➤ <i>“As issues of market regulation, competition, and access all come up, suddenly this discussion turns into a health reform conference, not just a technology conference.”</i> ➤ <i>“Let’s start at where the service is provided—start with the consumption end, not the invention end and work backwards to figure out where we’re going wrong.”</i> |
| Themes | <ul style="list-style-type: none"> ➤ Cost effectiveness is important, but so are outcomes. ➤ The speed of innovation surpasses the availability of information and analysis as technology is diffused. ➤ Decision-making to purchase technology is moving away from physician alone to other hospital and provider agents. ➤ Information is critical. ➤ Balancing adequate control with nurturing innovation is difficult balancing act. ➤ Community perspective should supersede individual perspective. ➤ Hospitals are competing to survive not just to compete. |
| Problems and Concerns | <ul style="list-style-type: none"> ➤ Physicians are challenged to keep up and do what is best for their patients. ➤ Marketing to physicians is longstanding tradition that will be forced to change. ➤ Long-term data about specific drugs and devices is hard to come by. ➤ How to ensure that information will enhance the patient experience. ➤ Consumers not automatically equipped to absorb and act on information. ➤ Difficult to compare and evaluate technology in a community-wide way. Only done now hospital-by-hospital. |
| Some Ideas | <ul style="list-style-type: none"> ➤ Need data and statistics to evaluate new technology effectively. ➤ Define a valuation mechanism that combines costs and outcomes – fragmentation of market makes this difficult. ➤ Look to payers to force proof of clinical efficacy – as with drugs. ➤ Need to move the sales focus from a personal relationship to discussion about effectiveness and value. ➤ Create a different sales approach with different incentives. ➤ Align consumer, provider, payer incentives with single goal of high value. |
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| Work Group | Functioning Market |
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| Quote of Note | ➤ <i>“If you accept that patients are portable, and information is infinitely portable, then you have to think about the future of health care delivery organizations in a completely different way.”</i> |
| Themes | <ul style="list-style-type: none"> ➤ A functioning market demands a well-informed consumer. ➤ Competition is not at the right level. ➤ Price controls without well-articulated goals and outcomes will not fix the problem (see Medicare). |
| Problems and Concerns | <ul style="list-style-type: none"> ➤ Because medicine is often complex, patients must rely on physician’s recommendations and decision-making. ➤ Price controls create cost-shifting. ➤ A pure market is profit driven – is that the right model for health care? ➤ Reform is nearly impossible because every stakeholder is protecting their own interests. ➤ Equity is an issue – only hospitals have to accept all-comers. ➤ Does a functioning market ensure inclusion? ➤ Can universal coverage and a functioning market co-exist? |
| Some Ideas | <ul style="list-style-type: none"> ➤ Align incentives to achieve the best outcome in the most efficient manner. ➤ Move to a portable medical record that is owned by the patient. ➤ Make the system easier to navigate. ➤ Change the power balance between the provider and the patient. ➤ Purchasers and consumers should unite to define what “product” they want – the market will move if a number of people start acting in concert. Only a few large groups—government, employers, associations—need to use data to drive decisions and the market will move. |
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| Work Group | Cross Subsidization |
| Quotes of Note | <ul style="list-style-type: none"> ➤ <i>“People want to make the price decision at the point of purchase, not the point of selection.”</i> ➤ <i>“In the name of competition, there are helipads at two hospitals within 4 walking blocks of each other.”</i> |
| Themes | <ul style="list-style-type: none"> ➤ It is important to define a set of services that a given community needs then build to meet those needs. ➤ Transparency applies to two products: health care services and insurance. |
| Problems and Concerns | <ul style="list-style-type: none"> ➤ How to reconcile what the policymaker thinks is appropriate vs. the patient’s demands. ➤ Providers set prices to what the market will bear in an effort to protect themselves from Medicare reductions. ➤ Capacity is constrained by availability of certain low-paying specialties like psychiatry. ➤ Outpatient facility expansion is a big problem. ➤ What happens when all the high margin services are pulled from the hospital? Can payers do anything to stop it? |

