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To: The Next President

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Re: Improving Health Care—By "Spreading the Mayo" (the Mayo Clinic Model, That Is)

Memos to the Next PRESIDENT

Voters in the United States consistently rank health care as a top concern, second only to their worries about the health of our economy. They seem to have two distinct but related things in mind: the moral imperative of insuring all Americans and the economic imperative of controlling runaway health care costs.

Your predecessor made zero progress on either front. Your administration will have to do better, despite drastic deterioration in the nation's finances.

With money tighter than ever, the progressive response to the public's demand for action on health care is to get greater value from each dollar spent. This will ease the strain on working families who face soaring insurance premiums. It will also come as a welcome relief to U.S. businesses facing foreign competitors who pay

nothing for their workers' health care. And this step would relieve pressure on public budgets squeezed by double-digit inflation in medical costs.

Finally, crucially, it will foster public confidence that long-overdue efforts to cover all Americans will not break the bank.

The unreasonably high cost of health care in the United States is a deeply entrenched problem that must be attacked at its root. For decades, we have been paying more for health care without getting better value in return. Just think: If the price of gasoline had gone up as much as health-care spending since 1980, we would be paying more than $9 per gallon.

These skyrocketing costs are the driving force behind Americans' frustration with health care. Why, for example, are our regular doctors so rushed they barely have time to see us? Because insurance companies and government programs have capped fees for primary care, creating an economic incentive for doctors to cram in more patients rather than devote quality time to those who need it.

Meanwhile, U.S. companies are paring back coverage or dropping it altogether as they try to cut costs to compete against low-wage competitors abroad, or against high-wage workers covered by tax-financed national health insurance.

The health-care crisis threatens to hobble key sectors of our government. States have less to spend on education and roads as public health-care programs consume an ever-larger share of their budgets. Furthermore, the federal government is bracing for a fiscal tsunami as the oldest members of the massive baby-boom generation retire and start claiming health and retirement benefits.

The path out of this dilemma begins with the recognition of a basic paradox: Unlike cars, furniture, or clothing, quality in health care actually costs less, not more. That is because a big chunk of our medical bills goes to pay for unnecessary care. The scale of waste is shocking: Peter Orszag, director of the Congressional Budget Office, estimates that 5 percent of the nation's gross domestic product—$700 billion per year—goes to tests and procedures that do not actually improve health outcomes. Thus, dramatically reducing waste and raising the quality of health care is not just a good idea from a medical perspective—it is also the best way to hold down health-care costs.

Consider a concrete example of this paradox: the world-famous Mayo Clinic in Rochester, Minn. Mayo's reputation for first-rate care attracts patients from all over the world, including many for whom money is no object.

But riches have not corrupted Mayo. To the contrary, Mayo offers all its patients Cadillac care at Chevy prices. A Dartmouth study showed that Mayo costs the government 17 percent less than the national average for treating Medicare patients with major chronic diseases.[1]

Mayo is not the only example of a high-value health provider. Intermountain Healthcare in Utah takes care of chronically ill Medicare patients for nearly one-third less than the national average. Geisinger Medical Clinic in Danville, Pa., even offers patients a warranty against medical failures.

The federal government boasts a success story of its own: the Veterans' Administration (VA). Under President Clinton, this much-maligned agency underwent a dramatic turnaround. The VA cut hospitalization rates in half by improving access to primary care for

veterans with chronic illnesses. At the same time, the VA improved the health of veterans with heart problems and other diseases.

What these organizations have in common is a commitment to "integrated care." Although they vary in the particulars, each gives patients a lead doctor who coordinates all their care, including their interactions with hospitals and specialists. Each uses health-information technology to boost efficiency through continuous improvements in medical practice. Each pays health-care professionals for the value, not the volume, of the services they provide.

How can we drive the entire U.S. health-care system toward this integrated-care model? Well, as our new president, you could issue a "Mayo challenge" based on a simple proposition: Every American should have access to health care as good and economical as that provided by the Mayo Clinic.

Next, you could use the power of the bully pulpit to focus policymakers' attention on the many obstacles that stand in the way of integrated care.

For example, doctors typically are paid on a "fee-for-service" basis. That encourages them to order more services—more procedures, more tests, more examinations—but it does not necessarily lead to the best, most efficient, or most medically appropriate care. According to Brent James at Intermountain Healthcare, hospitals typically spend more than one-half of their budgets on unnecessary treatments, including efforts to correct preventable foul-ups.

Another obstacle to integrated care is the fact that individuals rarely get to choose their own health insurance. Most Americans have job-based coverage, which means their employers pick their health plans. To please their workers, employers typically choose plans that include as many area doctors as possible. Such sprawling networks of providers, however, are rarely as efficient as smaller groups of doctors capable of working as an integrated team.

Government programs and policies also pose obstacles to integrated care. Both Medicare and Medicaid, for example, use price controls to clamp down on fee-for-service payments to doctors. This gives doctors an incentive to generate a high volume of services to make up for the lower prices, regardless of whether those services are medically necessary.

Similarly, the federal tax code gives workers and employees a bigger tax break for spending more on care, regardless of whether it is efficient or not. The sad truth is, current public policies subsidize mediocre medicine and fail to systematically encourage economical, high-quality care.

