

# Tools for Health System Redesign: What Does a Hammer Look Like?

Mark Pauly

May 25, 2006

# The Setting

- Some service industries have reconfigured for apparent efficiency improvements (banking, movies, accounting) while others have not (haircuts, restaurants, law).
- Maybe a similar change is possible in health care.
- If so, what are the tools that will cause it to happen and do more good than harm?

# Two Kinds of Redesign

- Technology-efficiency redesign: doing more with less (or a lot more with a little more). Fervently wished-for, possible in part, but nothing close to a guarantee.
- Rationing redesign: doing less with less (or doing no more with the same amount). Unavoidable, only a matter of when.

# The questions and my answers

- “What tools are necessary to increase efficiency?” Better incentives for sure and better knowledge maybe. Technology? Computers in the right hands. Leadership? Fuhgeddaboutit.
- Will better and cheaper data on cost and quality help? Not as manna from heaven, but as an aid to improved incentives.
- How can financial incentives reward quality? Dumb question! Not sure why we want to since we have too much middle class quality now. Need to reward the *right quality*.
- Who should incentives hit? Everyone, including innocent bystanders.

# What feasible goal and tools?

- The nirvana goal: marginal benefit equals (minimum) marginal cost.
- For static quality: as much as is worth the money.
- For new technology: same
- For “effort” to minimize costs: same, as applied to “the supply of efficiency.”

# Heterogeneity: Many syllables and many meanings

- I assume that different Americans will want different choices and probably different systems— if not necessarily the “Canadian system without a country” model.
- Choices will be awkward: since making choices means making (individual) mistakes, and the rich will make different choices. Need to bite the bullet (and we should, in a truly efficient world). Pick the right tradeoff so we have the optimal number of choices and the optimal number of mistakes.
- There are as yet almost no tools to deal with this.

# Tools for the Bad Industrial Engineering Problem

- The charge: medical care (especially hospital) is not produced with max tech efficiency, so mistakes and costs are high. Reason: thick headedness (and bad data).
- Solutions: Help IHI spread the Gospel. Find a way to put the active ingredient in a box and mail it to Idaho.
- The Problem: without a good understand of causes, empiric treatment may not work well.

