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## Interview with Dr. Arnold Milstein

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## VBP Interview with Dr. Arnold Milstein

**Arnold Milstein, MD, MPH**, is the Medical Director of the Pacific Business Group on Health (PBGH), the largest employer health care purchasing coalition in the United States. He is also the U.S. Health Care Thought Leader at Mercer Health & Benefits. His work and publications focus on private and public sector health care purchasing strategy, clinical performance measurement, and the psychology of clinical performance improvement.

A co-founder of both The Leapfrog Group and the Consumer-Purchaser Disclosure Project, Dr. Milstein heads performance measurement activities for both initiatives. The New England Journal of Medicine's series on employer sponsored health insurance described him as a "pioneer" in efforts to advance quality of care. In 2004 and 2005, he received the highest annual award of World-at-Work, the largest global organization of human resource managers, and of the National Business Group on Health (NBGH). The NBGH award cited nationally recognized innovation and implementation success in health care cost reduction and quality gains. In 2006, he was the first private sector purchaser specialist to be elected to the Institute of Medicine.

Dr. Milstein was educated at Harvard (BA-Economics), Tufts (MD) and UC-Berkeley MPH-Health Services Evaluation and Planning).

**VBP:** *You have a unique perspective on eliminating waste in the U.S. healthcare system. Would you give us the "nutshell" version?*

**AM:** In the broad context, we are experiencing upward creep in the unaffordability of health insurance...an average policy for a family of four has grown from 15% to over 100% of annual minimum wage earnings. This reflects health care spending that steadily outgrows our Gross Domestic Product (GDP) and income, mostly due to the net cost additive effect of reliable treatment innovations. This annual cost-additive effect presents an increasing challenge because higher-income Americans are not stepping forward to ease the burden for others. Given this scenario, we need to do two jobs:

1. Eliminate the current level of waste or "fat"
2. Annually capture new efficiencies that are equal to the cost-additive effect of valuable treatment innovations.

How much of our current spending is "waste"? Spending could be cut by 50% without any adverse impact on the health care system (evidence from the Dartmouth Atlas). If all American physicians practiced with the same conservative resource use as the most

conservative and high quality physician groups in the top performing regions (e.g., Seattle, Minneapolis), 30-40% of current spending could be eliminated without loss of quality or patient satisfaction. Another 20-30% of spending could be eliminated if the remaining services were delivered at benchmark levels of cost per service.

**VBP:** *What do you see as the broad, systemic changes necessary for eliminating waste?*

**AM:** We can eliminate >50% of the waste in the system by taking the following sequential steps:

1. Reduce service volume by 30% by emulating the resource use patterns of the best performing physician groups in the best performing regions.
2. Once service volume is brought under control, work toward lowering unit prices for services to the level of those in the lowest cost, highest quality delivery systems.

Note that, after eliminating all baseline waste, each year of biomedical “miracles” adds 2-4% to health care spending. This means that reengineering must deliver a perpetual 2-4% annual efficiency capture in order to prevent, rather than simply postpone, affordability problems.

**VBP:** *We keep hearing that electronic medical records (EMR) are part of the solution. Where do they fit in your theory?*

**AM:** EMRs play an important role. Just taking the paper out of health care by adopting free-standing EMRs will eliminate 3-4% of the waste in the system. If EMRs become fully interoperable (i.e., each provider’s system able to share patient information with other providers’ systems) an additional 3-4% of “fat” can be shaved.

But EMR’s are not a panacea. Like any industry that aspires to world class levels of quality, reliability and efficiency, health care needs an electronic platform to test and rapidly implement performance-enhancing service innovations.

The interesting question is, “Is there sufficient management and IT expertise in health care to enable robust and perpetual performance gains?” World class, or even elementary, process engineering skills are not taught substantively in most medical or nursing schools.

In manufacturing and advanced service companies, an electronic platform is used to design process improvements, implement the improvements, monitor the effects of the improvements, and rapidly standardize to the new process when it has been improved. Health care needs to begin to work this way. Without a well designed electronic platform, rapid cycle testing and adoption of many simultaneous service innovations is not possible.

Currently, only a handful of health care systems (about 2% of the nation’s systems) “get it.” A few examples are Inter-Mountain Healthcare System, Virginia Mason, Mayo, Kaiser Permanente, Vanderbilt, Duke, and Partners’ in Boston.

**VBP:** *What role does the consumer play?*

**AM:** Consumers can have a powerful effect on any industry. Weak assertion of customer values makes for poor performing industries. American customers need to be educated on how to say “no” to high prices without corresponding evidence of superior quality and lower total longitudinal cost of care.

