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.'

Organizing a Health System

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

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.

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

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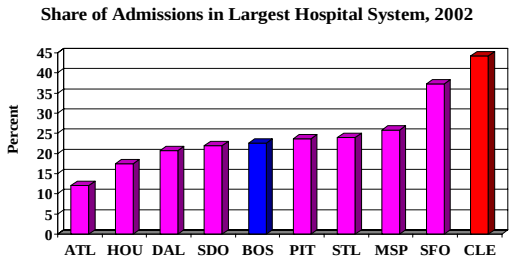
Source: Dartmouth Atlas of Health Care, 1998

The Largest Hospital System is Very Large



Source: AHA data.

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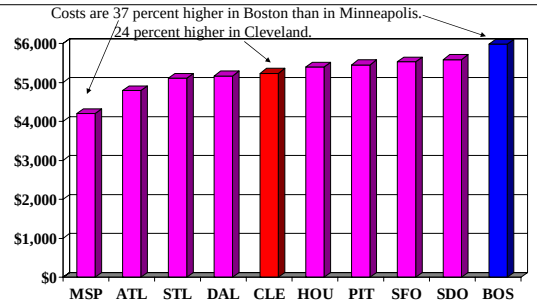
Medicare Spending Per Enrollee, 2001



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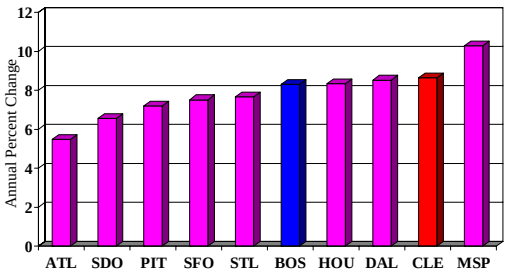
Note: Medicare Part A and B reimbursement excluding skilled nursing, home care, and long-stay inpatient care.

Source: Dartmouth Atlas of Health Care, 2001

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



Source: FEHBP

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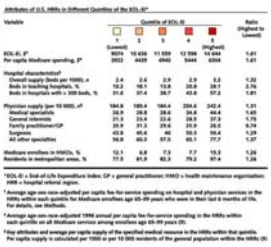
Medicare spending, Health Care Resource Levels, and Other Key Attributes of U.S. HRRs



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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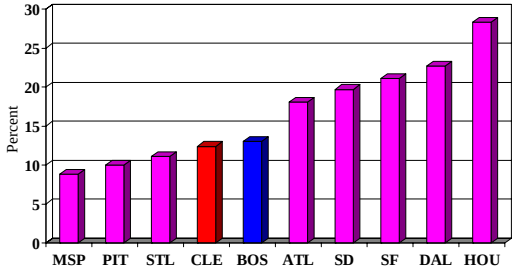
Uninsured as Percentage of Total Population, 1997



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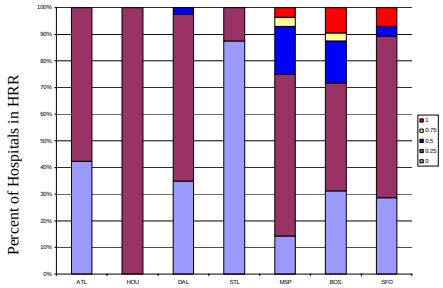
Source: http://www.census.gov/hhes/hlthins/historic/hihist6.html

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.

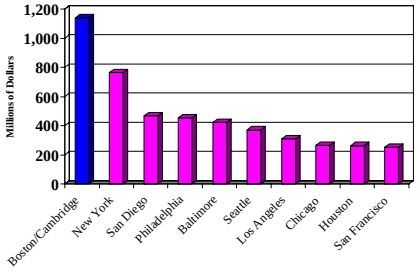
Process Measures–Computerized Physician Order Entry



Key definition: 1: The hospital fully put into practice Leapfrog's safety practice; .75: The hospital has made good progress; .5:The hospital has made a good early stage effort; .25: The hospital has not yet made a good early stage effort; 0: The hospital did not provide this information

Source: http://leapfroggroupdata.org/

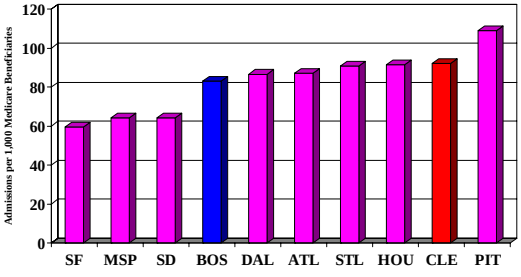
Top 10 Recipient Cities of NIH Funding, 1998



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

Medicare Admissions for Ambulatory Sensitive Conditions, 2001



Source: Dartmouth Atlas of Health Care, 2001

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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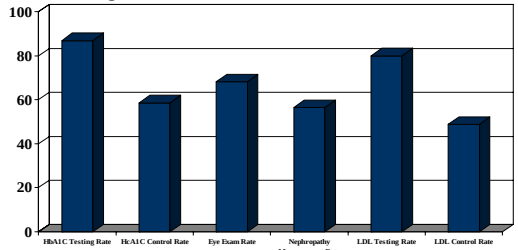
Goals (continued)

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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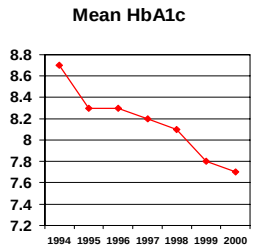
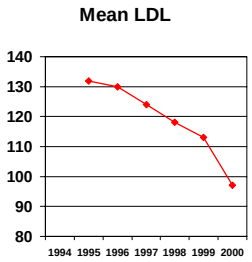
Clinical Results





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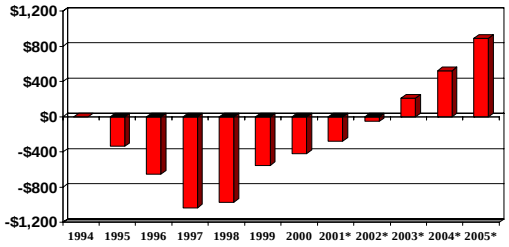
But Quality Doesn't Pay



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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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