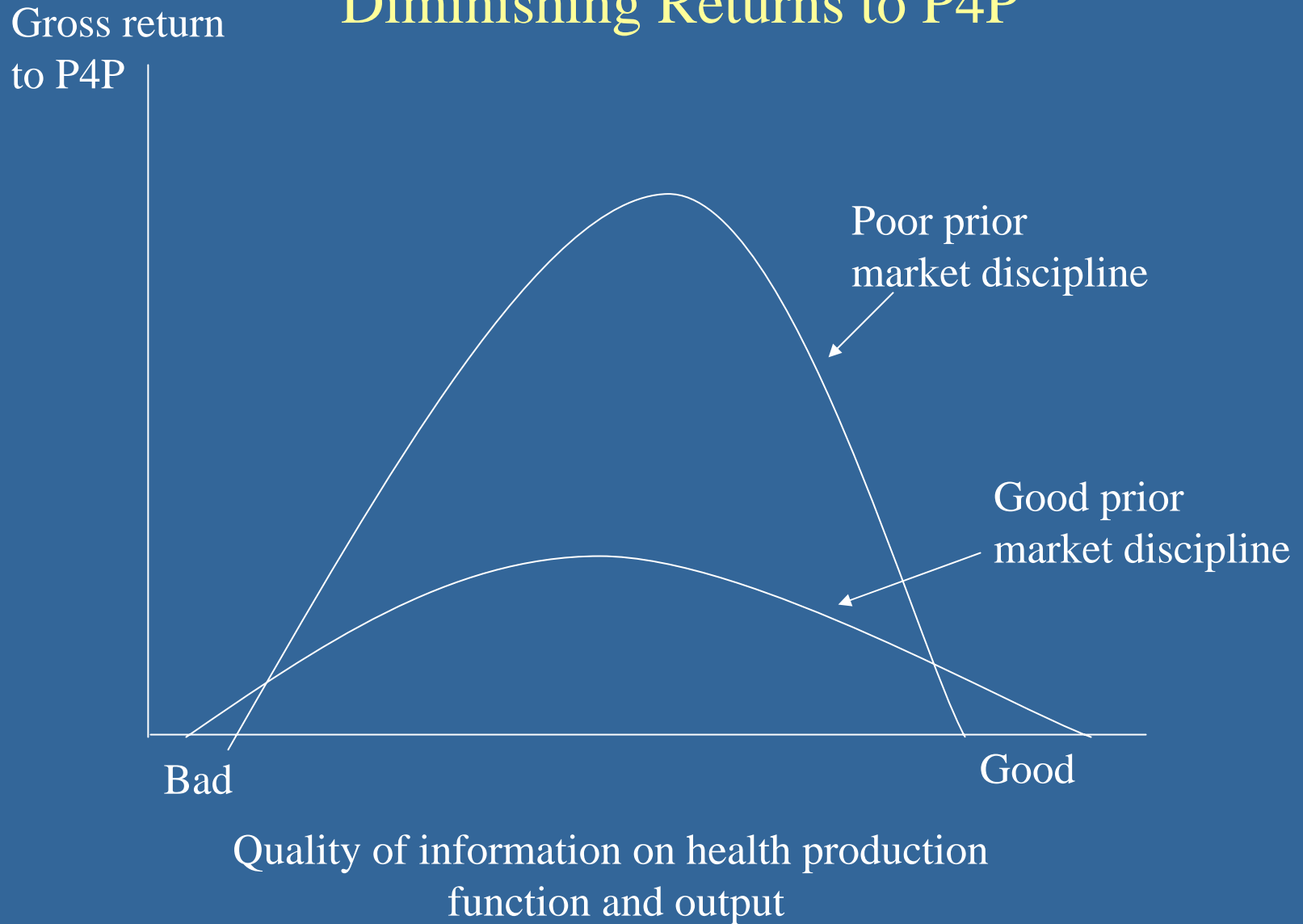
# Tools for the Bad Incentives Problem

- Some payment systems fail to reward improvements in efficiency.
- Define any output, price it so profit is positive, and quality should be its own reward—higher profitable volume rewards higher quality supplier.
- But if consumers or competition are deficient, this reward will not exist. Can it be built in externally? P4P assumes yes.

# Some Analytics on P4P

- Two kinds of information: accurate unbiased outcome measures and knowledge of health production function.
- P4P is useless when both are zero and when both are perfect. In the latter case, pay only for the right thing. See “Croquet Wicket” diagram.
- P4P is most valuable when outcome info is good and production info is bad: does this ever happen?

# Croquet Wickets: Increasing and Diminishing Returns to P4P



# Tools for the Bad Choice Problem

- Consumers may not choose the highest quality option (given price).
- Maybe the problem is they do not know, but it could be they do not care.
- For choice of quality, given cost (or with negative cost), “skin” does not have to be in the game. It does if the choice is to be between high cost high quality and low-low.

# Does All of this Add up to Transformation?

- Probably not in the institutional/organizational structure: I don't see new mergers or alliances.
- Changes in the physical process of care? Yes, for diagnostic services. But that is not a large share. The real impact will be on the volume and mix of procedures and products.
- Unless lifestyle and health habits can be changed, I see no revolution.

# Is IT a cause or an effect?

- Seems worth a try, though why worry if it's so great?
- Capital requirements: you can rent it.
- Physician reluctance/lethargy/fear: link to payment.
- Interoperability: needed some, but minimal if delivery is integrated.
- No estimates of dramatic drops in cost but might transform quality.

# Rationing Redesign I

- For the non-rich, current trends of real spending growth (associated with beneficial but costly new technology) outrunning income growth cannot be sustained.
- Not enough prospects for improved efficiency to offset the need to limit, sooner rather than later.
- But we do not have a discourse, much less tools, to limit new technology.

# Rationing Redesign II

- Financing: Closed end defined contribution with constrained growth: people pay for more themselves with their after tax dollars if they want.
- Information: the dollars per QALY billboard for managed care, information on cost effectiveness for using your spending account.
- Will the pipeline switch the type and volume of products to help us avoid agony? Cheap cancer drugs? Seems to be going the other way at present.

# Conclusions

- I am required to say: cap the tax exclusion.
- Will greater if uncomfortable attention to diversity in ability to pay and value make a difference? It could.
- Efficiency improving tools are worth a try; at least then we can get back to work.
- For rationing, in the short run, just pay people less until and if something bad happens.