Changing the health care consumer’s mindset about cost and quality requires an integrated approach that combines data from a variety of sources and presents it in a clear and actionable way.

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Executive Summary

Consumers are accustomed to getting better quality by paying more for many types of goods and services. For example, when buying a car, a higher price often indicates better engineering or more features. In health care, however, cost and quality have no correlation. Thus, facilities with the highest costs for medical services may provide low quality care, and, conversely, high-quality facilities may charge the lowest fees for care. Beyond point of service, there are other factors that drive up the cost of care. For example, medical services may be overutilized – and more care doesn’t necessarily mean better care. High costs of care can also be driven by the results of poor quality care, such as hospital readmissions, preventable infections, and complications resulting from poor chronic-condition management.

Some information about the quality of health care is available to the public, but inconsistencies and a general lack of consumer-friendliness across multiple data sources make it difficult for people to easily compare providers. Changing the health care consumer mindset about cost and quality requires an integrated approach that combines data from all these sources and presents it in a clear, actionable way. Specifically, health care consumers need tools that intelligently consolidate quality and cost information, enabling them to make side-by-side comparisons of providers.

Introduction

Unfortunately, the old adage “you get what you pay for” does not apply to health care in the US. Despite having the most expensive health care system, the US ranks last overall compared to other industrialized countries such as Australia, Canada and Germany on measures of health system performance in key areas such as quality, efficiency, access to care, equity and the ability to lead long, healthy, productive lives. Specifically, the US ranks last among these countries despite spending $7,290 per capita on health care in 2007 compared to the $3,837 spent per capita in the Netherlands, which ranked first overall (Figure 1).

The massive spend on health care in the US has not resulted in high-quality care. In fact, a 2004 study reviewed 40 million medical claims over a two year period and found no correlation between the cost and quality of care (Figure 2). One factor that drives these high costs is that large provider groups often negotiate more favorable rates with health plan network carriers. This results in considerable price variance among in-network providers, even within a specific geography, with no regard to provider quality. The market pressures that would ordinarily align cost and quality do not come into play because health care consumers do not have access to the data needed to make informed decisions.
High health care costs are not only incurred at point of service. They can also be the result of how health care is administered over time and the resulting outcomes, particularly when care is provided out-of-compliance with evidence-based medical standards. As a result, more than $300 billion is wasted every year in avoidable costs due to unneeded care, preventable complications or errors, or the right care not being delivered (Figure 3).³
Health care providers and lawmakers in the US are making significant efforts to address these issues. For example, Medicare, the largest health care purchaser in the US, will no longer pay for certain avoidable hospital complications. However, payers without policy-making power, such as employers and other health care purchasers, face continued increases in overall health care spending and bear the high costs of poor quality care. This has a significant impact on the cost of goods for US products, and the ability of US companies to compete. As one executive put it, “There is more health care than steel in a GM vehicle’s price tag.”

Figure 3: Annual Excess Costs in Clinical Services

The Impact of Low-Quality Care

A variety of publically available data make it possible to evaluate some aspects of the quality of care provided by physicians and hospitals. The following examples illustrate how low-quality care affects both the cost of care and patient outcomes.

Overuse of tests and procedures drive unnecessary spending

The fee-for-service health care reimbursement system in the US provides incentives for health care providers to deliver care based on volume, not outcomes. In other words, the more tests and procedures they perform, the more the providers are paid, regardless of whether this leads to better care for patients. For example, evidence suggests that most back pain is resolved with rest, physical therapy or
other conservative treatment that does not require an MRI. Yet in the US, MRIs of the lower back account for about 0.5% of total employer spending on health care, and nearly a third of these MRIs are for patients who had not first tried other potentially effective treatments. Such unnecessary MRIs create significant financial costs: In one region of the US, Castlight found that the median price of an MRI is $837 (the cost in this region varies from $409 to $2,488). Additionally, overutilization of MRIs increases the patient’s risk and stress and potentially causes time to be lost from work.