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| | <ul style="list-style-type: none"> ➤ Is there a regional difference in cross-subsidization? |
| Some Ideas | <ul style="list-style-type: none"> ➤ Look to other states for examples of collaboration – where have hospitals come together to discuss who will be best at what? ➤ Put all the stakeholders in a room and ask them what they want the health system to look like. Combine community interest with competition. ➤ Standardize quality data. ➤ Establish a common-ground definition of what we expect from the system. ➤ Produce cost data for each service then talk about what margin is appropriate. ➤ Establish some criteria for buy vs. build. ➤ Evaluate the quality outcome for moving a service out of the hospital. |
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| Work Group | Role of the Purchaser |
| Quote of Note | <ul style="list-style-type: none"> ➤ <i>“Building more heart hospitals because we don’t want to pay directly for mental health doesn’t create very good incentives to prevent heart disease.”</i> ➤ <i>“The question of capacity is really tied to the larger question of how do we achieve a high-performing healthcare system that is more efficient and effective?”</i> |
| Themes | <ul style="list-style-type: none"> ➤ Any change will create winners and losers. ➤ Purchasers try to use consumers as a lever to demand value, and drive volume to high-quality performers. Despite their best efforts, the underlying cost trends are still high. ➤ Per the Porter concept: competition should take place at the provider level. ➤ Low tech should not be forgotten. Sometimes the existing treatment is just as good. ➤ Public health is undervalued and underfunded. |
| Problems and Concerns | <ul style="list-style-type: none"> ➤ It doesn’t make sense to build a heart hospital just to cross-subsidize other services. ➤ High-deductible plans will not change behavior or reduce costs. Too much spending happens at levels where consumers have no obligation. ➤ Is society willing to accept a system where wealthier people have access to better care than everyone else? ➤ Do people get a lot of procedures and devices that they don’t need? ➤ If the hospital is crowded, does that always mean you build another hospital? Why can’t hospitals operate at 85%+ capacity? |
| Some Ideas | <ul style="list-style-type: none"> ➤ Spend more time reflecting on benefits of technology – longer, healthier lives. ➤ Pay attention to Medicare who is changing the way they reimburse hospitals to try and eliminate some of the incentives to over-invest in high-margin services. ➤ Purchasers have to re-think what they are asking the plans to do; plans have to re-think what they are asking the providers to do. |
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| Work Group | Role of the Insurer |
| Quote of Note | <ul style="list-style-type: none"> ➤ <i>“In some ways, Medicare heavily influences the adoption of technology in the delivery system and in the insurance industry.”</i> |
| Themes | <ul style="list-style-type: none"> ➤ Insurers have a responsibility to bring safe, valuable, and effective services to their |

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| | <p>enrollees. So, the insurer will impact innovation by expecting the highest quality with the most value for the cost.</p> <ul style="list-style-type: none"> ➤ We should have a strong belief that we are improving quality with new technology before moving forward. |
| Problems and Concerns | <ul style="list-style-type: none"> ➤ Insurers have a very limited ability to control the diffusion of technology once it enters the public domain. ➤ Need more research on the value of new technology—but how do you define value? ➤ Consumers don't understand the system and don't know what they really want. ➤ Elected officials should not make decisions about coverage. |
| Some Ideas | <ul style="list-style-type: none"> ➤ All services delivered must be based on sound evidence of effectiveness and value. ➤ Since insurers pattern their reimbursement decisions off of Medicare, how can insurers influence Medicare. CMS makes coverage decisions where other payers are trying to make evidence-based decisions. ➤ States could require that all studies be registered to ensure transparency of results. |
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| Work Group | Quality, Value, and Access |
| Quote of Note | <ul style="list-style-type: none"> ➤ <i>“All five conditions that define a market are defied in healthcare. When supply exceeds demand, the market breaks down.”</i> ➤ <i>“Minnesota has always risen to the occasion on every problem we have faced. We have the capacity to innovate here but it has to come from the ‘people’ not the government.”</i> |
