

Prescriptions for Better Health Care: What Greater Cleveland Can Learn from Other Regions

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Two Issues In Health Care

1. Should areas try to be health care magnets?
 - Biotech and big pharma?
 - NIH money?
 - 'Let's get everyone else to spend more.'
2. What would a good medical system be like?
 - 'Let's spend less.'

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Organizing a Health System

- What does it mean to be a high quality health care market?
- How can an area achieve that?

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Preview of Findings

- The health system is good ... but good isn't good enough.
 - We need the 21st century health care system.
- *Local* action is the priority.

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Dimensions of Comparison

- System Organization
- Costs
- Access
- Quality

- We don't have perfect measures for all of these, but we can do pretty well.

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Summary Information for Target Markets, 1995-1996

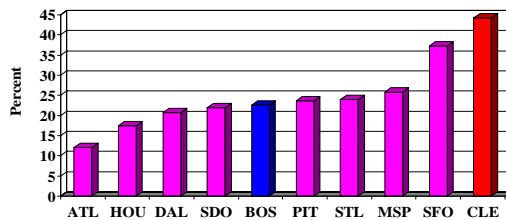
Market	Total Population (1995)	Medicare Enrollees (1995)	Acute Care Beds per 1,000 Residents (1995)	Physicians per 100,000 Residents (1996)	Specialist Physicians per 100,000 Residents (1996)
ATL	4,200,842	352,220	2.9	173.0	115.5
BOS	4,456,609	536,340	2.6	260.4	174.7
CLE	2,115,071	274,040	3.4	210.2	138.1
DAL	4,894,326	407,080	2.8	163.4	108.9
HOU	4,654,165	325,460	3.4	171.3	117.1
MSP	3,659,195	349,700	2.5	174.3	102.0
PIT	3,057,775	509,880	3.6	191.9	126.4
SD	3,006,551	156,340	1.9	194.1	132.1
SF	3,433,446	252,480	2.1	248.8	160.6
STL	3,202,811	404,240	3.6	182.3	117.9

Source: Dartmouth Atlas of Health Care, 1998

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The Largest Hospital System is Very Large

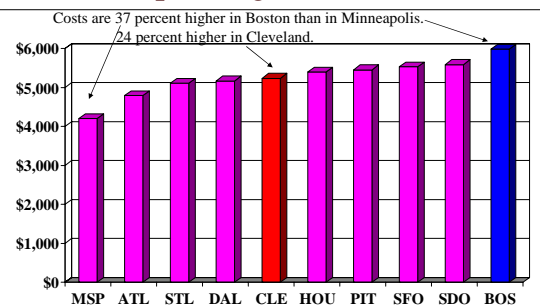
Share of Admissions in Largest Hospital System, 2002



Source: AHA data.

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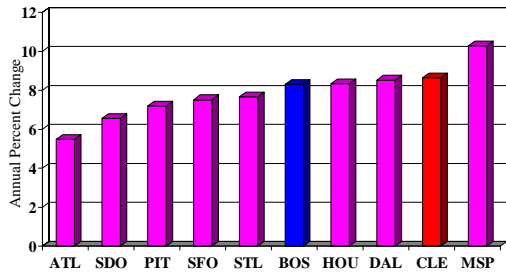
Medicare Spending Per Enrollee, 2001



Note: Medicare Part A and B reimbursement excluding skilled nursing, home care, and long-stay inpatient care.
Source: Dartmouth Atlas of Health Care, 2001

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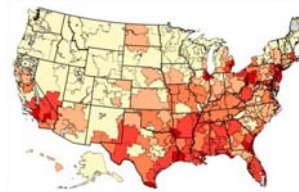
Annual Percentage Change in Average FEHBP Family Premiums, 1997-2004



Source: FEHBP

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Medicare spending, Health Care Resource Levels, and Other Key Attributes of U.S. HRRs



