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The Medical Care Quality Research and Improvement Act of 1989

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Written Statement of

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This statement is written in an effort to help the Committee assess the need for The Medical Care Quality Research and Improvement Act of 1989 (H.R. 1692). Below it is argued that the inability of consumers, payors, and providers of health care to assess quality of care is a major contributor to health care cost inflation. Without objective information evaluating alternatives, medical treatments are adopted on the basis of provider preferences, aggressive marketing, or unsuitable criteria (i.e., "If it costs more it must be better."). There presently is little economic incentive for providers to practice cost effective medicine in large part because purchasers of health care services can not differentiate low (high) cost providers from low (high) quality providers.

Research into the outcome, effectiveness, appropriateness, and other aspects of the quality of medical treatments is needed not only to promote good health care, but also to assure the efficient functioning of the market for health care services. Quality assessment must go beyond merely determining the efficacy of a given procedure, it must also determine the efficacy of the procedure relative to its alternatives. This is important regardless of how health care is financed, but if we are to continue to have a private health care delivery system we must provide information which allows individual purchasers of health care to weigh the costs and balances of their health care choices.

A public-private partnership is needed to finance, perform, and disseminate the results of research on the measurement of the quality of health care services. The private sector cannot supply all the needed information alone. Utilization review firms which presently review the existing literature for information of this kind are reluctant to share this information even with providers whose cases they are reviewing: it is their stock in trade; their investment. In order for the market for health care services to function properly this information must be widely available. Moreover, the concepts and terminology of this research must be standardized so that all participants are speaking a common language and the results from one project can be directly compared with results from another. The public sector can, and should, help achieve this objective.

The remainder of this statement reviews the causes of health care cost inflation, the measurement of health care quality, and the need for research on quality measurement.

Health Care Cost Inflation

National health care expenditures rose by 8.5% in 1986 and 9.8% in 1987. The United States now spends over 11.5% of its Gross National Product (GNP) on health care. The effect of health care cost inflation is similar to a tax on labor. In the long run, most economists agree that labor bears the full burden of health care cost inflation; in the nearer term employers face higher labor costs and lower returns on investments due to health care cost inflation. Health benefits have grown into a major component of labor costs; in 1970 health benefits comprised 2.4% of total compensation and 23% of total benefits. By 1987 health benefits accounted for 5.4% of total compensation and 33% of all benefits.

Public and private purchasers have adopted a number of health care cost management initiatives in an attempt to restrain the growth in their health care costs. The stated goal of these initiatives is to restrain costs without reducing the quality of care. All health care cost management strategies are therefore attempts to correct for the failure of the market for health care. Health care costs will continue to rise for a number of reasons

including the changing demographics of the workforce, the labor intensive nature of health care services, and the introduction of new technology, even if the market for health care services functioned perfectly. The market for health care services fails in that the mix of services provided is not necessarily the mix fully informed consumers would wish to purchase, and the services provided are not produced at minimum cost.

The failure of the market for health care services is the inability of consumers of health care to evaluate the quality of the services they purchase. The widespread availability of health insurance coupled with the characteristics of the provider reimbursement policies of private and (since the introduction of Medicare) public insurers has reduced or eliminated the incentives to weigh the benefits of common procedures and practice patterns against their costs. The result is that new technology is introduced with little or no evaluation of its benefits relative to costs. Providers adopt practices based on personal preferences. Patients lack the information necessary to evaluate the quality of care they receive before, during, or after an episode of illness. Medical researchers have had little or no incentive to assess the relative benefits of the procedures they developed; to be adopted, new procedures did not have to be more effective or less expensive than existing procedures.

Medical research has produced a rapid expansion in treatment options without concurrent research on the relative efficacy of each option. This has prevented the formation of a medical consensus on the proper treatment of a given set of symptoms. It has been well documented that large variation in practice patterns exists among physicians practicing in the same geographic area¹. The paucity of research on medical outcomes results in the practice of medicine as an art rather than a science. Malpractice proceedings, which are intended to punish incompetent providers, instead force lay juries to decide the appropriate medical practice for a given condition. The threat of malpractice suits may lead physicians to perform more procedures than they deem necessary or cost effective. Reynolds, Rizzo, and Gonzalez estimate that the combined costs of malpractice insurance premiums, settlements and defensive medicine may be as high as \$14 billion per year, leading some physicians to stop performing some high risk procedures.²

The sources of health care cost inflation relate back to the allocation of risk. Tax policy not only encouraged the spread of health insurance, but aided the accommodation of health care cost inflation as employees were pushed by general price inflation into higher marginal tax brackets. The spread of health insurance and the characteristics of health insurance in which the insurer bears the risks associated with the uncertainty in the efficacy of treatment, increased the demand for health care services and stimulated the development of new procedures. Hospitals and physicians in competitive markets are quick to adopt new technology, raising their costs. Providers, given a longer list of potential procedures that could be performed for a given condition, provide more intensive and more specialized care. The increased costs of health care services increases consumer demand for health insurance.