**Avoidable readmissions make up 10% of all hospital costs**
Potentially avoidable readmissions account for $1 of every $10 spent on hospital care. Such readmissions can result from poor care during the initial admission, inadequate discharge instructions, poor care coordination or failure of appropriate follow-up care. Hospitals that focus on better discharge planning can significantly reduce their readmission rates. With 90% of readmissions considered unplanned, and with clear variations in readmission rates among hospitals, this is an important quality indicator to help consumers avoid the potential increased risk and stress of being readmitted to a hospital.

**Hospital-acquired infections increase costs and mortality rates**
Many hospitals have mounted comprehensive infection-control programs and have done an excellent job of dramatically reducing preventable hospital-acquired infections. Unfortunately, there are still some hospitals that have standardized rates of infection as high as five times the national average—this means that more than 4 of every 1000 patients cared for at such a hospital developed a preventable infection during their stay. Each avoidable central-line infection not only costs about $42,000 on average, but also could result in the patient’s death.

**Lack of evidence-based chronic-condition management increases costs due to complications**
Nearly half of adults in the US—133 million—have a chronic condition, and the number of people with chronic conditions is increasing by 1% per year. Health care costs for this population represent 74% of private insurance spending. While some of these costs are expected due to the nature of chronic conditions, other costs can be avoided by ensuring that people are getting the right care. About 45% of US adults do not receive care recommended by national guidelines, and patients are generally not aware of what care they should or should not receive. Compounding this are dated systems infrastructures and poor care coordination, resulting in duplicate tests or procedures for 18% of chronic care patients. Just by closing gaps in care, employers could realize a savings of $1.49 per employee per month (PEPM).
Defining High-Quality Care

The Institute of Medicine (IOM), the health care branch of the National Academy of Sciences, proposed six specific facets of high-quality health care:11

- **Safe**: Avoiding harm to patients from the care that is intended to help them.
- **Effective**: Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and misuse, respectively).
- **Patient-centered**: Providing care that is respectful of and responsive to individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions.
- **Timely**: Reducing waits and sometimes-harmful delays for both those who receive and those who give care.
- **Efficient**: Avoiding waste, including waste of equipment, supplies, ideas and energy.
- **Equitable**: Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location and socioeconomic status.

Consumers Want High-Quality Care

Health care consumers want to find high-quality care but have limited access to actionable information on provider quality. Often the available data are not that meaningful to consumers or relevant to the specific health care decision that a consumer faces. In the absence of understandable information on provider quality, some consumers simply select a high-cost provider in the belief that high cost equals high quality.12 These consumers also may believe that “more is better” when it comes to health care. Giving consumers the right information to make high-quality care choices continues to be a significant challenge.

A recent survey13 of consumers by Consumer Reports found that

- Medical errors and complications are among consumers’ top concerns,
- About 25% believe that there are big quality differences among providers,
- Medical/drug costs are consumers’ biggest economic concern, and
- Consumers want to trust their sources of information.

When asked about hospital quality data, the survey found that

- 16-20% of consumers identified “quality of care” as essential, and
- 11% of those individuals identified “quality of doctors” as essential.

When asked which specific types of information they wanted to know about providers, respondents rated hospital-acquired infections and medical errors/preventable complications as “very important to know,” yet this information was also some of the least used when selecting a hospital.
Five Best Practices in Helping Consumers Identify High-Value Providers

Employers focused on driving down health care costs and better meeting the health care demands of their employees are converging on the need for a solution that provides meaningful, comparative information about provider quality and costs in a comprehensible and actionable way. For such a solution to be successful, it must accomplish the following five objectives.

1. **Aggregate quality data from credible and independent sources**

   Developing appropriate quality metrics requires large data sets and special expertise in statistics and medicine. Significant amounts of quality data are needed about physicians and facilities, representing various populations such as adults and children, and further defined by major conditions and procedures. In addition, the data must include patient experiences.

   Currently, such information exists in many forms from a wide variety of sources. The following organizations are just some of the resources that provide subsets of the quality information needed to support effective consumer decision-making:

   - The Centers for Medicare & Medicaid Services (CMS)
   - The Leapfrog Group
   - The National Committee for Quality Assurance (NCQA)
   - The Joint Commission
   - Regional, multi-stakeholder collaboratives for performance measurement and reporting
   - Patients themselves

   Such organizations have the expertise to provide evidence-based and statistically sound data on different aspects of quality. This data must then be consolidated into a set of metrics that give the consumer a full picture of the quality performance of a physician or facility (Figure 4). The metrics fall into three categories:

   **A. Process measures** — Did the provider/facility do the right things when providing care? For example, did the physician check a diabetic’s blood sugar at least one time during the past year?

