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Obtaining Greater Value From Health Care: The Roles Of The U.S. Government

Only with strong federal leadership can Americans be assured of receiving the best care in the world.

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ABSTRACT: The problems of quality and cost in the U.S. health care system are unlikely to be solved without strong leadership from the federal government, which can mobilize action to set national priorities for quality; develop and promulgate standards for care; and stimulate implementation of performance measures and standards for providers. All of these functions would best be carried out by a new federal agency. Furthermore, the federal government should design payment policies based on the performance standards, invest in needed information technology, and invest in research related to improving care and in training professionals to support nationwide quality improvement.

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The quality and cost problems of the U.S. health care system are not going away. The Institute of Medicine (IOM) proclaims that the system is in need of "fundamental change" and that "patients, doctors, nurses, and health care leaders are concerned that the care delivered is not, essentially, the care we should receive."[1] These concerns apply equally to all types of care—preventive, acute, chronic, and end-of-life—and to all six of the IOM's dimensions of health care quality: safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity.[2]

Health care costs in the United States, already the highest in the world, have continued to rise. Health insurance premiums, for example, rose more than 11 percent in 2002.[3] Employers are reacting primarily by transferring greater responsibility for the costs of care to their employees and retirees.[4] State and federal budget deficits are leading to cutbacks in basic health care services.[5]

Most troubling, efforts to address this crisis have been focused on shifting and minimizing costs, strategies that have not worked well. Little attempt has been made to ensure that the United States does not spend scarce resources on ineffective or poor-quality care. Focusing on quality improvement will ultimately be

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more successful than focusing on cost containment alone, since improving quality at any given level of cost improves value. Moreover, improving quality of care could, in the long run, lead to lower health care costs. This paper argues for a major expansion of federal activity to improve the quality of care and discusses some of the roles that the federal government should play.

The Need For Federal Intervention

Given the well-documented quality problems in the U.S. health care system, why has the nation been so slow in developing and implementing solutions? Although there are many possible answers, the most important is that the U.S. health care industry is highly fragmented and has no single organizer or leader.[6]

Ideally, leadership would emerge from within the industry, but that is unlikely in a system with so many independent components: more than 5,500 acute care hospitals, 18,000 nursing homes, 800,000 physicians, and myriad other health professionals; licensure boards and regulatory agencies in all fifty states and other jurisdictions; multiple accrediting organizations; hundreds of professional organizations, boards, and societies; hundreds of insurers; and thousands of self-insured payers.

With no viable approaches on the horizon and with health care accounting for 14 percent of the nation's gross domestic product (GDP) in 2001, improving the quality of care, and hence its value, is neither a peripheral nor an elitist issue. Lasting solutions can only be implemented through public-private partnerships and through collaboration of all parties involved. But first there has to be a leader.

■ **Guidelines and standards development.** The fundamental rationale for federal leadership is that the development of guidelines and standards for care and performance—and research on quality improvement and the infrastructure to support it—are, collectively, a classic public good. Like sharing the results of medical research, there is virtually no cost in making guidelines or standards available to all. Since many can benefit from their use, they should be made available free of charge, or at no more than the cost of dissemination. This would make them unprofitable for any private body, or even state government, to develop on its own.

On the other hand, the cost of developing national quality standards is not huge. For example, the British National Institute on Clinical Excellence (NICE), which develops guidelines for the National Health Service (NHS), is spending only about £15.5 million per year out of national health spending of about £58 billion. The payoff in terms of potential life years saved could be substantial. Somewhere between 44,000 and 98,000 lives are lost annually in the United States just from medical errors in hospital settings, figures that fail to include the health consequences of underuse or overuse of health care, or errors in nonhospital settings.[7]

■ **Largest payer and provider.** A federal leadership role is also warranted because the government is the single largest payer for health care and the single largest provider of care, through the Veterans Health Administration (VHA), Department

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of Defense, and Indian Health Service. The federal government can engage in strong and concerted actions to improve care and to set the stage for others to follow. Indeed, it is the only entity that can get the attention of all interested parties.

■ **Private market failure.** The inability of the health care industry to improve care sufficiently on its own and to increase the value that Americans receive for their dollars is an indication of private market failure. Markets function best when basic rules are established and enforced (for example, the stock market). Private market failure also occurs in health care because consumers' preferences are not necessarily reflected in the prices that payers are willing to pay. Third-party payment is based on the value those third parties place on services, as well as on providers' willingness to provide services at those rates, not necessarily the value patients place on these services. If a hospital provides higher-quality care, it is unlikely to be paid a higher rate—even if the patient were willing to pay more for such care.

■ **Organization and facilitation.** Federal organization, regulation, and facilitation can make an enormous difference, even in a country with strong private corporations and state governments. Witness the automobile industry and our ability to drive more safely and efficiently owing to auto safety, emissions, and federal highway standards. Similarly, the federal government's role in organizing or structuring the health sector could be designed to preserve—indeed strengthen—the largely private nature of the health care industry, while providing ample room for state-based enhancements.

