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2006 International Symposium On Health Care Policy: What is a High Performance Health Care System and How Do We Get There?
Commonwealth Fund and Alliance for Health Reform
November 3, 2006

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ED HOWARD: ...Let's get started if we can, and we'll try to keep as close as we can to the schedule that's on your agenda so that we can maximize the time for discussion, get you involved early.

I'm Ed Howard with the Alliance for Health Reform. Some of you – I can't imagine that this is true – but some of you may not know what the Alliance for Health Reform is. We've been, for the last 15 years or so, doing bipartisan non-biased programs for Congressional staff and media and the health policy community here in Washington. Our Chairman is Jay Rockefeller, a Democrat from the state of West Virginia, our Vice Chairman is Bill Frist, a Republican from the state of Tennessee. And our goal has been, and continues to be, that the policy disagreements on health care in Washington are just that. Disagreements on policy and not on facts. And so our job is to try to get the best people on different sides of most important issues, get them together, let them talk through what the issues are, let you be exposed to the arguments on both sides, if there are both sides, or many sides, and to allow you to draw your own conclusions. And I think you'll find that the folks who have put this program together this morning have exceedingly succeeded in that task.

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I should say, by the way, that Humphrey Taylor, who's a participant in this, is also a member of the board, and we're very pleased to have him here. The first time that he's been both in the audience and telling me what to do at the same time. This event will be webcast, it'll be available for you to take a look at, at least on Monday morning, maybe by the close of business today, on KaiserNetwork.org. And you can relive every thrilling moment, once you get that webcast in place.

In the back of your packets there is a blue evaluation form, which I would ask you to identify at this time, so that you can make sure that you fill it out and help us improve these programs as we go along. And at the appropriate time, you will have a chance to answer questions, and there are microphones, I think three of them, at different points in the room, so you should be able to get to a microphone and ask your question.

Robin Osborn and her colleagues at Commonwealth have put together, I think, and incredible array of experience and insight for this morning's program of clinical and policy problem solving in the United States and elsewhere you'll find represented on this program. Lots of people who understand both the idea of improving quality of care for specific conditions, the idea of speeding the movement toward electronic

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health records. And the more one hears, the clearer it is that the problems from place to place in this world are pretty similar, and that there are innovative approaches that appear in many places that we can all learn from in the exchange of information.

Now, those of you who are in our regular audience, I want to thank you for coming. You ought to be prepared to take a lot of notes, you ought to be prepared to ask probing questions when we get to that point in the program, and I can assure you that I'm going to try to learn as much as I can in this morning, this afternoon, and I urge you to do the same thing.

My only other duty this morning is to introduce the aforementioned Robin Osborn. She's the Vice President and Director of the Commonwealth Fund's International Program on Health Policy and Practice. Those of you who are here only for this morning may not know that this is the end of a three day meeting that Commonwealth has put together every year for the last several years. Robin is, as director of their international program, the person who has done most to assemble this program and we're looking to her to set the scene this morning and give us a context in which to hear the rest of the program. So, Robin?

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ROBIN OSBORN, M.B.A: Thanks very much, Ed, for that kind introduction. On behalf of the Commonwealth Fund, I'm delighted to welcome you here today and to thank you for joining us for the Commonwealth Fund's Ninth Annual International Symposium on Health Care Policy. I know that I'm speaking on behalf of Karen Davis, President of the Fund, and Dr. Steve Schoenbaum, Executive Vice President, whom we'll hear from later today, when I say how pleased we are to be able to conduct this morning's session here on Capitol Hill, and to be able to include in the program a broad audience of congressional staff and Washington policy makers.

We're particularly grateful to the Alliance for Health Reform, Ed Howard, Ann Montgomery, Nancy Peavey, and Laura Eastman for their collaboration in arranging this morning's program. And to John Iglehart and Health Affairs for their partnership in organizing the annual event. For those of you who are joining us this morning, the Fund's Annual International Symposium brings together health ministers, senior government officials, and leading international health policy experts to share strategies and spark creative health policy thinking in response to pressing health care issues that are common across our health care systems.

The Commonwealth Fund has, since 1918, conducted research and sponsored service delivery innovations, helping to

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address many of the most urgent health policy problems in the United States. Recognizing that many of the issues of greatest concern to the Fund, access to adequate preventive and primary care, quality of care, responsiveness to patients' concerns, reducing barriers to health care for vulnerable populations, long term care for the elderly, and ensuring value for money in health care are matters of concern in other industrialized countries. The Fund established its international program in health policy and practice. The program is premised on the belief that while health care systems may be financed and organized differently, and operate in different political and cultural contexts. It's valuable, nonetheless, for policymakers, researchers, and journalists to look beyond their own borders at the policies and innovations in other countries.

