The Quality Imperative
A Commentary on the U.S. Healthcare System
Austin B. Frakt, PhD, Aaron E. Carroll, MD, MS

Introduction
The U.S. healthcare system is ailing, despite the passage of the Patient Protection and Affordable Care Act (ACA) in 2010. Although it was a monumental advance, the ACA was not comprehensive healthcare reform, as it focused principally on expanding access to health insurance. The ACA largely, although not entirely, avoided swiftly and directly addressing two other problems that plague the healthcare system: high and rapidly increasing spending and poor population outcomes.

Considering politics and market dynamics, neither poses issues that are simple to solve. The $2.6 trillion U.S. healthcare economy involves many powerful interest groups and major political constituencies. As the 2009–2010 health reform debate demonstrated, making major changes to healthcare delivery and financing poses fundamental challenges to the U.S. legislative system. Yet, technically, reducing growth in healthcare spending seems paradoxically trivial: Adopt a model from any industrialized nation that has achieved lower healthcare spending growth (Figure 1).

A more-difficult challenge is to increase broadly the quality of the U.S. healthcare system, as measured by population-level outcomes. In fact, a substantial problem is that it is difficult to improve quality in ways that can be measured easily. However, in some areas, quality improvements can be achieved relatively easily. Adhering to best practices and heeding the lessons of certain clinical trials simultaneously could improve quality and reduce waste and costs. Thus, in many respects, we already know some ways to improve healthcare quality; it is imperative that we apply the available tools to do so.

The Cost and Quality Context
Domestic trends and international comparisons make clear the fact that U.S. healthcare spending is high and growing rapidly. Notwithstanding decades of concern about healthcare spending; the passage of numerous incremental reforms to public health programs (notably to Medicare and Medicaid); and various private-sector innovations in health insurance and its provision, healthcare spending has grown from 9% of the U.S. economy in 1980 to 18% today. Over that period, growth in spending has outpaced that of other wealthy nations, as well as overall inflation, economic growth, and the wages of workers (Figure 1). Per-person healthcare spending in the U.S. was about $7500 in 2008, an extreme outlier relative to other Organisation for Economic Co-operation and Development (OECD) nations, even accounting for the greater wealth the U.S. enjoys. Federal spending on health programs now accounts for 23% of the federal budget and is expected to grow to 34% by 2035. By all accounts, this growth is unsustainable.

High healthcare spending in the U.S. might be viewed as acceptable, or at least grudgingly tolerated, if it resulted in consistently high-quality and broadly enjoyed health outcomes. But it does not. Numerous studies, examining dozens of measures of population health, have concluded that the U.S. lags far behind its peer nations in many measures of healthcare quality. Figure 2 summarizes how the U.S. compares to several other OECD nations on various dimensions of healthcare quality: To adequately meet the needs of a diverse population, and to receive good value in return for expenditures, the U.S. must improve the quality of health care delivered.

Cost-Savings the U.S. Can Implement Now
Of course, we, as a country, always have a choice and are free to spend as large a proportion of the U.S. economy on healthcare as desired. However, doing so implies some unpleasant consequences: potential massive increases in taxation; huge increases in debt; dramatically lower spending on other goods and services (such as education and defense); or some combination thereof. In a 2010 Health Affairs article, Joseph Newhouse, faced with these choices, explained why the
trajectory of total U.S. healthcare spending must be bent downward. Key to his argument, however, was the observation that it is not enough to simply address healthcare spending in federal programs, notably Medicare. The healthcare spending problem must be solved nationally, for both public and private payers.

The real question, therefore, is not whether to spend less on health care (relative to the economy or projections of current trend) but how. Either less can be spent on everything, or spending can be targeted. The former approach risks reducing spending on necessary, efficient, and life-extending care. The latter approach offers an opportunity to reduce waste and improve quality as spending is controlled. Increasing quality and reducing waste, as spending is tamed, sounds hard, and it is. But the U.S. already knows where to begin and has an idea of how to do it.