Attributes of U.S. HRRs in Different Quintiles of the HRRs, 01*

Variable	Quintile of HRRs, 01					Ratio (Highest to Lowest)
	1	2	3	4	5	
HRRs, 01†	10,400	11,000	12,000	14,000	14,000	1.41
Per capita Medicare spending, 01†	4000	4000	4000	4000	4000	1.00
Hospital characteristics†						
Control (percent)	2.6	2.6	2.6	2.6	2.6	1.00
Beds in teaching hospitals, 01	16.2	16.1	15.8	16.0	16.1	1.00
Beds in hospitals with < 100 beds, 01	17.0	17.0	16.7	16.8	17.0	1.00
Physician supply (per 10 000), 01	180.6	180.4	180.4	180.4	180.4	1.01
General internists	29.0	29.0	29.0	29.0	29.0	1.00
General obstetricians	21.9	21.4	21.6	21.5	21.9	1.00
Family practitioners/GPs	29.0	27.1	27.0	27.0	28.2	1.00
Surgeons	40.0	40.0	40.0	40.0	40.0	1.00
All other specialists	69.8	69.8	69.8	69.8	69.8	1.00
Medicare enrollment in HRRs, 01	12.1	8.8	7.3	7.7	10.8	1.28
Enrollment in non-teaching areas, 01	27.0	40.0	40.0	39.0	39.0	1.00

Notes: 01 = first of 10 3-digit ZIP codes; GP = general practitioner; HMO = health maintenance organization; HRR = hospital referral region.

*Average age was not available for HRRs for the control spending on hospital and physician services in the HRRs within each quintile for Medicare enrollees age 65-99 years who were in that tier 6 months of the year (data not available).

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‡Key attributes and average per capita supply of the specified medical resource in the HRRs within that quintile. Per capita supply is calculated per 1000 in per 10 000 residents of the general population within the HRRs, 01.

Source: Fisher, E. S. et al. *Ann Intern Med* 2003;138:273-287

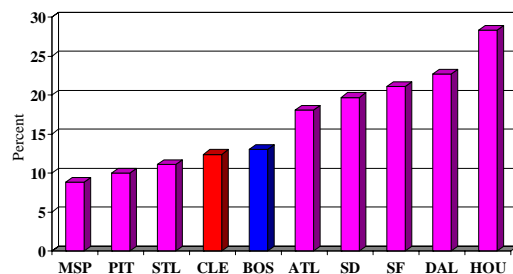
Annals of Internal Medicine

Cost Conclusions

- Boston is very high cost; Cleveland is high, though not as high.
 - Costs in both areas are higher than they need to be.
 - Cost increases in both areas are about the same as in the rest of the country.
- Where there's a surgeon, there's an operation.

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Uninsured as Percentage of Total Population, 1997



Source: <http://www.census.gov/hhes/ahhs/historic/hhltat6.html>

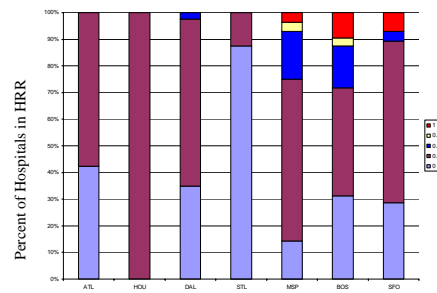
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Access Conclusions

- Boston and Cleveland do fairly well on access
- ...
- ... however, high costs do limit access
 - 16,000 more people would be insured if premiums in the Boston MSA fell by 10 percent.

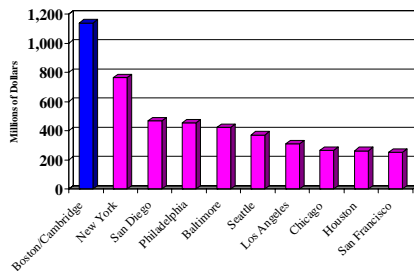
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Process Measures—Computerized Physician Order Entry



Key definition: 1: The hospital fully put into practice Leifrog's safety practice; 2: The hospital has made good progress; 3: The hospital has made a good early stage effort; 4: The hospital has not yet made a good early stage effort; 5: The hospital did not provide this information
Source: <http://leifroggroupdata.org/>