**VBP:** *How can employers/purchasers of health care influence the health care industry to make the necessary changes?*

**AM:** Focus on creating a “performance-sensitive” market where the most leverage is – with individual physicians. Physicians are the only ones who are legally empowered to write orders for all categories of health care resources, and they heavily influence patient behavior. Even more important, no one has greater ability to insist upon integration of IT-enabled process engineering in hospitals and all other facets of care delivery. Employers should support only those insurers and/or business coalitions that will deliver, report and incentivize improvement in two measures for each physician.

1. An aggregate quality metric, i.e., a single specialty-relevant statistic for each physician.
2. An average total spending metric (i.e., average, case severity mix-adjusted, total cost per episode-of-care and year-of-chronic-care) for patients primarily managed by each physician.

Such a performance-sensitive market could catalyze health industry transformation.

**VBP:** *Is there evidence that these strategies will be successful?*

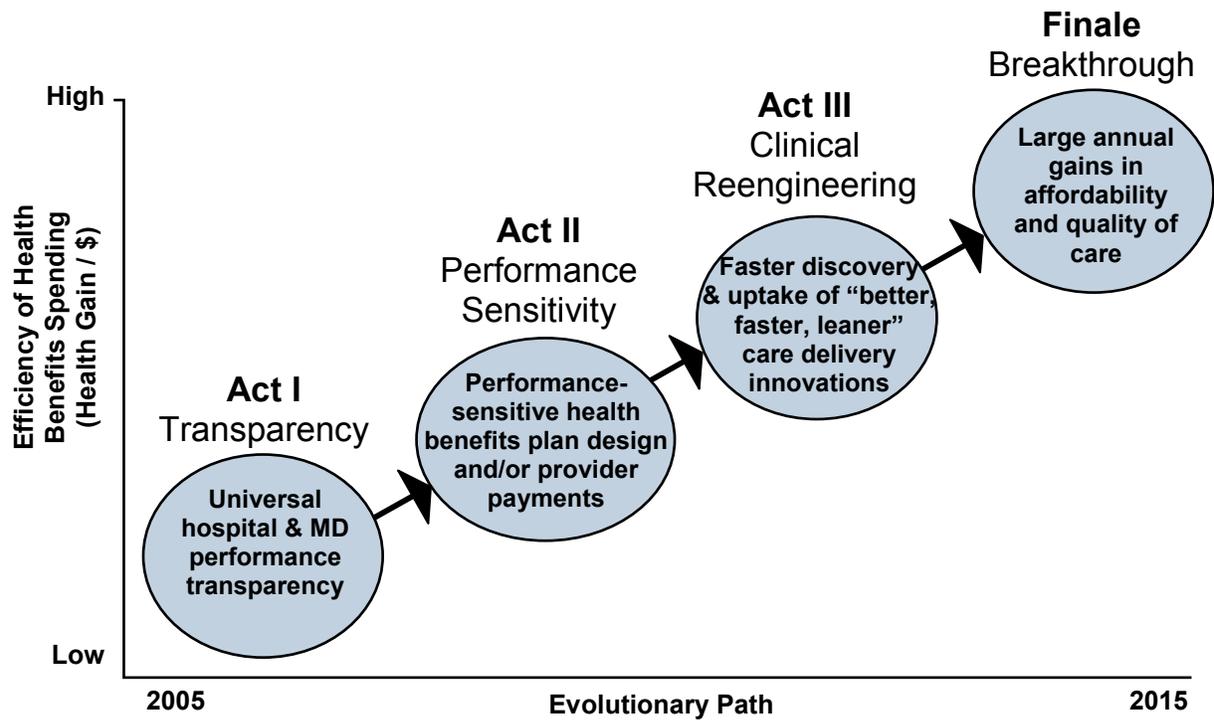
**AM:** The large Las Vegas gaming companies and their union improved quality and reduced health care spending by 10% relative to the insurance trend over a 2-year period through such an approach; and even greater progress is likely to occur in their next phase.

Another example is Massachusetts State employees. Unlike Las Vegas, the state employees are distributed over six different health plans. The state persuaded health plans to merge their claims data to enable more reliable physician performance assessments, and each plan was permitted to use its judgment with regard to strategy(ies), i.e., tiering the network, limiting the network, and/or P4P. In partnership with the Massachusetts Medical Society and state performance improvement leaders such as MHQP, continuous refinements are underway.

**VBP:** *Your work has been described as “motivating physicians to lead health industry performance breakthrough.” How do you represent your model for such changes graphically?*

**AM:**

## **“A FEW SIMPLE RULES” to Speed Uptake of Clinical Engineering**



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