



**Statement of Debra L. Ness
President, National Partnership for Women & Families
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Good morning Senator Wyden. Thank you for this opportunity to speak today on the need for reform of our health care delivery system. The National Partnership for Women & Families is a non-profit, non-partisan advocacy organization with three and a half decades of experience promoting access to quality health care, fairness in the workplace, and policies that help women and men meet the competing demands of work and family. Over the past decade, our work to expand access to quality, affordable health care has grown in urgency and importance. Health care is central to the well-being of women and families. It is a key determinant of their quality of life, their economic security, and their ability to thrive, prosper, and participate in our society. Indeed, ensuring that all individuals have access to quality health care will be a key determinant of our nation's vitality. I am particularly pleased to engage in this discussion with you because of your leadership and commitment to improving our nation's health by introducing the first bi-partisan health care reform proposal in over a decade, the "Healthy Americans Act". We share many of the same ideas, and I look forward to further discussion on them.

Meaningful Reform Must Address Quality, Cost and Coverage

There is no question that our current system is unraveling. Quality and safety problems are rampant, costs are out of control, and we are faced with historic levels of Americans who lack health insurance, are underinsured, or live in fear of losing the coverage they have. The need for reform is clear and urgent. There is growing consensus that we must, as a nation, make quality, affordable health care available to all individuals. But we must also recognize that we cannot achieve this goal without *comprehensive reform of our current delivery system*. The foundation for meaningful reform lies in shared recognition that current quality is unacceptable, costs are unsustainable, and the lack of coverage is inconsistent with basic American values. Meaningful reform must recognize that *quality, cost, and coverage are inextricably linked and inseparable in our quest to achieve a health care system that delivers quality, affordable health care for all*.

Unsustainable Costs Make Care Unaffordable and Deplete the Resources Available to Expand Coverage

There is no question that the continuing escalation of health care costs is not sustainable. The burden of cost is shared by all but falls most heavily on consumers. From 1999 to 2007, average

employee contributions to their health insurance rose by 102 percent, while average wages only increased by 3 percent. Earlier this month, the Senate Finance Committee heard testimony on the rising costs and poor quality of our health care system in relation to the rest of the world. By any measure, U.S. spending on health care is greater than other developed countries. In 2006, the United States spent \$2.1 trillion, or 16 percent of GDP, on health care, translating to \$7,026 per person annually. And from 2007 to 2017, government economists expect U.S. health care spending to almost double from roughly \$2.2 trillion to \$4.3 trillion, while the share of GDP devoted to health care is expected to grow from 16.3 percent to 19.5 percent.

Higher Costs Are Not Buying Better Quality – Quality and Safety Problems Are Rampant

Even worse, all the money we are spending isn't buying us better health. Quality is abysmal. While we have some of the brightest, best trained, and most committed health care professionals in the world, we know that patients are not getting the best care in the world. Whether it's the wrong diagnosis, the wrong operation, the wrong medication – preventable medical errors kill more than 180,000 Americans each year. And two million of us acquire infections every year in the very hospitals that are supposed to make us well. As Beth McGlynn, with the Rand Corporation, said in her testimony to you earlier this month, on average Americans only get the right care for their condition 55 percent of the time. And quality varies widely depending on where you live. The research published in the Dartmouth Atlas documents dramatic differences in treatment patterns throughout the country. For example, in Elyria, Ohio – also known as the “stent capital” of the United States – Medicare beneficiaries receive angioplasties at four times the national rate. While no one is claiming doctors in Elyria are intentionally providing inappropriate care, there is no evidence that their patients are better off than patients in other parts of the country who are treated less expensively and less invasively. We do, however, know that Medicare is paying over \$11,000 for each angioplasty.

For women and people of color, quality care is even further out of reach. They tend to receive lower quality health care, even when insurance status, income, age, and severity of conditions are accounted for.

For example:

- It is estimated that 16 to 30 percent of the 600,000 hysterectomies performed each year are unnecessary. With complication rates of 25 to 50 percent, this means that 24,000 to 90,000 women unnecessarily suffer complications such as severe bleeding, bowel or bladder injury, infection, blood clots, depression, or heart attack.
- Women who are having a heart attack are 39 percent more likely to be incorrectly diagnosed than men.
- In 2002, African American women were 36 percent more likely to die from breast cancer than white women.
- Medicare beneficiaries with limited English skills are less likely to receive cancer screening services, such as mammograms, than those who speak English.

