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## The Cottage Industry Crumbles: QI and the Foundations of Health Care

*By Michael L. Millenson*

Confident predictions about the future of health care are notoriously unreliable, be it the surefire status of single-payer (c.1973) or the unstoppable march of "managed competition" (c. 1993). Yet, while the noisy 50-year war over the design of the ideal health insurance system continues to command headlines, a quiet consensus has developed that is beginning to shape the future of actual patient care.

When compared to even 5 years ago, the expectations of payors, government, and the general public about what providers should be doing and how they should be held accountable for doing it have changed significantly. Legislatures and oversight organizations are adding new requirements related to safety, evidence-based care, and transparency on a regular basis. Old standards are being toughened. The pace of change is increasing.

What gives the current situation the potential to be transformational rather than transitional? Three powerful forces are converging to undermine what was previously a cottage industry and reshape it into a high-quality, cost-effective, care delivery system. These forces are:

- *Economics*. For the first time, the economic inefficiency of American health care is being defined as a problem affecting both our economic and national security, according to Comptroller General David Walker. That assessment by the head of Congress' United States Government Accountability Office has drawn support from the public and private sectors, from all points on the political spectrum, and from the American Association of Retired Persons (AARP).
- *Technology*. The slow adoption of information technology (IT) by health care providers, a high-visibility failing, is being tracked by employers, health plans, and government. Meanwhile, health plans and government agencies have begun routinely using IT to identify hospitals and physicians who fall short of quality and cost standards.
- *Zeitgeist*. The "spirit of the times" is exemplified by increasing public intolerance for unsafe and unnecessary care. Whether it be large corporations refusing to pay hospitals for "never events" (ie, egregious medical errors, such as wrong-site surgery, which should never occur), or *The Onion* satirizing doctors for not washing their hands, the spotlight on costly care deficiencies has become impossible to avoid.

A series of statistics illustrates why out-of-control health care costs are being scrutinized. Health care was the nation's greatest tax expenditure in 2005, and the growth of health care costs (Medicare and Medicaid), along with Social Security, far outpaces overall economic growth at a time of deep and worrisome federal budget deficits.[1] According to a Boston University study,[2] if the growth in health care expenditures from fiscal 2000 to 2005 had been limited to the same rate as the overall US economy, the savings would have totaled $1 trillion – an amount roughly equivalent to the entire US defense budget in fiscal 2005, *plus* the total spent by all levels of government on elementary and secondary education.

This is the framework within which arguments over "pay for performance" must be viewed. At present, incentives are modest. For example, the employer-sponsored Bridges to Excellence

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program rewards physicians who provide evidence-based diabetes care with a small financial payment and a public listing of their names. If these voluntary provider incentives fail to prompt significant improvements, however, the only alternative is bigger incentives and stiffer penalties from payors. Moreover, as with Bridges, the accountability will be provider-specific.

Unlike the managed competition movement of the mid-1990s, the effort to press providers for higher-quality, more cost-effective care is likely to enjoy broad public support. As Kaiser Family Foundation 2006 data show, premiums for employer-sponsored health insurance in the United States have been rising significantly faster on average than workers' earnings since 2001, although the pace has recently slowed.[3] Even among larger companies, the percentage of employees who can afford to pay their share of those benefits is declining.

Just as importantly, the new demands for accountability are seen as both justified and achievable. The medical literature regularly reveals new examples of inefficiency. One oft-cited study is Elliott Fisher and colleagues' research concluding that high-spending Medicare regions have the same or lower technical quality, health outcomes, and physician and patient satisfaction than lower-spending regions, while consuming up to 60% more resources.[4,5] The next step is to apply similar measures to individual hospitals and publish the results.

The CMS/Premier Hospital Quality Incentive Demonstration (HQID), involving more than 260 hospitals, translated quality improvement research theory into practice. HQID showed measurable success in improving care quality in 5 clinical areas, saving a startling 1,284 lives from heart attacks alone. According to Premier's analysis, if all pneumonia, heart bypass, heart attack (acute myocardial infarction), and hip and knee replacement patients nationally received most or all (76% to 100%) of a set of widely accepted care processes in 2004, it could have resulted in nearly 5,700 fewer deaths, 8,100 fewer complications, 10,000 fewer readmissions, and 750,000 fewer hospital days. In addition, hospital costs could have been as much as $1.35 billion lower.

Health IT alone does not improve care, but it is a critical tool for doing so, particularly in the area of patient safety. Especially in large, complex organizations, focused use of IT is essential for measuring and managing care to consistently achieve high-performance results. More pragmatically, payors and government are using sophisticated databases to hold hospitals, physician groups, and even individual physicians accountable for meeting certain care standards. Analytic computer technology plus Internet dissemination technology has made it possible to identify high performers (either in outcomes or in adherence to evidence-based practices) for specific procedures, specific hospitals, and specific physicians. Patient satisfaction data is moving in the same direction. Providers also need a means for measuring and managing their processes to avoid losing control over their professional reputations and their reimbursement. It is precisely this inability of a cottage industry to cope with measurement and management demands that will force providers to confront a choice: change or professionally "die" (ie, seek to earn some sort of living until retirement or simply retire immediately).

Some health care organizations have approached the "manage and measure" challenge by proactively posting their performance data online. Perhaps the foremost example of this trend is the decision by Louisville's Norton Healthcare to post more than 200 specific clinical and patient satisfaction measures while providing an easy graphical comparison between Norton's performance and national benchmarks for each measure.

While the *zeitgeist* of health care is shaped by economic and technological forces specific to the health care industry, it is also affected by events in the broader culture. Transparency and accountability are ascendant, whether in ratings of graduate schools or one-click access to your neighbor's house price and real estate taxes. Meanwhile, a new generation of physicians is entering practice with different expectations than their elders about income, autonomy, and technology. Some have also emerged from training with a new understanding of "quality care" that looks beyond the "I know it when I see it" empiricism of the cottage industry model to the data-driven model of benchmarks related to both individual patients and to specific patient populations.

At first, the undermining of the old ways will bring uncertainty rather than utopia. Some quality improvement measures are applicable to hospitals, others to groups of physicians, and others to individual physicians. It is not always obvious which measures can reliably be tied to which group. There will be arguments over who should be doing the measuring (eg, health plans, consumers, peers). And, for all the talk of "blame the system and not the individual," no one expects regulators, accreditors, or attorneys to abandon the concept of individual accountability.

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Science historian Thomas Kuhn famously pointed out that the "traumatic" process of a "paradigm shift" does not occur until the defenders of the old ways "can no longer evade anomalies that subvert the existing tradition." The evidence that the cottage industry model of medicine wastes money and kills and injures patients needlessly is decades old. But it is only because of powerful economic, technological, and cultural pressures that the traumatic process of change, uncomfortable yet irreversible, is finally under way.

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