WHAT DO I KNOW ABOUT DELIVERY OF HEALTH CARE SERVICES?
– ABSOLUTELY, POSITIVELY, AND EMPHATICALLY – NOTHING AT ALL!

Stephen L. Bakke – September 8, 2009

This is a follow-up to my recent report on suggestions for health care reform.

Commentary

None of the Congressional proposals have proposed anything which is likely to do anything to change our health care delivery system in a way that systemically makes it more efficient and effective in a way that clearly saves costs while improving medical outcome of programs and treatments. Remember, the Obama Administration's claim is that it intends to add approximately 15% more individuals to the insurance rolls. Given that (go ahead and work with the numbers), how can they spend so much money, add to the numbers covered and save costs overall. It doesn't make sense, particularly when relying on the several dozen expensive new bureaucracies regulating and intimidating, and the strong arm of the government artificially setting maximum rates for services and insurance costs. You can't squeeze blood out of a turnip.

Also, while I do feel I have presented a solution which helps move in the direction of reducing costs, I am still left somewhat empty as to how to tackle an important aspect of any dependable, sustainable, and substantial cost reduction. The suggestions I have made rely on changing the payment systems (including the tax reform aspects), improving the decision process, encouraging market forces, ensuring market transparency, and changing certain external influences, in order to "bend the cost curve." The external influences I refer to include tort reform, removing state mandates, and removing state borders as barriers to competition by insurance carriers.

I have read much about the regional differences in health care costs. There are several examples of much acclaimed health care delivery efficiencies, especially in the Medicare program. While Medicare reform is not the focus of the current reform debate, it does lend itself to examination for what we can learn. One of the best examples is the recent national coverage of the comparison of the Mayo Clinic's cost per Medicare enrollee compared with a community in Texas. The differences in relative costs were incredible. There appears to be no explanation related to different medical requirements of the two communities, nor the relative health of the communities. And there is no difference in medical outcomes which explain it. The differences are represented to be in the different philosophies and approaches to delivery of services.

There are several experts in this field. Refer to the list of books and research studies listed in the report which enumerates my suggestions for reform. One such group is The Dartmouth Institute for Health Policy & Clinical Practice, which has done significant research in this area and offers a set of suggestions and procedures to improve the efficiency and effectiveness of medical services through altering the delivery system. The Institute often examines differences in efficiency and costs by comparing community and regional differences. This is just one source

of suggestions for improvement in delivering health care services. Following is some information taken primarily from one of their numerous studies and reports.

The Dartmouth Institute Report

A December 2008 white paper was titled "Improving Quality and Curbing Health Care Spending: Opportunities for the Congress and the Obama Administration." The stated goal of this report was to propose strategies to move the nation toward organized delivery systems, improve the quality of health care and scale back costs and cost growth. While this project doesn't deal primarily with Medicare, the study found an astonishing variation in costs, region to region. They found a 2.5 fold proportionate "variation in Medicare spending in different regions of the country, even after adjusting for differences in local prices, age, race and underlying health of the population." This difference in spending seems meaningless in terms of efficiency or outcomes. "Patients who live in areas where Medicare spends more per capita are neither sicker than those who live in regions where Medicare spends less, nor do they prefer more care. Perhaps most surprising, they show no evidence of better health outcomes." In general, more spending doesn't translate automatically into better outcomes.

The study goes on to identify key shortcomings which influence the problem of efficient delivery of services and costs. Included in these were:

- Disorganized, poorly coordinated, and inefficient care that results in the underuse of effective medical interventions and overuse of physician visits, consultations, hospitalizations, etc.
- Clinical decisions that fail to adequately take patient preferences into account.
- Undersupply of primary care physicians and oversupply of physician specialists.
- Insurance markets unequipped to deal with geographical variation of costs.

Dartmouth's report focused on the Mayo Clinic. The report stated that "using the Mayo Clinic as a benchmark, the nation could reduce health care spending by as much as 30 percent for acute and chronic illnesses." I presume they used their comparative studies of Mayo and others when they came up with health care reform elements which they recently introduced by stating, "The Obama administration and the Congress should build consensus around the following priorities for a new American health care policy (this is just a partial list of their suggestions):

- *Promote the growth of organized systems of care* – They "offer a set of specific payment changes that would spur hospitals and other providers to develop organized delivery systems that would reduce the underuse of effective care and the overuse of unnecessary care through a shared savings program.
- *Require informed patient choice and shared decision making* .
- *Geographic equity and regional markets* – These are offered for further study and reform (i.e. we should introduce geographical differentiation where it doesn't now exist) – "…… health care market boundaries differ from geographic/political boundaries. Today's insurance market is ill equipped to encourage more efficient delivery systems such as organized group practices, in part because the cost of insurance premiums is not closely linked to actual costs of medical care in a given market. As a result, citizens in markets

where providers are better organized and more efficient are subsidizing the inefficient, more costly care in other regions of the country."

For me to presume to spend any more time, effort, ink, and paper on this subject would be way too foolish on my part. I know nothing about this; I don't want to try to understand how to improve delivery of health care services – it's above my pay grade; and I know my attempts to do so may tend to mislead.

Suffice it to say, I added this discussion merely to inform the reader that there are many unreported or underreported studies by credible organizations (in contrast to misleading studies by the World Health Organization or The Commonwealth Fund) that have been ignored as sources of guidance as our politicians try to take on this terribly complex issue and solve it in "way too short" a period of time.

That's enough about something I **(ABSOLUTELY, POSITIVELY, AND EMPHATICALLY)** know nothing about.

Sources of Information

The major sources of information used in developing my health care commentaries were included in my recent report on health care reform recommendations.