Cost management strategies can be viewed as attempts to limit moral hazard and to force patients and providers to assess the expected cost and benefits of each treatment decision. The benefits of care and the quality of care

¹ For a good review of the evidence see Wennberg, John, and Alan Gittelsohn, "Variations in Medical Care among Small Areas" *Scientific American*, Vol 246 (1982) pp: 120-135

² Reynolds, Roger A., John A. Rizzo, and Martin L. Gonzalez, " The Cost of Medical Professional Liability" *The Journal of the American Medical Association*, 1987: 257; pp: 2776-2781

are clearly related concepts. Viewed in this way it becomes clear that health care cost inflation and health care quality are inseparable issues. All effective health care cost management strategies must assess the quality of health care.

Health Care Quality

Defining and measuring health care quality are controversial and costly endeavors. Quality of care is a multidimensional concept: it can be viewed narrowly (as clinical effectiveness) or broadly (as all the attributes of medical care that patients value). The difficulty with any multidimensional concept is weighting the disparate components. Even if individuals agree on the attributes of care that determine its quality, they may disagree about the relative importance of each attribute. While any definition should include the efficacy of treatment its importance relative to other components of quality is subjective.

Third party payers are beginning to use a definition of quality care that, at least implicitly, requires not just that care be efficacious but also cost effective. In a sense, if two treatment regimes provide the same level of patient satisfaction and yield the same outcomes, the lower cost treatment is judged to be higher quality. Utilization review is an example where the payer determines quality care as the least expensive care.

Measuring health care quality is at least as difficult as defining it. Donabedian classified attempts to measure quality of care as studies of structure, process, and outcome.³ Structure refers to the attributes of care: the qualifications of the care givers, the resources available at the site of care, and other attributes. Evaluation of the process of care examines the activities of care givers, the decisions made at each step in an episode of illness, and the appropriateness of the care provided. Outcome measures the effects of care on health status and patient satisfaction.

These measures of quality are interrelated. As Donabedian and others⁴ have pointed out measures of structure and process are only important as indicators of quality if they are related to outcomes, and measures of outcomes are important only if they can be related back to the structure and process of care, and not to environmental or other factors.

Structural measures of quality have historically been employed in the various accreditation processes used by both private agencies (the Joint Commission on the Accreditation of Health Care Organizations (JCAHCO) for example) and public agencies (such as the Health Care Financing Administration (HCFA)). As an example, in reviewing a hospital JCAHCO looks at a long list of structural measures such as the physical plant of a hospital and medical staff organization. The relationship, however, between some of these factors and health outcomes seems tenuous at best.⁵

Process is an important component of quality assessment because it focuses directly on the uncertainty in the efficacy of treatment. Given this

³ Donabedian, Avedis, "The Quality of Care: How Can It Be Assessed?" *Journal of the American Medical Association*, Vol 260, No. 12 (Sept. 23/30, 1988) pp: 1743-1748

⁴ Wyszewianski, Leon, "Quality of Care: Past Achievements and Future Challenges" *Inquiry*, Vol. 25, No. 1 (Spring, 1988) pp:13-24

⁵ JACHCO is moving toward adopting outcome measures of quality in addition to their structural measures. See O'Leary, Dennis, "The Joint Commission Looks to the Future" *Journal of the American Medical Association*, Vol. 258 (Aug. 21, 1987) pp:951-52

uncertainty, the logic of medical decision making is an important determinant of quality and cost effectiveness. Process measures are used by Peer Review Organizations (PROs) in reviewing the quality of care received by Medicare recipients and by organizations that perform utilization review. Generally examining the process of care involves assembling a panel of physicians who review medical records to determine the appropriateness of the care received. A number of studies employing this method have indicated that a significant proportion of the treatment provided to patients is inappropriate.⁶

As with structural measures of quality of care the relationship between process and outcomes is not well established. The information needed to determine the effect of process on outcomes is not yet available. Researchers examining the quality of medical evidence argue that, ". . .for at least some important practices, the existing evidence is of such poor quality that it is virtually impossible to determine even what effect the practice has on patients, much less whether that effect is preferable to the outcomes which would have occurred with other options."⁷

One list of outcome measures could be described as "the five Ds": death, disease, disability, discomfort, and dissatisfaction."⁸ Outcome measures have intuitive appeal in that they can be relatively inexpensive to collect and appear to be easy to interpret. For example, HCFA has begun a program which releases hospital mortality rates in an effort to provide consumers with information on hospital quality. Hospitals indignantly, and correctly, pointed out that the problem with simple outcomes measures is that good quality care may not prevent a poor outcome and that providers treating sicker patients are more likely to have bad outcomes regardless of the quality of care they provide.

Simple outcome measures must be adjusted to account for factors other than the quality of care which might affect outcomes. These factors include the types of cases a provider treats (casemix), the severity of illness, and patient characteristics. A number of systems have been developed to measure case mix and severity. Diagnosis Related Groups (DRGs) classify inpatient admissions by diagnosis. They can be used to determine a hospital's casemix and are used by Medicare to reimburse hospitals. There are a number of systems such as APACHE and the Medical Illness Severity Grouping System (MEDISGRPS) which use physiological indicators to measure a patient's risk of dying to determine the severity of the patient's condition.