Well-designed studies have shown that, often, treatments are offered, and paid for, that do not improve outcomes. Let’s consider just a few. About three quarters of a million new vertebral fractures occur in the U.S. each year, and people aged >50 years have a nearly 25% chance to have at least one such fracture over their lifetimes. Most such fractures heal, but a substantial number cause chronic pain. Although surgery for these fractures has been controversial, the number of vertebroplasties paid for by Medicare nearly doubled from 2001 to 2005. A 2009 study showed that vertebroplasty for vertebral fractures was no better than sham (fake) surgery in reducing pain. In spite of this study, Medicare still pays for 100,000 such procedures each year, at a cost of $1 billion annually.

In addition, studies show that more than 5% of people in the U.S. aged >30 years and more than 10% of those aged ≥65 years have frequent knee pain from osteoarthritis. In 2009, more than 500,000 of them underwent arthroscopic surgery, at a cost of $3 billion. Yet a 2002 study showed that arthroscopic surgery for knee pain was no better than sham surgery.

An enormous list could be amassed of treatments that have been proven to be ineffective, let alone cost ineffective. These could include routinely using estrogen in menopause for chronic disease prevention, suppressing arrhythmias post–myocardial infarction, doing internal carotid artery bypasses, using α-blockers as first-line therapy to prevent stroke, giving estrogen to men with coronary artery disease, giving high-dose glucose infusions in the critical care unit, using β-blockers perioperatively, and inappropriately using implantable cardioverter-defibrillators. Recently, the Choosing Wisely campaign, in partnership with medical provider organizations, identified five tests or procedures that are of questionable

![Figure 1. Healthcare spending as a percentage of GDP in 31 OECD countries](image-url)

Note: Source: OECD health data, 2010

GDP, gross domestic product; OECD, Organisation for Economic Co-operation and Development
value, in each of nine medical specialties (www.abimfoundation.org/Initiatives/ChoosingWisely.aspx).

The exact amount spent on these procedures every year is not known, yet it is known that they are all still common, expensive, and do not improve outcomes at the population level. They provide a ready, if politically challenging, means to reduce spending without decreasing quality. In fact, eliminating them would increase quality because doing so would avoid needless health care, which itself carries risk. The key is to reform institutions and payment systems within the broader healthcare system that would provide incentives to eliminate them. This is not a simple task; knowing what to do is not the same thing as getting everyone to agree to do it.

The Way Forward

Of course it is not enough to describe areas in which spending can be reduced without decreasing quality. A description also must be provided of how to motivate actors within the system—patients and providers—to change their behavior. Two fundamentally different views about how to do this have been offered recently.

One approach is to place the burden on patients by increasing cost-sharing. Advocates of this approach, among them current congressional Republicans, point to the RAND Health Insurance Experiment as support. Results of this project do show that individuals with higher deductibles and copayments incurred lower healthcare spending. However, that project and subsequent work have shown that individuals are ill-equipped to differentiate between necessary and unnecessary care. When patients cut back on utilization, they did so indiscriminately. About half the forgoing care would have been good for their health.19,20

The other approach, more associated with congressional Democrats and President Obama, is to focus on treatment modalities that are more effective than others and empower experts to reduce program spending on those treatments that prove less valuable. The American Recovery and Reinvestment Act of 2009 allocated $1.1 billion for comparative-effectiveness research, studies that compare the clinical effectiveness of treatments.21 The ACA further supports research of this type by establishing the nonprofit Patient-Centered Outcomes Research Institute.22 The first step in reducing wasteful health spending is to identify it, which is exactly what comparative-effectiveness research does.

The second step is to create institutional structures that use this information to deliver care that can be justified on the basis of strong evidence of effectiveness. In some cases, such structures would expand care to improve quality (e.g., financing without copayment for clinical services vetted by the U.S. Preventive Services Task Force). In other words, not all comparatively effective or cost-effective quality improvements would necessarily be cost-saving; they should nonetheless be pursued if they are effective.