I think there's often a conventional wisdom here in Washington, and it operates similarly in the other countries, for each to believe that it has the best health care system in the world. And [inaudible] is not to dispute that, mostly because what we have learned, in the work that we've done, is that no country is the worst or the best. Each performs well on some measures, and shows room for improvement on others. But what we hope to do, through cross-national comparative research and exchanges such as this morning, is share country policy experiences and results, highlight innovations, and

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identify where country approaches may offer lessons to be learned.

The core countries of the Fund's international program and health policy are Australia, Canada, Germany, New Zealand, the United Kingdom, and the United States. And we've been particularly pleased to have been able to expand this year's program to include senior government officials and experts from the Netherlands and Denmark. Yesterday morning, we presented findings from the Commonwealth Fund's 2006 International Health Policy Survey of Primary Care Physicians in seven countries, which was simultaneously released as a Health Affairs web exclusive article. The survey findings in the Health Affairs article, which I think are in your meeting packs, compared doctors' views of their health care systems, and experiences in their practice with patient safety, quality improvement activities, access and coordination of care, use of electronic medical records, management of chronic illnesses, and financial incentives for quality. I'll share some of that data in a few minutes as background to the discussions that will follow.

For this morning's program, we've focused on examples of country innovations that we think are particularly relevant to the United States, and issues that are prominent on the U.S. health policy agenda. We'll hear about strategies to improve quality and health care delivery for heart disease in the U.K.

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and long term care in the Netherlands, and the various approaches underway in ten countries to implement electronic medical records, with a more close up look at Demark, which is very much a leader.

I'd like to thank our country experts this morning for joining us, and for the thoughtful background papers that they've prepared. And especially to thank our moderators today, Dr. Jonathan Perlin, Former Undersecretary for Health for the Veterans Health Administration, and now Chief Medical Officer and Senior Vice President for Quality for Hospital Corporation of America, and Dr. Mark McClellan, who'll be joining us later today, Visiting Senior Fellow at AEI-Brookings Joint Center for Regulatory Affairs, but probably more familiar to this audience in his recent role as Administrator for the Centers for Medicare and Medicaid Services.

And last, but not least, our appreciation to the congressional staff, whom we are thrilled to have on the program this year, and who are working on these particular issues and have generously agreed to provide first-hand reactions to the models and approaches that will be presented this morning. I expect that we'll have a very rich day, and before I turn the program over to Dr. Perlin, I just wanted to quickly provide some context, particularly for those who have

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joined us this morning, in terms of how the U.S. compares with some of the other countries on a number of important measures.

These charts come from recent international surveys done by the Commonwealth Fund in collaboration with Harris Interactive. And we too thank Humphrey Taylor for his great support, and from OECD Data, and work prepared by Gerard Anderson and his team at Johns Hopkins. And all of the charts which you'll see today are available on our website, www.cnwf.org.

I'm quickly going to run through these charts, and I would ask the international guests in our audience to be a little bit indulgent, because I'm going to take a U.S. perspective on these, for the U.S. audience who hasn't been with us for the last two days and hasn't seen some of these. I'll mostly focus on how the U.S. looks. I don't mean to shortchange other countries in doing that.

When it comes to health care spending, the U.S. is clearly an [inaudible], spending almost twice as much percent of GDP on health care as the average OECD country. If you look at this chart, what's interesting, the red bars across are the public expenditures on health care. And you can see that U.S. public spending is comparable to other OECD countries, but what's layered on top of it is then private spending, and out

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out-of-pocket spending. And for the U.S. the out-of-pocket spending, again, is about twice the OECD average.

U.S. spends more per hospital day than any other OECD country, spends more on physician services per capita, more on pharmaceuticals per capita. When it comes to utilization, though, the U.S. is often at the other end of the spectrum. Short lengths of stay, fewer visits on average to doctors in the course of a year, and yet — and this probably is not a surprise – high uptake of high-tech, expensive procedures, the U.S. is usually an early adopter.

Access to care, financial barriers. Here, you can see that across countries – and this comes from our survey of sicker adults that we did in 2005, so these are high users, these are the frequent fliers in the health care system – and you can see that across all countries, there are significant numbers of patients who reported that they didn't fill prescriptions, had a medical problem but didn't see a doctor, or skipped tests or follow-up treatment due to financial barriers. The U.S. stands out with one in two saying they had to forgo needed care, and as we've seen in all our past surveys as well, the U.K. is the most protective.

One of the other issues that comes up frequently, and it's a pressing issue in many of these other countries, not all of them, is waiting lists. Waiting time to get elective

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surgery, admission for hospital, waiting time to see a specialist or have diagnostic tests. In our surveys, those are not reported as significant problems by U.S. patients, but what we did see when it came to primary care, is that in the U.S. and in Canada, it's much harder for patients to get in to see a doctor on the same day when they need care.

