# *Health Policy Newsletter*

**Volume 9, Number 1** **January, 1996** **Article 1**


## From the Editor

# The Secret to Reforming Medicare: High Quality Care Costs Less


**David B. Nash, MD, MBA ***

*Thomas Jefferson University





**Suggested Citation**:
Nash, DB. From the editor: The secret to reforming Medicare: high quality care costs less. Health Policy Newsletter 1996; 9(1): Article 1. Retrieved [date] from http://jdc.jefferson.edu/hpn/vol9/iss1/1.

# From the Editor

# The Secret to Reforming Medicare: High Quality Care Costs Less

---

High quality care costs less. At first glance, this may seem to violate the widely held belief that there is a trade off between cost and quality. Twenty years of research, some borrowed from the industrial sector, has taught us that evaluating and improving the process of medical care, creating systems for accountability and tracking the outcomes of care will enable us to indeed lower overall cost and improve quality, simultaneously.

In the current cacophony of voices on Capitol Hill calling for widespread across the board, budget cuts for Medicare, this central tenet seems to have been ignored. Medicare, as a thirty-year old social experiment is a success. It has provided an important health safety net for tens of millions of older Americans. It has protected the disabled. Medicare now provides almost one-third of the patient care revenues received by major teaching hospitals. And, as a result has nurtured the greatest concentration of academic medical centers and affiliated medical schools in any country in the world.

In addition to providing this essential financial support for the national academic enterprise, Medicare has been a "vivid model of societal responsibility that all payors for health care services must be convinced to follow."(1) As the new year begins, we seem to have signed a new social contract, one that has abrogated our thirty-year responsibility and has allowed the for-profit private sector to reform the health care system. It appears as though we have collectively surrendered in our attempt to legislatively improve the system and have allowed fundamental shifts in the national health care power structure. In short, we have turned to the power of the market and the desires of the shareholders to create the reforms we were unable to create ourselves.

On this thirtieth anniversary of the Medicare program, I believe we can do much more to lower costs and improve quality, contemporaneously.

I believe there are ten policies we could adopt tomorrow to begin the process of improving the quality of medical care for all Medicare beneficiaries and protect the trust fund. These ten policies are based largely on research and experience already evident within the system. These ten policies are easily implementable, apolitical, and they will make sense to clinicians, pharmacists, nurses, and all health care professionals.

Let me highlight very briefly each of the ten policies.

1. Support and expand the national Peer-Review Organizations Fourth Scope of Work. For the first time, the PROs have adopted the tenets of continuous quality improvement. We should pay more attention to their non-punitive feedback about physician performance and welcome their evaluation of Medicare.

2. Enforce the patient self determination act. Researchers at Jefferson(2) have demonstrated conclusively that enforcement of the PSDA will save tens of millions of dollars in the last months of life for many hopelessly ill Medicare beneficiaries. The PSDA will enable patients to participate in their own care and will enable physicians to comfortably confront difficult issues at the end of life.

3. Create a system for accountability. Medicare should begin to immediately re-release severity adjusted morbidity and mortality information about all aspects of inpatient care. This will contribute to a healthy competitive atmosphere and enable consumers to be savvy shoppers of health care.

4. Change medical education. We could do more to create the appropriately trained physician of tomorrow by concentrating on the science of clinical evaluation and expanding opportunities in the curriculum for courses on health policy and related topics.

5. Support the tools of health services research. We must re-invigorate the Agency for Health Care Policy and Research, the only federal agency created solely as a locus of activity on clinical practice guidelines, quality improvement and related work. Adoption of only one-fifth of the Agency's recommendations from the patient outcome research teams would lead to millions of dollars of cost savings.

6. Adopt national practice guidelines. Most clinicians understand that there is overwhelming evidence of unexplained clinical variation in medicine. National practice guidelines supported by specialty societies and based on solid science would save millions of Medicare dollars.

7. Re-align incentives for practitioners. We must create a linked inpatient and outpatient DRG like system to end the perverse incentives separating hospitals and doctors. In addition, we should foster bundled payments for high-tech, high-cost procedures such as coronary artery bypass graft surgery and the like.

8. Implement improved patient education systems with the advent of programs such as shared decision making with video disk technology. We can empower patients to participate more fully in their medical care. This will contribute to lower utilization of resources and happier patients.

9. Practice clinical benchmarking. The evidence from the University HealthSystem Consortium is incontrovertible. Benchmarking should also be expanded to include the Medicare supported United Network for Organ Sharing or UNOS. Build on the lessons we have learned from the UHC for kidney transplantation nationwide.

10. Finally, implement performance assessment systems. Jefferson Medical College has been a national leader in linking medical student and residency evaluations with eventual performance in practice. Much more could be done to enhance physician performance through toughened credentialing and privileging systems.

With 160 billion dollars of spending in 1994 the Medicare program is the "largest system" in the United States surpassing General Motors as the country's number one business type operation.(3) Yet it spends less that one-half of one percent of its total budget on systems to improve quality and lower costs. Let's give this ten point plan a chance before we irrevocably damage one of our most successful social experiments. As usual, I am interested in your views.

- David B. Nash, MD, Editor

**References**

1. Cohen JJ. Happy birthday, Medicare. Academic Medicine 1995; 70:894.

2. Chambers CV, Diamond JJ, Perkel RL et al. Arch Intern Med 1994; 154:541-547.

3. Etheredge L. Reengineering Medicare. For the Health Insurance Reform Project at George Washington University, Washington, D.C. May 1995.