Poor Quality Has High Cost – 1/3 of Health Care Dollars Are Wasted

These quality problems not only have human costs – there are also huge financial costs. A full one-third of our health care spending is wasted on medical mistakes and poor quality care, and billions of dollars are lost while millions go uninsured. To take just one example, according to the CDC, preventable hospital acquired infections result in up to \$27.5 billion in additional health spending every year.

Current Payment System Is Driving These Cost And Quality Problems

We can see the cost problems. We can see the quality problems. And we can see the enormous costs of these quality problems. But perhaps the most important thing for us to see is how the payment system itself is actually *driving* both these cost and quality problems. The delivery system we have, not surprisingly, largely reflects our payment system. In many ways, our system perversely rewards the very things that drive up health costs and undermine quality, causing millions of patients to get care they don't need or, worse, care that makes them sicker.

We have a payment system that rewards volume regardless of quality or outcomes. It is a system that pays for procedures and services regardless of whether they are appropriate or needed. It is a system that values expensive technology over patient-centered care, and pays for acute care but not the primary and preventive care that keeps people from getting sick in the first place. It is a system that pays the same whether the quality is good or not.

The Dartmouth Atlas research has shown us that volume of services patients receive, and the cost of care in an area, are highly correlated with that area's concentration of specialists. In essence, the supply creates its own demand. Yet more is not better. The Dartmouth research has also consistently shown that patients in parts of the country where medical spending is the highest usually do no better – and often fare worse – than patients where spending is the lowest. The most recent edition focused on Medicare spending in the last two years of life at major medical centers. The most extravagant, UCLA, averaged \$93,000 per patient. The Mayo Clinic, by contrast, averaged only \$53,000 per patient. Yet the patients at UCLA lived no longer than those at the Mayo, and on a number of quality indicators Mayo outperforms its rivals.

We Can Realign Payment Incentives to Both Improve Quality and Control Costs

We have the capacity and resources to provide the best health care in the world. We have stellar institutions and highly committed health care professionals. And when we do it right, no one can beat us. But the sad fact is - more often than not - we don't do it right. A 50/50 shot at getting good care is simply not good enough.

The good news is that we can realign the payment system to help us do better without spending more. We can re-align incentives to drive quality improvement and foster better use of our health care resources. To get to better quality, we don't need to pay *more*, we need to pay

smarter, and by paying smarter, we can change the way care is delivered, improve quality, and have more resources to expand coverage.

The Path Forward – Putting Patients First

Providing high quality, patient-centered care should be the goal that guides both changes in payment and redesign of delivery. It means designing a system that focuses on ensuring that every patient gets the **right care, at the right time, for the right reason**. Ironically, putting the patient first requires a major paradigm shift for our current system. It calls for significant change both in what we provide and how we provide it.

I outline below five areas essential to achieving these goals.

Enhance Primary and Preventive Care

First, we need to improve incentives for the effective delivery of comprehensive, life-long preventive and patient-centered primary care. Access to good primary care is proven to keep people healthier, improve patients' experience with the health system, and reduce overall health spending. Because traditional primary care services are woefully undervalued by our current payment system, we need a new model of payment and care delivery. One compelling and promising approach is the "patient-centered medical (or health) home." At its most optimal, the medical home is envisioned as a way to provide a comprehensive, continuous source of primary care for people of all ages and conditions. The American Academy of Pediatrics defines a medical home as accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally sensitive. And when it's done right, the medical home has great potential to both improve quality and reduce costs. There is, in addition, emerging evidence that when individuals have access to a medical home, racial and ethnic disparities in access and quality are reduced or even eliminated. And the savings can be significant. In North Carolina, the medical home initiative in the Medicaid program saved \$231 million in the first two years.

While the medical home model holds great promise, it will only succeed if we can ensure that it is truly patient-centered, crafted in a way that benefits patients and families first and foremost, and is embraced by consumers as an effective way to receive health care. Many consumers will remember the "bad old days" of gatekeepers and HMOs, and need to trust that the medical home is not just the latest attempt by employers and health plans to save money. To date, there has been encouraging work done to clearly define the systemic components of a patient-centered medical home, and to determine how best to pay for this new form of care. But we still have a great deal of work to do to understand what patient-centered care really means, and what it will take to achieve it.