   **B. Outcomes** — Did the patient get the desired result from treatment? For example, was the physician effective in helping his/her diabetic patients keep their blood sugar within normal ranges?
C. **Patient experience** — Did the provider or facility meet the patients’ expectations? For example, did the patients believe the doctor communicated and listened well?

![Figure 4: Aggregated Display of Quality Metrics](image)

**2. Make it easy for consumers to identify the relevant quality information**

Consumers are more likely to choose high-value providers when cost data is presented alongside easy-to-interpret quality information. However, because people value different attributes about physicians and facilities, that information must be presented in a way that makes it easy for the consumer to identify which information is most relevant to their situation and personal preferences. For example, a person looking for a primary care physician may place a higher priority on other patients’ experiences with a doctor, while a newly pregnant woman may be more interested in the quality of the hospital where her obstetrician delivers babies (Figure 5).
Figure 5: Make It Easy to Identify Relevant Information

3. Provide information that is easy for consumers to understand

Many consumers struggle to understand and navigate the health care system, and they can be intimidated and confused by medical jargon. Even when they are given relevant information about provider quality, if that information is hard to understand, then the consumers often assume that a low-cost provider is substandard. Thus, it is important to present information in an understandable way, and to provide education and guidance on how to get the most from their health care provider (Figure 6).

An effective tool for consumers should

- Present content at an appropriate reading level;
- Provide content in a language native to the employees;
- Consolidate, where appropriate, measures into a single rating that clearly identifies whether a hospital provides better or worse care than others; and
- Help employees learn how to get the most from their care and understand what care they need based on scientific evidence (Figure 6).
4. Support workplace benefits that encourage employees to select high-quality providers

Behavioral change is often most effectively driven by incentives combined with relevant information to guide the consumer. Increasingly, employers are implementing health benefits that incentivize employees to select high-quality providers and facilities. Incentives paired with the right information and tools can drive even more measurable change.

For example, consider elective inpatient surgeries, which can be costly and can have a significant impact on an individual’s quality of life should the surgery not go as expected. Many employers are starting to address this issue by implementing Centers of Excellence programs that have a benefit differential. With this model, employees have an incentive to choose designated facilities that have been identified to provide the best value care for a specific type of procedure (Figure 7). There is evidence that employers can save $1.20 PEPM by directing employees to such Centers of Excellence.\(^{15}\)
Why choose a Hospital of Quality?

When you choose a Hospital of Quality, you can be sure you’re getting the most from your health care benefits. Not only are Hospitals of Quality already pre-screened for your procedure – they’re also significantly lighter on the pocket. Acme has designed an incentive program to encourage employees to choose wisely.

<table>
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<td>Total out-of-pocket</td>
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<td>$8,170</td>
<td>$9,918</td>
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Figure 7: Incentives Can Help Drive Consumers to High-Value Providers

5. Measure the Impact of Behavior Change

Knowing how health care dollars are being spent is the first step in developing programs targeted at an employer’s specific population. The ability to evaluate that data after implementing new programs helps demonstrate program effectiveness at driving behavioral changes, improving employee health and reducing costs. For example, while clinical quality measures provide information about how well a physician provides evidence-based care to their patients, applying the same criteria to employee populations over time will demonstrate how effective an employer’s programs are at changing behavior and improving care quality (Figure 8).

Figure 8: Impact of Fully Integrated Solution on Patient Compliance with Evidence-Based Medicine
Conclusion

To enable employees to get the most from their health care dollars, employers increasingly recognize the need to provide their employees with incentives to seek out high-value providers as well as the tools to identify those providers. Without access to information, consumers will fall back on the assumption that a higher cost of care equals a higher quality of care—an assumption that is far from accurate and results in excessive cost and sometimes harmful outcomes. Increasingly, tools are available that support incentives that reward smart choices, ultimately driving employees to get the right care from the right providers at the right cost.

References