

A supply-side approach to health care

By Karen Davis
Special to *The Seattle Times*

Starbucks has just joined a prestigious club. But membership has come at a high cost.

Chairman Howard Schultz says he now spends more on employee health coverage than on materials to brew his profitable coffee. Thanks to double-digit increases, the company will spend \$200 million this year on health care.

Schultz's problems are not unique. Costco, Microsoft and Boeing are in the same boat. Nationally, it is more of the same. America's carmakers have sounded similar alarms.

If something is not done soon, the number of uninsured and underinsured will grow as more employers scale back benefits or quit extending coverage to workers altogether.

So what can be done?

Here in King County, health costs are rising rapidly. This has led employers, providers and health plans to form an unusual collaboration — the [Puget Sound Health Alliance](#) — to lower costs and improve quality. I applaud their effort — and I know they're learning that the answers are never easy.

For too long, employers and others trying to reduce health costs have focused on the demand side of health care, looking for the quick fix. But expediency has come at a cost, leading to more fragmentation and complexity. Instead, they need to look at the supply side of the health-care market to find solutions. Here are 10 supply-side approaches that show promise:

- *Reduce high-cost hospitalizations.* A fifth of congestive-heart-failure patients are readmitted within a month of leaving the hospital; half are readmitted within a year. If patients were given better information on how to maintain good health and were better managed, up to half of these readmissions could be prevented. Insurers need to cover this service.
- *Reduce variation in payment for care of patients with similar conditions.* Researchers have reported wide variation in Medicare charges for patients with the same condition, largely due to the number of physicians involved, geography and lengths of stay in intensive-care units. It makes no sense for insurers to pay widely different rates for comparable care and similar outcomes.
- *Reduce overuse of medical procedures.* There is extensive discussion about overuse of health services, but little attention paid to measuring the problem. Informing patients about risks and benefits of treatments, such as surgery versus medical management, should be a condition for approval of procedures. Physicians also need to better manage patients taking multiple medications to reduce overprescribing and drug interactions.
- *Stop paying for medical errors.* Medicare pays hospitals more when patients experience complications, even when they are caused by preventable medical errors such as hospital-acquired infections, falls or medication errors. This should not be allowed. In Minnesota, one health plan has stopped paying for specific medical

mistakes identified by a national quality group. These are mistakes that should never happen, such as wrong-site surgery. The plan is drawing a largely symbolic line between what is acceptable and what is not.

- *Negotiate pharmaceutical prices.* U.S. drug prices are twice as high as that of many other countries. There are ways to control these outlays. Medicare should negotiate prices to a consistent level with other major industrialized countries or base reimbursement on the lowest-cost-effective drugs and use the savings to get more seniors covered for prescription drugs.
- *Standardize insurance products to reduce administrative costs.* Simplifying and standardizing private insurance could significantly reduce administrative expenses. Health providers incur major administrative expenses due to variations across benefits covered, payment regulations and coverage policies. Standardizing products and promoting common practices across all insurers could save administrative costs.
- *Use evidence-based medical guidelines for tests or procedures.* Establishing and following clinical guidelines for medical procedures could achieve significant savings and promote better care. In one example, a hospital encouraged obstetricians to follow clinical guidelines and induce labor after at least 39 weeks rather than earlier. As a result, total maternal and neonatal variable costs were reduced by \$300 per case over one year.
- *Ensure that every patient has a regular provider to coordinate and manage care.* Three-fifths of uninsured patients lack a regular doctor. About half of the uninsured receive their usual care from emergency rooms. Many state Medicaid programs have demonstrated savings from primary-care case management. Other payers should follow this lead. All enrollees should have a regular provider who ensures preventive care and manages their chronic conditions.
- *Reduce duplication.* Lack of care coordination is a pervasive problem. Many sicker adults report having duplicate tests performed by different health professionals or lacking necessary test results when they visit a physician. Antiquated paper-based information systems are often the culprit.
- *Implement modern information technology.* Savings would be easier to achieve if health-care providers used updated information-technology systems. Such systems can lower administrative costs, reduce medical errors, and make it easier to retrieve test results and review medications. They also can give physicians timely access to complete medical histories, which can help avert hospitalizations.

It is time to devote the necessary resources to study and test out the utility of these "supply-side" approaches. None will be painless to implement but these are real-world examples that could not only save money but also save lives.

Karen Davis is president of the Commonwealth Fund, a national philanthropy focused on improving health-care access and quality. She is scheduled to deliver Group Health Cooperative's sixth annual "Hilde and Bill Birnbaum Lecture on Benefiting Patients through Health-care Research," in Seattle today.

end