| Themes | <ul style="list-style-type: none"> ➤ Productivity is doing the right thing, the right way, all of the time. ➤ We're investing in technology development but not in disease prevention. ➤ Physicians as scientists use technology. Physicians as social scientists might focus more on human interaction and holistic health. ➤ Consumers need help to stay healthy and develop a productive provider relationship. ➤ Community awareness and education is the only way to achieve patient-centered, rather than provider-centered care. ➤ We pay in the aggregate for healthcare services but our choices are individual. |
| Problems and Concerns | <ul style="list-style-type: none"> ➤ The healthcare system is not focused on continuity of care for the patient, nor focused on helping the patient decide. ➤ The healthcare professionals in the “pipeline” are not being educated to do it differently. ➤ Fantastic technology doesn't always produce good outcomes. ➤ Do we need hospitals as they are? ➤ The profit motive has changed the delivery of health care. Competition isn't about improving outcomes its about gaining market share. ➤ Health plan data on tiering is not helpful if it is cost only. High cost might be high quality but consumer doesn't have enough information to know. ➤ Technology vendors are creating demand for sometimes inappropriate or unnecessary technology. ➤ Hospital purchasing alliances have contributed to the problem of inappropriate acquisition and diffusion. |

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| | <ul style="list-style-type: none"> ➤ Consumers don't easily make the connection between behavior and health. Early education for children is essential. |
| Some Ideas | <ul style="list-style-type: none"> ➤ Public health nurses, social workers and other health professionals have to be engaged. ➤ Critical to look at supply side. What investments do we need to keep people healthy: more diagnostic tools, nursing follow up, patient tracking? ➤ More funding for prevention will reduce disease and dependence on technology. ➤ Consumers want to choose what system keeps them healthy, not necessarily which is the cheapest. ➤ Use the IOM Six Aims to establish a community standard for care and weigh all technology utilization decisions against that standard. We can't measure success without standards. |
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| Work Group | Capacity of Healthcare Facilities |
| Quote of Note | <ul style="list-style-type: none"> ➤ <i>"More information is not enough. Good information is what we need."</i> ➤ <i>"We have to decide if the Medical arms race is the problem, or a symptom of the problem. All ideas should remain on the table and NIHP should foster a wide-open debate."</i> |
| Themes | <ul style="list-style-type: none"> ➤ Help the community understand that there are methods that work for most diseases. Consumers should demand the gold standard. Standardization of care is essential. ➤ What drives technology development and diffusion is that people are sick. ➤ We don't pay for value, we pay for procedures. ➤ Defining "need" is top priority. How do we measure the community's need for a new medical facility? ➤ Regardless of geographic location, everyone wants a hospital nearby. |
| Problems and Concerns | <ul style="list-style-type: none"> ➤ How do you tell if there is a quality outcome and how is that juxtaposed with costs? ➤ Building trust after a product recall or adverse event is difficult for lack of quality data. ➤ This problem is not only one of technology and equipment but of human resources, especially in rural communities. ➤ DTC promotion and marketing of technology is confusing to consumers and impacts the patient/provider relationship. ➤ Why do two hospitals just 4 blocks apart each have a helicopter? |
| Some Ideas | <ul style="list-style-type: none"> ➤ Look at root causes and invest in identifying and disseminating the evidence of the best care for a given disease. ➤ Help the consumer understand the costs—costs of treatment, of facilities, of diagnoses, of illness. ➤ Institute central planning so that we can work towards a common goal of keeping people healthy. |
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| Work Group | Clinician as Entrepreneur |
| Quote of Note | <ul style="list-style-type: none"> ➤ <i>"In the physician/consumer relationship, only the physician can be the decision-maker. The consumers will never possess enough information to fully act on their own. Therefore, the consumer must trust the physician and the physician must be trustworthy."</i> ➤ <i>"We need to bring the discussion back to quality. If the focus is on quality, then care will</i> |