Of course, the government cannot simply order doctors to practice integrated care. But it can offer incentives for its voluntary adoption. Here's how:

Step One: Change the Medical Payment System

The federal government should encourage all those who pay for health care—employers, insurers, consumers, and public programs—to shift from the current fee-for-service model to a "package price" for a specific set of health-care services.

For example, a patient having surgery would receive a single bill for all necessary medical services rather than separate bills from each specialist. Here is another possibility: Patients could pay a package price for a medical

"home base"—an integrated-care network that would coordinate all of their primary, preventive and chronic disease care.

To make such sweeping changes across today's fragmented delivery and payment system, the federal government should create regional public-private partnerships with the nation's 60 employer-led coalitions, which already cover 34 million Americans. These partnerships should also include state governments, some of which—like Washington under Gov. Christine Gregoire—have already launched their own efforts to encourage integrated care.

In addition to embracing the new payment system, the partnerships would share data on patient outcomes and costs to determine which models of integrated care are the most cost-effective.

Armed with such evidence, the partnerships could also weed out overpriced medical services. Unlike other countries, the United States does not ration or limit access to innovative products and services. That creates a special responsibility for researchers and doctors to be discriminating about the use of new technology and techniques.

If two treatments or drugs are equally effective from a clinical standpoint, then all payers—from private health plans to Medicare and Medicaid—should refuse to pay for the most expensive one. To support such decisions, the federal government should invest more in assessing the comparative effectiveness of medical products, devices, and practices.

Step Two: Let Individuals Choose Their Own Health Plan

To offer consumers a menu of competing health-insurance plans, states should set up purchasing pools as an alternative to employer-chosen coverage. Federal employees and members of Congress already have such a system, called the Federal Employees Health Benefits program (FEHB). But with only about 15 percent of the market in the Washington, D.C., area, FEHB is not big enough to stimulate the formation of integrated health-care systems.

In Wisconsin, a similar purchasing pool (called an "insurance exchange") for state employees covers more than 25 percent of the Madison market. For decades, this program has enabled workers to choose from competing plans based on standard benefits and common yardsticks of price and quality. Recently, it stopped paying more to health-care plans that merely cost more without showing proof of better patient outcomes. As a result, doctors have been encouraged to join integrated-care groups. Health-care costs in the region are 14 percent below the statewide average.

The federal government should take a similar approach to covering Medicare's 44 million beneficiaries. By pegging Medicare payments to cost-effective outcomes, the federal government can use its enormous purchasing power to spur development of integrated-care options for seniors currently enrolled in Medicare's traditional fee-for-service program.

Finally, Washington can supply consumers with better information about the price and quality of care offered by health plans and providers. The Consumers' Checkbook guide to health plans, for example, helps federal employees choose every year from at least nine health plans. Such tools will become even more convenient and customized when services such as GoogleHealth and Microsoft's HealthVault automatically filter data to match a patient's individual health needs.

Step Three: Leverage Federal Health-Care Spending to Encourage Savings from Integrated Care

Government programs and subsidies add up to 57 percent of the nation's health-care spending. That spells a lot of potential leverage to encourage integrated care. But the last thing we want is for Congress to stifle innovation by micromanaging medical payments as it does now with Medicare price controls.

Instead, Congress should create a new regulatory body modeled loosely on the Federal Reserve Board to oversee new systems of medical payments. A Health Fed, as former Sen. Tom Daschle has proposed, would set national goals for health-care spending and patient outcomes based on the potential gains for integrated care.

For example, if states fail to meet their goals for higher quality and lower costs, the Health Fed would allow the residents of those states to buy health insurance in a FEHB-like system, creating a large competitive market for health care. Conversely, the Health Fed could reward states that exceed their goals with extra funds to offset costs of covering the uninsured.

The Difference Between Integrated Care and Managed Care

Americans are famous for their ingenuity. But when it comes to health care, we have managed to create a system that delivers high-cost medicine of uneven quality, when what we need is exactly the opposite: a system that delivers high-quality medicine at reasonable cost.

In producing such a system, policymakers will have to rebut the inevitable criticism that integrated care is just a rebranded version of managed care. The first rebuttal to this assertion is that managed care was not a complete failure.

After insurance companies began aggressively managing health-care costs in 1994, spending in the entire sector held steady at just under 14 percent of GDP through 2001. Since then, health-care expenditures have risen to more than 16 percent of GDP, but the seven-year run of essentially stable health-care costs was no small achievement.

The second rebuttal is that managed care as practiced by the insurance companies was based on indiscriminate cost control. It sparked a backlash among doctors and patients who complained that health plans were denying coverage of necessary services. In contrast, integrated care is doctor-led and restrains costs by eliminating services that doctors themselves determine are medically unnecessary, and by serving patients without costly errors or gaps in care.

More will have to be done to reform the legal and regulatory systems that surround health care. Perhaps most fundamentally of all, individuals need to take more responsibility for their own health habits. Those changes go beyond the scope of this memo. Reducing costs by raising quality through the widespread adoption of integrated care is the first and most important step.

1. "Tracking the Care of Patients with Severe Chronic Illness: Dartmouth Medical Atlas of 2008," Dartmouth Institute for Health Policy and Clinical Practice, Press Release, 2008, *www.dartmouthatlas.org/press.shtm*.

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