Measure-Report-Reward

Second, we need a more transparent and accountable health care system. This means we need to measure the quality of care patients receive, publicly report the results, and reward providers who deliver high value care. We know this: measurement and public reporting drive significant

gains in quality of care. For example, in 1996, only about 62 percent of eligible heart attack patients received beta-blockers. Then health plans began to measure beta-blocker use and by 2003, the rate improved to 95 percent. Similarly, in Pennsylvania, hospitals' inpatient mortality rates plummeted from above the national average to well below the national average after implementation of hospital-specific public performance reports. The Pennsylvania Health Care Cost Containment Council (PHC4) has been operating for more than ten years and releases an annual report on hospital performance, including re-admission analyses. The Council estimates that the improvements resulting from its measurement and public reporting efforts represent the equivalent of over 19,000 lives saved and \$740 million in saved health care costs.

Collecting good data on race, ethnicity, and language along with quality metrics can also drive significant improvements in the care received by people of color. "Expecting Success", a Robert Wood Johnson Foundation-funded project to help hospitals improve quality and reduce disparities in cardiac care, found that simply by tracking data on patients' race, ethnicity, and primary language, hospitals are better able to understand their patient populations, track how they are doing on quality metrics for these populations, and pinpoint and address problem areas.

Measuring the way health care providers perform also allows us to hold them accountable, which leads to improvements in care that save lives. And evidence is mounting that it is cost-effective. Both public and private purchasers can help drive dramatic improvements in cost and quality by adopting value based purchasing. A CMS-run demonstration project with the Premier hospital system has provided groundbreaking evidence that changing payment incentives can generate better patient care, reduce costs, and save lives. Hospitals in the demonstration were required to report on their performance on a series of quality measures for patients with conditions such as heart disease and pneumonia. Those hospitals that performed the best received a higher payment than others. The results were dramatic. Participating hospitals improved clinical quality and outcomes by an average of 17.3 percent and saved an average of \$1000 per patient over the first three years. In just one clinical area – heart attacks – the hospitals estimated they saved an additional 1300 lives.

CMS needs to build on this demonstration project and become a more active purchaser of health care goods and services through value-based purchasing. As the nation's largest purchaser of health services, the Medicare program serves as a key lever in driving payment changes. If the Medicare program moves away from simple fee-for-service, and towards paying for the delivery of appropriate, high quality, efficient, equitable, and patient-centered care, other purchasers will follow. Incentives should be based on provider performance and should promote savings by rewarding care that is clinically effective. It also means not paying for bad care. CMS is starting to move in the right direction on this by refusing to pay for hospital acquired infections and other serious adverse events. Congress should move quickly to give CMS additional authority to implement value based purchasing, first for hospitals, and eventually, for physicians. Senator Wyden, I commend you for including in your legislation, the Healthy Americans Act, provisions to support better and broader performance measurement and reporting.

Adopt Health Information Technology

Third, we need comprehensive adoption of interoperable, secure and confidential health information technology and exchange (HIT). It is the essential platform for transparency. Specifically, it will speed the use of quality measures and facilitate public reporting of quality information that is meaningful to providers, patients, and payers. It will also accelerate clinical decision support that can improve quality and safety. We should ask ourselves – why is it that L.L. Bean knows exactly what size and style of sweater I bought in 2003, but my own doctor may not know what lab tests I received last week? We have the technology available to ensure that accurate and actionable medical information is available in a secure and private form when and where it is needed, for both patients and clinicians.

That's why I want to commend you and your colleagues on the Senate Finance Committee for including in this year's Medicare bill a provision to drive adoption and use of e-prescribing. This is a critical first step to empower patients, physicians, pharmacists and payers to reduce medication errors, enhance informed decision-making, reduce costs and, most importantly, save lives. In July of 2006, the Institute of Medicine (IoM) estimated that preventable medication errors kill an estimated 7,000 Americans each year and injure nearly 1.5 million more. Encouraging, and then requiring, broader physician adoption of e-prescribing through Medicare will help physicians avoid 1.9 million adverse drug events over the next ten years. Senator Wyden, I commend your leadership on this issue, and also for including in your health reform legislation provisions to encourage even broader adoption of electronic health records and health information exchange.