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| | <i>improve, over utilization will reduce because the bad uses will be eliminated, and costs will begin to decrease. To get to quality, we need more information and a focus on value not volume.”</i> |
| Themes | <ul style="list-style-type: none"> ➤ Evidence-based medicine can take 17 years to “prove.” Questions that must be answered include how physicians decide what to practice if it takes so long to prove something, once something is proven should it be used as much as possible? ➤ Employers are complaining about drastically increasing healthcare costs. Some of it is linked to increases in per unit care costs. However, a large portion of it is linked to the amount of care utilized. By understanding usage, employers can work to push employees towards high value care. ➤ We need a better focus on quality neutral technology – technology that provides the same level of quality at a lower cost. ➤ There is a lack of understanding in healthcare between incremental costs and incremental benefits. How do we know that a step forwards cost brings an equal or greater amount of benefit? |
| Problems and Concerns | <ul style="list-style-type: none"> ➤ In the patient/physician relationship, only the physician can truly make decisions about the patients care. The patient will never have complete information. The system/provider frequently has variables other than the patient’s care as its motivation. The physician’s incentives are currently about quantity not quality. ➤ In a large system, practice groups have not figured out how to share technology and still provide the desired care for the patients. As a result, there is excess technological investment and inefficient technology use. ➤ The pricing structure forces non-radiologists to bring imaging into their practice in order to generate revenues. This leads to investments in low-quality equipment and low-quality care. ➤ Referrals are frequently made through collegial associations, not based on knowledge of care quality. ➤ Cuts in reimbursement rates encourage physicians to increase volume in order to make up for the loss in revenue. |
| Some Ideas | <ul style="list-style-type: none"> ➤ The internet has proven that access to information can improve quality and decision-making. We need to take steps to improve both the information available and the dissemination if it into the market. ➤ When the consumer knows and understands value, they will choose high value. As Senator Durenberger mentioned, people are transportable and information is infinitely transportable. Once again, information will improve the system. |
| Workgroup | Role of Government |
| Quote of Note | <ul style="list-style-type: none"> ➤ <i>“Imaging centers do not create their own demand. The demand is created by referrals.”</i> ➤ <i>“The Government’s role is to increase transparency, educate and promote health.”</i> |
| Themes | <ul style="list-style-type: none"> ➤ Role of government is multi-faceted and defined differently by each stakeholder group. Some want intervention and regulation while others want government out. ➤ Government as purchaser has to evaluate effectiveness and safety as well as cost. ➤ Urban/rural disparity in access to services and beds is an issue government needs to address. ➤ Is innovation value and do we value innovation inappropriately? |

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| <p>Problems and Concerns</p> | <ul style="list-style-type: none"> ➤ Government is leading perpetrator of cost-shifting. Issue must be addressed. ➤ End of life costs are too high because no one wants to have difficult conversation with family. Government could set example by only paying for evidence based care at EOL. ➤ Supply of Primary care and behavioral health providers at risk for lack of adequate rewards. Current market encourages specialization. ➤ Patients won't tolerate conservative approach to treatment and do not want to accept personal responsibility for health. ➤ Collaboration is discouraged by anti-trust regulations. ➤ Purchasers think collaboration increases prices but some think that competition leads to redundancy and thus higher prices. |
| <p>Some Ideas</p> | <ul style="list-style-type: none"> ➤ Purchasers should start to expect the use of technology based on evidence ➤ Government insistence on use of EBM might relieve some over-utilization by the "fix-me" consumers. ➤ Some said tort reform necessary to get costs under control. Others said impact not as great as perceived. ➤ Keep the government out of the MD/Patient relationship ➤ Create a reimbursement system that ensures that government pays for the actual cost of care. ➤ Government regulation of pharmaceutical industry was strongly supported by group. |