■ **Limited role so far.** The federal government's role in improving health care has been limited to date. In 1998 the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry recommended the creation of the National Quality Forum, a voluntary, public-private partnership that is working primarily on improving measures of quality. The Agency for Healthcare Research and Quality (AHRQ) manages an active research program in quality of care and patient safety, although AHRQ's funding represents less than 0.02 percent of national health care spending and only 0.9 percent of what the federal government spends on medical research through the National Institutes of Health (NIH). The VHA has been a leader in sponsoring quality improvement activities, including developing and implementing a systemwide electronic clinical information system.[8] Medicare has also supported a quality assurance program since its inception in 1966; most recently, Congress allocated just over $1 billion for the next three years of Medicare's quality improvement work, about 0.14 percent or less of the overall three-year Medicare health care budget.[9]

The federal government's efforts to improve quality receive relatively little funding and represent a limited scope of possible activities. The IOM's documen-

tation of a "chasm" between the quality of health care that Americans receive and the care they expect indicates that the current level of spending on quality improvement is grossly insufficient. The IOM has also stated that the government's roles as a regulator, purchaser, and provider of care can be leveraged to do more to improve the care of people covered by federal programs.[10] The government can devise and sponsor use of uniform measurements of health care quality; foster information systems for measuring quality that would then be available to the private sector; and develop rewards for excellent performance in providing care. These interventions could also serve as models for care provided in nonfederal programs. But the federal government can and must go further, not limiting its roles to the care it pays for or provides.

Setting National Quality Priorities And Standards

Setting priorities for improving care in the United States has been a diffuse process. The IOM has played a role, and for the past few years a federal interagency committee has considered quality-of-care concerns.[11] The federal government is uniquely positioned as a catalyst to public discussion of national priorities for health care quality—to define the most critical problems and to set standards for care. Explicit standards for the care that every person should expect to receive and national quantitative goals for performance should facilitate allocation of resources and the tracking of local and national progress toward achieving those goals. We suggest that a new agency should have explicit responsibility for setting these priorities.

■ **Federal-state collaboration.** State governments have traditionally played an important role in health care regulation and financing. There is large, unjustifiable variation, however, in the quality of care delivered in different states.[12] Modern technology is making it increasingly possible to provide medical care across the regulatory boundaries of state lines and to set national standards of care. Federal and state governments, in their regulatory roles, could get more leverage from licensing policies and practices, which now vary greatly from state to state. For example, there are approximately seventy state boards of registration for physicians and osteopaths across the country. Several provide the public with relatively simple information about licensed physicians through Web sites, but these sites vary enormously in content and in quality.[13]

The federal government, working with states and their boards, could design and recommend a national process for licensure (not necessarily a federal license), monitoring of care, and public reporting. The federal government could also convene the states to develop reporting methods and analysis for adverse events and the ability to respond to clusters of adverse events. Analogous federal-state collaboration already exists for surveillance of communicable diseases and investigation and management of epidemics.

Currently, federal and state governments collaborate with accrediting organi-

zations, such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the National Committee for Quality Assurance (NCQA), to evaluate quality of care in hospitals that provide services to people covered by Medicaid or Medicare or enrolled in health maintenance organizations (HMOs). The federal government should continue to work closely with these organizations to define accreditation standards. Next steps might include tying licensure, relicensure, or board recertification of physicians or health care delivery organizations to performance; public reporting of performance information; and requiring health professionals to be licensed through accountable health care delivery organizations such as hospitals, large multispecialty group practices, and integrated delivery systems.

■ **New agency's role.** Ultimately, care will not improve to the degree that it must unless there is a national approach to developing clinical care guidelines and performance standards. A prior federal effort to develop clinical guidelines through the Agency for Health Care Policy and Research (the predecessor of AHRQ) was extremely controversial.[14] That function must be revisited.

An independent agency should be established with roles and responsibilities analogous to those of the U.S. Food and Drug Administration (FDA). The new agency would review evidence of effectiveness and, through public and private partnerships and collaboration with professional societies, establish clinical guidelines and standards for staying healthy, getting better when ill, and living with chronic illness. This agency would also determine the parameters of care that all Americans should expect, including, for example, having a regular source of care, access to medical records, and reasonable waiting times. The agency would establish national performance standards and collect, publicly disseminate, and track data on performance to gauge how well those standards are being met.

The earlier guideline-development activities foundered on political shoals. Thus, the new federal effort must develop its agenda after broad consultation with the public and with all sectors of the health care industry. The priorities should be important problems affecting multiple aspects of health care delivery and financing, which would be addressed by developing evidence-based guidelines and standards of performance.