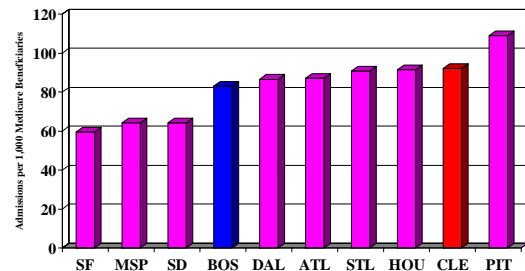
Top 10 Recipient Cities of NIH Funding, 1998



Note: 43% of the Boston total went to hospitals, 21% went to medical schools, and 19% went to other colleges or universities.
Source: NIH; Standard & Poor's/DRI; PriceWaterhouseCoopers

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Medicare Admissions for Ambulatory Sensitive Conditions, 2001



Source: Dartmouth Atlas of Health Care, 2001

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Quality Conclusions

- The top institutions in the country do ok with respect to basic process and outcome measures.
 - Other institutions do less well.

- Overall, the system is good.

- But good isn't good enough, especially given what we're spending.

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What Would It Take to be the 21st Century Health Care System?

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Big Changes Are Needed

- Changing payments for a small share of patients in an area is guaranteed to have poor results.

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Goals

1. Cost reduction of 10 percent relative to the nation over the next decade.

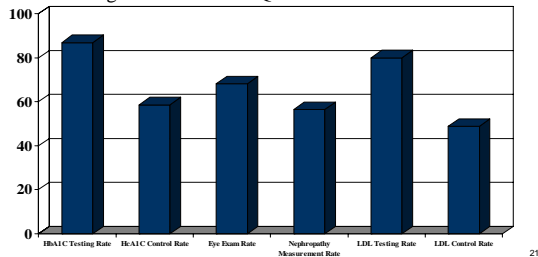
2. Hospitals universally adopt leading process of care measures, as defined by Leapfrog Group
 - Computerized Physician Order Entry systems (CPOE)
 - Staffing in ICUs
 - High volume for conditions where there is substantial learning-by-doing

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Goals (continued)

3. Improvement in clinical quality

■ Cutting shortfalls in NCQA scores in half



Source: NCQA

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Quality Can Improve: Diabetes Management at HealthPartners

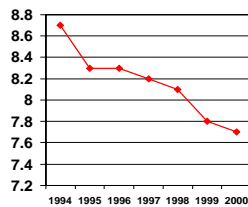
Primary Components of Diabetes DM Programs:

- * Dissemination of guidelines
- * Provider education
- * Member education
- * Screening programs
- * Performance feedback to physicians
- * Patient reminders
- * Case management
- * At-risk lists

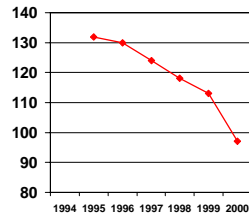
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Clinical Results

Mean HbA1c

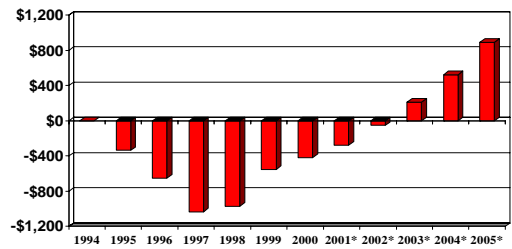


Mean LDL



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But Quality Doesn't Pay



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Goals (continued)

4. Commitment to widescale measurement and data dissemination
 - Hospitals, physician groups, and insurers

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Key Ingredients To Make It Happen

- A significant degree of provider integration
- Agreement among important actors
 - Insurers
 - Big *and* small hospitals
 - Physicians
 - Large Employers
 - Government
- An (independent) idea factory/implementer

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The Medical-Industrial Complex

- Economists are generally wary about picking winners
 - Japan v. Latin America in the 1950s
 - Cold fusion
- But health care has all the features of the next computer era
 - People want the stuff
 - It has a lot of spillovers

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If I were giving advice to the mayor...

- Lure health research as much as possible
- Play up Universities
- Businesses like:
 - A generally educated workforce
 - Areas with a lot of amenities

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