Consumerism And Payment Reform: Seeking To Create A More Perfect Union

by Peter V. Lee

Customer-Directed Healthcare Reform with Episode Pricing
edited by Douglas Emery
(Mason, Ohio: Thomson, 2006), 208 pp., $39.95

Promoting market forces through "consumerism" is increasingly described as the silver bullet to the health care system's dysfunctions. At the same time, many critics have challenged its applicability when consumers have little information but many urgent needs and when most decisions are made for them by others. Often the debaters rehash ideologies, instead of proposing practical solutions.

In *Customer-Directed Healthcare Reform with Episode Pricing,* editor Doug Emery and contributors discuss how a "bottom-up market oriented strategy"—centered on organizing payment and care delivery around episodes of care—holds out the promise of being more patient-centered and cost-efficient and delivering higher quality. The book's strength lies in bringing together contributors who describe in both theoretical and concrete terms how to make the payment system part of a solution, rather than an impediment to progress. However, far too many of its chapters idealize this strategy as the "one truth" and scapegoat "managed care orthodoxy."

At the core of the "episode orthodoxy" is a well-framed discussion of how to consider differently the three major types of risk in health care: probability risk (the uncertainty of unknown future events—the classical risk for which insurance is purchased); technical risk (the uncertainty associated with how a particular patient will fare once a condition is known—these are risks largely controllable by practitioners based on their expertise and organization); and choice-utility risk (the risk undertaken by consumers in choosing particular paths, which requires consumers to have information that they can act upon).

Under fee-for-service (FFS) payment, providers avoid exposure to all three types of risk and therefore have shown little interest in managing any of them. Under capitation, providers are exposed to all three. The lesson of the 1990s—learned the hard way by many medical groups—is that very few providers were able to effectively manage probability risk, and many struggled with choice-utility risk, especially as direct-to-consumer (DTC) drug advertising flourished.

There is no doubt that wider testing of episode-based pricing would be worthwhile. One of the merits of this book is its description of four attempts to do so: the Centers for Medicare and Medicaid Services' Heart Bypass Center demonstrations; Anthem's Cardiology Services Network; the Oxford Specialty Management program; and Utah's Designated Service Provider program.

Each program showed substantial financial savings and improvements in clinical quality; some showed improved patient experience. So why hasn't episode pricing swept the health care market? The four programs constitute a grim picture of inadequate legacy information systems; consumer confusion; entrenched providers; regulatory concerns; and lack of consistent, committed leadership when the status quo appears "good enough."

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DOI 10.1377/hlthaff.25.4.1182

The authors specify how some of these problems can be addressed. The chapter on creating information systems clearly articulates the value of a "new class of information intermediaries" that could transform unconnected data into information that can be acted upon. The challenge of engaging patients is insightfully described as one not just of getting them to be "better consumers," but also of getting them to be contributors of information, supported with tools that accommodate their skills and needs. The authors describe how the creation of usable information requires greater focus on creating outcomes measures, recognizing when process measures are appropriate, and assuring appropriate risk adjustment.

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Some providers might see episode payment as dangerous because it could penalize them for the "quality of the colleagues or institutions they choose." This is precisely the danger our system desperately needs. Today, outside of integrated delivery systems, there is no mutual accountability for referrals made or for coordination (or the lack of it) among providers. Even more than consumers, physicians should be encouraged to ask about the quality and efficiency of those they work with and refer patients to—and should be held accountable for acting on that information.

The problems are daunting, but they underscore the need to promote better health information technology, payment reform that aligns incentives not only with quality but also among the many stakeholders, and the need to engage consumers with usable tools. America's health care system cannot wait for the "episode nirvana" held out by Emery and his colleagues, but their contribution is to identify the flaws of current systems and a potential path to better ones. Providers' reward for efficient resource use and good outcomes might be in the form of episode-based payment, but it could also be in the form of identifying high-performance networks and changing payments to actively factor in the quality of care delivered, as illustrated by FFS augmented by pay-for-performance bonuses.

The underconnected nature of the book's chapters means that there are inconsistencies. One chapter lauds disease management vendors' use of call centers that apply "standardized assessment tools and care plans" as one example of the "focused factory" needed to address the "fragmented way in which health care services [to the chronically ill] get delivered" (p. 30). A following chapter describes programs with a "bank of nurses armed with algorithm-based computerized protocols" as a prime example of the "demand management" (p. 181) systems used to avoid providing needed care.

Referring to articles from 1995 claiming that organized delivery systems "made money" by institutionalizing delays and difficulties in making appointments bears little resemblance to the large groups across the country that have launched same-day access programs and demonstrated repeated clinical performance that is better than disintegrated care. Other chapters laud these same demons by appropriately applauding the benefits of integration in describing the work of Hill Physicians in California and Park Nicollet in Minnesota.

The authors put so much stock in market forces and in episodes of care as the way to organize both payment and care delivery that they seem to forget one thing: Health care is about treating whole people, not merely bundles of episodes. A "focused factory" that does a great job with heart disease might not do so well for a depressed patient with multiple chronic illnesses. Whether one agrees or disagrees that episode pricing represents the silver bullet required to address the U.S. health care system's ills, we're all fools if we think that we can fix our system without changing how we pay for care, leadership, testing new ideas, and building on the best-known care delivery methods.