The new agency would separate the generation of evidence by AHRQ, the NIH, and others from the translation of that evidence into guidelines and standards. Although stakeholders that might be affected adversely by a guideline that differed from their current practices or business interests might object, the new agency would require them to provide scientific evidence to support their arguments. Disagreements would be adjudicated by weighing the evidence, rather than by a process of political influence. When there simply is not enough evidence to support the proposed guideline, the issue would become a research priority for AHRQ or the NIH.

Setting Performance-Based Payment Policies

Together, federal and state governments pay for almost half of all U.S. health care spending. They can exert enormous leverage by developing, implementing, and evaluating models to link payment to guidelines and performance standards. Federal and federal-state programs (principally Medicare and Medicaid) should lead by designing and implementing financial incentives for health care providers that meet high levels of quality.

Equally important, government can remove major financial disincentives to quality improvement (for example, payment for preventable readmissions or duplicate tests). Federal action to devise better incentive programs to reward high quality would provide models for private-sector financing of health care.[15]

National quality performance standards would reduce waste and ensure payment for indicated or necessary health care services only. The same standards could be used to protect providers from malpractice litigation.

Investing In Infrastructure, Technical Assistance, Research, And Training

■ **Infrastructure.** Improving quality of care is going to require improvements in infrastructure, such as the development and implementation of clinical information systems. The federal government could play a major role in accelerating the diffusion of technology, as it has done historically with new farming technologies. Financial incentives could be designed to reward health care providers that adopt information technologies, such as computerized physician order entry to minimize medication errors, or decision-support systems to facilitate accordance with clinical guidelines.

■ **Technical assistance.** Through loans or loan guarantees, the federal government could help provide the capital that health care institutions—particularly non-profit ones lacking ready access to capital markets—might require to improve their information systems. The Hospital Survey and Construction Act (Hill-Burton), passed in 1946, provides a precedent. Following its enactment, more than $4.6 billion in grants and $1.5 billion in loans aided nearly 6,800 health care facilities in more than 4,000 communities. In return, facilities agreed to provide free or discounted medical services to people who are unable to pay full price.

Beyond capital investments, the major barrier to making the transition to an information-driven health care system is the lack of national standards for clinical computing. The United States has just taken its first steps in this direction.[16] The federal government could and should recommend a minimum data set for clinical information systems and develop a clearinghouse of information about effective computing practices. It should support the development and ongoing maintenance of national standards for coding, communications, and interoperability of clinical information systems. Additional federal support will likely be required to supply technical assistance to health care providers so they can implement clinical systems to improve care. Such responsibilities require strong leadership at the

highest levels of federal agencies.[17]

■ **Research and training.** Current federal investment in research on effective clinical practices is insufficient. A substantial increase is needed in AHRQ and NIH funding for research on effectiveness and cost-effectiveness, which is critical to ensure that the care of all Americans is based on science. Investing in human resources also is essential: Government needs to support the training of a cadre of professionals who will be the future leaders in the development of clinical information systems, the development of better evidence on clinical effectiveness, and the advancement of the science and methods of quality improvement.

The Medicare program should broaden the scope of Quality Improvement Organizations' (QIOs') work. QIOs could continue to provide technical assistance and sponsor learning collaboratives and other local or regional demonstration projects that would build the evidence base related to promising quality improvement programs. Furthermore, these activities would assist providers in achieving levels of clinical performance that meet national quality standards—not just for people covered by Medicare, but for everyone.

The IOM's *Fostering Rapid Advances in Health Care* recommends that government stimulate private-public collaboration to develop demonstration projects at the community and state levels in information technology development, chronic disease management, and primary care enhancement.[18] There must also be a plan for transforming local demonstrations into national practices.

■ **Public reporting essential.** Remarkably little information about health care system performance is available in a form that the public can use, if available at all. Having an accountable health system, in which quality is corroborated by valid data, ultimately requires public reporting of information on the credentials and performance of health professionals, hospitals, nursing homes, and other institutions that provide health services. This requires compiling valid data on performance with adequate sample sizes and controlling for case-mix and physician clustering effects.[19] These obstacles can be overcome with carefully designed methods; no longer is it acceptable to use these limitations as excuses to withhold information from the public. Federal and state governments must make public as much information as possible about how our health care system fares relative to the standards of care we set.

Improving the quality of health care is essential to the health and productivity of the United States. Positive change will happen only when the federal government has taken a stronger leadership role to ensure that quality improvement efforts throughout the health system are appropriately targeted and coordinated. This will require strong executive commitment supported by appropriate legislation. Government leadership does not preclude the continued existence or strengthening of a largely privately owned, operated, and financed health care system.[20] Nonetheless, strong federal leadership is needed to develop and implement a strategy to enhance the value that the United States derives from its

spending on health care. Only then can Americans be assured of receiving what they always thought they were receiving—the best care in the world.

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