These and other similar systems have been used by providers and insurers to evaluate the quality and cost effectiveness of care. For example, a hospital can assign a severity measure to each patient within a DRG. Then the hospital can evaluate each physician's outcomes, using mortality or morbidity rates (such as length of hospital stay). Within each DRG the physician with the most severely ill patients should have the highest rates of bad outcomes and the highest costs. The accuracy of this style of quality evaluation depends upon the degree to which the severity and casemix measures capture the effects of factors other than quality on outcomes.

⁶See for example, "Does Inappropriate Use Explain Geographic Variations in the Use of Health Care Services?" *Journal of the American Medical Association*, Vol. 258, No. 18 (Nov. 13, 1987) pp: 2533-37

⁷Eddy, David M., and John Billings, "The Quality of Medical Evidence: Implications for Quality of Care," *Health Affairs*, Vol 7, No. 1 (Spring, 1988) pp. 19-32

⁸ Lohr, Kathleen N., "Outcome Measurement: Concepts and Questions" *Inquiry*, Vol. 25, No. 1 (Spring, 1988) pp: 37-50

Patient satisfaction is an outcome measure that is relatively easy to collect. There have been a number of studies attempting to assess patient satisfaction and its relationship to the structure and process of care. In reviewing this literature Cleary and McNeil note that, "The most consistent finding in the satisfaction literature is that characteristics of the provider or the organization that make care more 'personal' are associated with higher levels of satisfaction."⁹

Satisfaction of course, is subjective. Attributes of care which some patients find satisfactory others may find unacceptable. The HMO industry regularly reports survey results which indicate that their enrollees are very satisfied with the care they receive. However, at least two studies have found high levels of dissatisfaction among HMO enrollees who were assigned, but did not chose, that style of care.¹⁰

The above discussion indicates that there is no single measure that adequately captures all the dimensions of quality of care. The definition of quality is at least in part subjective, but even the measurement of the characteristics of care over which individuals might disagree is incomplete. Moreover, the information necessary to determine if a limited set of easily observable characteristics, such as mortality rates, nurse to bed ratio, or board certification, could serve as indicators of quality is not yet available. The result is that it is unclear what exactly our health care dollar is purchasing.

Policy Implications

There are underlying causes for health care cost inflation other than market failure.¹¹ A growing, and aging, population and advances in health care technology increases the demand for health care services. The increased demand drives up costs as the health care industry competes with other sectors for resources. As a matter of public policy these increasing costs would not be troublesome if more health care were actually being provided. One definition of economic growth is more people purchasing more products.

The problem is that the market for health care services fails. The risks from the uncertainty in the efficacy of treatment have largely not been born by either providers or patients. There is not a market mechanism which evaluates the benefits of new, or existing, treatments against their costs. Instead, competition among providers encourages the adoption of new practices in order to offer a wider range of potential services. Providers who offer cost effective practice are not rewarded by the health care market in the absence of information justifying that style of practice. In most other markets price and quality rise together. Patients lacking any other information on quality may see no reason to move to a less expensive provider.

The market is unable to produce the amount of quality assessment necessary to ensure the provision of cost effective care. Cost management requires that quality assessment methodologies be developed and widely

⁹ Cleary, Paul D. and Barbara J. McNeil, "Patient Satisfaction as an Indicator of Quality Care" *Inquiry*, Vol. 25, No. 1 (Spring, 1988) pp:25-36

¹⁰ See for example Welch, W.P., and Richard G. Frank, "The predictors of HMO Enrollee Populations: Results for a National Sample," *Inquiry*, Vol.23 No. 1 pp: 16-22 (Spring, 1986) and Garfinkel, S.A., W.E. Schlenger, K.R. McLerory, F.A. Bryan, B.J.B. York, G.H. Dunteman, and A.S. Friedlob, " Choices of Payment Plan in the Medicare Capitation Demonstration," *Medical Care*, 24 (7) pp:628-640, (July, 1986)

¹¹ See Ginzberg, Eli, "A Hard Look At Cost Containment," *New England Journal of Medicine*, Vol. 316, No. 18 (April 30, 1987)

disseminated. Private firms have little incentive to expend the resources to develop quality assessment methodologies if other organizations can freely make use of those methodologies. However, to establish their credibility with providers and patients quality assessment firms must reveal their methodologies. Facing this paradox many third party utilization review firms will under supply quality assessment even in the presence of heightened demand for it.

The challenge for public policy is to promote both the research necessary to evaluate the quality of care and the incentives for providers to adopt cost effective practices. The cost management initiatives that have been implemented provide incentives to purchase and provide cost effective care but do not affect the majority of insured persons. More importantly the market cannot provide cost effective care until it can be determined what care is cost effective and what exactly the tradeoffs are between cost and quality. H.R. 1692, The Medical care Quality Research and Improvement Act of 1989 may provide the necessary first step in constructing an efficient health care delivery system.