As noted, individuals are not always able to distinguish between helpful and unhelpful health care. However, they need not do so. Empowering physicians to make such determinations is one of the implicit goals of the ACA. The law establishes the rules governing new accountable care organizations (ACOs), integrated systems of providers responsible for the care of a population of patients and at risk for the associated costs, with bonuses and penalties tied to measured quality. ACOs can theoretically play a positive role in increasing quality, including through measures that reduce wasteful spending.
Organizations with ACO-like structure known for high-quality and efficient care already exist, including Kaiser Permanente, Group Health Cooperative of Puget Sound, Geisinger Health System, and the Veterans Health Administration. ACO-like concepts are being pursued also by Blue Cross/Blue Shield of Massachusetts. Although ACOs are no panacea, and may themselves raise other issues, they are a reasonable start toward encouraging the provision of higher-quality care.

Lastly, the ACA attempts to reduce one of the high barriers to development of a more rational, efficient Medicare program: politics. The act establishes the Independent Payment Advisory Board (IPAB), which will have the authority to make Medicare spending recommendations that must be considered, without amendment by Congress, under expedited procedures. In brief, Congress faces a collective action problem that the IPAB would help to address. The IPAB is severely restricted by law, in terms of the range of its purview (e.g., until 2020 it cannot suggest changes to hospital payment rates). Nonetheless, it is the type of body that could, one day, streamline Medicare’s ability to implement more-efficient payment structures, ones that provide greater incentives for reducing provision of care that has been proven by research to be less effective than other approaches.

Conclusion

The U.S. healthcare system has deeply entrenched problems relating to access, cost, and quality. These issues have continued for decades, despite many attempts to resolve them. If past experience is any guide, caution should be taken in suggesting that the U.S. is on now on the right path to solving them. Even if there are clear technical policy solutions to the problems, it is clear that politics remains a chief barrier.

From the authors’ perspective, there is no question that if politics and informational barriers due to proprietorship were no obstacle, the system could be optimized for cost and quality. In some sense, this type of optimization is what the ACA is attempting to do through a politically feasible, gradual path that seeks to minimize the political backlash that has doomed other attempts at serious reform. Within the context of the structures and bodies established by the ACA, there are positive steps that could be taken to reduce waste, improve outcomes, and decrease future spending.

In the U.S. today, there are medical procedures known to do little to improve health outcomes and a lot to increase costs. The U.S. should begin, right now, to constrain insurance coverage for such treatments. But this is just the beginning; comparative-effectiveness research will identify more examples. ACOs can provide incentives to put that research into practice. The IPAB could be empowered to add larger incentives toward providing high-quality, efficient health care.

Beyond these steps, inclusion of cost-effectiveness research in reforms could be considered. It is true that this approach would open the door to the type of decision making seen in other national healthcare systems, such as the National Health Service in Britain. But with scarce public resources, does it make sense to cover treatments with high costs that deliver relatively few quality-adjusted life-years?

To supercharge the healthcare-system regime in this way will require not just an unprecedented act of political will, but unprecedented new data systems and data access. Much about the U.S. healthcare system and its performance is unknown, as it is locked up in proprietary databases or inscrutable paper records. Moving medical practice into the 21st century by promoting electronic medical records systems is another goal of the ACA.

The next logical step is to tie all these goals together: harness the data to inform comparative-effectiveness research, use that research in the practice of accountable medicine, and develop payment-system incentives to drive the chain of innovation in quality and efficiency. Changes such as these may sound like an impossible dream or a Draconian nightmare. Yet, if the U.S. is going to develop the health system those in the U.S. want, the one many Americans mistakenly think is already in place, such incremental, quality-focused, evidence-based reform is not a choice. It is an imperative.

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