Know What Works

Having health information technology and the means to exchange information will do us little good if we don't foster and support better and more reliable information about the effectiveness of care, including the relative benefits, risks, and costs of treatments and services. We need a robust federal commitment to comparative effectiveness research so that health professionals can ensure each individual patient gets the care that's right for them. We currently have a nearly \$60 billion annual investment in biomedical research. The output of all this research presents enormous opportunities for improving patient care, but is more than any one patient or physician could possibly absorb. Unfortunately, we currently spend only a minimal amount on the effectiveness research that will build an evidence base to help patients and physicians determine what care is right for them.

We should build on the critically important work done by the Agency for Health Care Research and Quality and ensure that comparative effectiveness research is driven by a transparent, priority-setting process that reflects the views of all stakeholders – most especially consumers. The research process must itself be transparent and credible to all stakeholders. The findings must be translated and communicated in ways that are accessible to the audiences that will benefit most – doctors and consumers. And, most importantly, the entire process, from identification of priorities to dissemination of findings, must be independent and immune from special interests and political influence.

Comparative effectiveness research is essential to reforming our delivery system. We need it as a nation, to meet the urgent imperative to allocate our health care resources more effectively. We need it so that doctors and other health professionals can better understand the relative merits of diagnosis and treatment options, and we need it as consumers, so we can make the best possible decisions for ourselves and our families, and spend our health care dollars as wisely as possible.

Empower Patients

Finally, we need a health care delivery system that helps empower patients to recognize and demand high quality care, to make sound health care decisions, and to become true partners – with their physicians – in managing their own care.

Information on Cost and Quality

We need a more transparent health care system that makes meaningful and reliable information about quality and cost available to consumers. Today, you can get more information about the toaster oven or TV set you want to buy than about your pediatrician or cardiologist. Consumers have a right to information about the quality, cost, and relative effectiveness of the providers and treatments they choose, but today they are forced to make most of these decisions in the dark. We simply cannot expect consumers to make wise decisions about how to spend their health care dollars without the right information.

Better Benefit Design

We also need to design benefits that give consumers incentives to make truly value-based decisions. That means ensuring that consumers have information about cost and quality and that incentives aren't simply designed to encourage consumers to choose the cheapest care. Would anyone ask a new mother to go out and find the cheapest pediatrician? Or a heart attack victim to find the cheapest cardiologist? We also need to design incentives that encourage consumers to seek out the primary and preventive care that will keep them well, to choose the highest value care when they get sick, and to support their efforts to effectively manage their chronic conditions. Benefit re-design based on value can dramatically achieve both better health outcomes and lower costs. For example, in 2001, Pitney Bowes lowered co-payments for asthma and diabetes medications for their employees. They reported a \$1 million savings from reduced complications.

Cultural Effectiveness and Language Access

Part of patient-centered care also means encouraging physicians and other health care professionals to provide care that is culturally effective and supports linguistically appropriate services. By 2050, the majority of the U.S. population will consist of people of color. Cultural and language barriers are key factors in the widening disparities based on race and ethnicity. Research shows that when providers are sensitive to the cultural needs and preferences of their patients, the care is higher quality and results in improved health outcomes.

Shared Decision-Making

Lastly, to truly transform our delivery system into one centered on the patient, we need to develop better tools and approaches to help consumers make decisions about their care. The

Foundation for Informed Medical Decision Making is doing ground-breaking work in this area. They are developing tools that enable patients to actively engage in decision-making with their providers. These tools provide patients with evidence-based, unbiased information about their range of treatment options. They enable patients to weigh the pros and cons, costs and benefits, and make a decision about their care that is consistent with their personal circumstances and values. There is growing evidence that when consumers have accurate information about treatment options and alternatives, they tend to make more conservative, less invasive, and less costly decisions. And those decisions often result in better outcomes. Without this kind of information, most patients rely on their doctors, whose recommendations may be rooted in practice patterns that reinforce the “more is better” mindset that permeates our health care system. The Foundation for Informed Medical Decision Making points out that for 70 percent of people who have a heart bypass operation, the result would have been the same if they had chosen medication alone. Many of those patients were probably unaware that they had more than one treatment option, and might have chosen differently.

Conclusion

Senator Wyden, I look forward to working with you and everyone in this room to achieve access to high quality, affordable care for all Americans. But we must also recognize that we cannot achieve this goal without comprehensive reform of our current delivery system. Meaningful reform must recognize that quality, cost, and coverage are inextricably linked and inseparable in our quest to achieve a health care system that delivers quality, affordable health care for all.