In our recent survey when we asked primary care doctors about this, this was confirmed from the doctor's point of view, where only 40-percent of doctors in the survey in the U.S. reported that they had arrangements for their patients to see a doctor or nurse after hours, as compared to example of the Netherlands, where 95-percent do. And this translates, particularly for U.S. and Canada, into increased emergency room visits, as the off-hours, after hours option by default, with one in four U.S. patients using an emergency room because they can't get in to see their regular doctor. It raises major concerns for quality of care, continuity coordination of care, but certainly, in terms of efficiency, it's a very expensive option.

When it comes to quality of care, the picture's somewhat mixed. On the left side, you can see this is preventive care, cervical cancer screening rates, and the U.S. stands out, doing a very good job compared to the other countries. On the right hand side a picture of acute care,

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it's 30 day in hospital mortality rates for heart attack, and here the U.S. is at the bottom of the range of nine countries. Chronic illness, which is an increasing burden in all of the countries represented in the survey, and here across countries, the one thing that stands out is that there's room for improvement. That, for example, with diabetes, half of the patients are not getting the recommended care, pretty much across countries. And this is confirmed by the landmark work that was done by Elizabeth McGlynn and colleagues at Rand.

Patient safety is an important issue across countries. This data comes from out sicker adults, and in the U.S., as you can see on the right, one in three had experienced a medical mistake, medication error, or test error in the past two years. What was striking when we then asked some questions of the primary care doctors, those who experienced medical errors told us, across countries – again, data is very consistent – two-thirds of them said that the medical error happened outside of the hospital. When we asked primary care doctors whether they had systems for monitoring and tracking analyzing medical errors in their practices, 40-percent across countries or more, except the U.K. had no such systems. And this is of particular interest and concern in the U.S., where we also are going through a cyclical malpractice crisis.

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We asked doctors about information technology, information systems, and other supports in their practices, and what we found was that there are four countries in the survey that really were leaders, and then the U.S. and Canada were pretty much lagging behind on use of electronic medical records. And this raised a number of questions for us, in terms of capacity and primary care practice, and doctors having the tools to take care of their patients and improve quality and efficiency. And here you can see as well, when it comes to functions, being able to prescribe electronically, which we know is a good thing to do. In terms of quality of care, U.S. and Canadian doctors don't have the capacity. And that pattern similarly followed, in terms of being able to order tests electronically, get results back, get alerts for potential harmful drug interactions for patients, reminders for preventive care.

The good news that we saw across countries was strong engagement by primary care doctors in quality improvement initiatives, and this is encouraging, and it's exciting. And quality really is getting traction. We looked at one of the strategies and one of the tools that is being used to encourage quality improvement, the use of financial incentives. And here we queried doctors about whether they had received, or had the potential to receive payment for having clinical targets, high

patient satisfaction ratings, managing patients with chronic illness and complex needs, preventive care, or other quality improvement activities. And I think to our surprise we saw that – we weren't surprised about the U.K. having the most financial incentives. They've implemented a very broad GP contract, which has extensive financial incentives for 147 indicators. But I think we were somewhat surprised to see that the U.S. – and we represent the most market-driven health care system here – was the least incentivized.

So, the conclusions that we might draw from that. I think the first is that all of the countries that we've been looking at and working with face similar challenges. No country's performance is perfect, each one has a lot of room for improvement. There are wide variations in health system performance, and those offer the opportunity for cross-national learning. In many cases we've seen the U.S. is at the bottom of the range on quality and access, and so, despite spending more, it raises the question about value for money. And I think what we see, as the good news and the great opportunity in these surveys, is that these issues are amenable to policy action and for learning from other countries' experiences. Thank you. I'll now turn it over to Dr. Perlin.

[APPLAUSE]

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JONATHAN PERLIN, M.D.: Good morning, and welcome to the Hart Senate Office Building. This is one of a number of congressional office buildings for international guests when you tune in and view congressional deliberations. They, more often than not, occur in one of the congressional office buildings. And so, sprinkled throughout this building are a number of hearing rooms. Some are smaller, some are larger. And the real business of the Congress actually is conducted day in and day out in these hearing rooms. This is a bit of an unusual vantage for me. As Robin mentioned, I was the Undersecretary for Health, and I got invited to those hearing rooms 27 times in the first 25 weeks of 2006, and do have to take some issue with Jack Rowe's conceptualization of VA's being immunologically privileged. In that regard, I don't think we quite were. But it really is an interesting place, where the discussion of the business of government goes on, day in and day out. And the individuals that really support the committees are staff members, and we're very privileged today not only to have experts from around the world to deliberate on the topics of quality and safety. But also members of the professional staff that really do the great legwork that makes possible intellectually robust deliberations, and the arguments of principle and policy that end up forming American law.

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I want to say thank you to the Commonwealth Fund and the Alliance for Health Reform. I can't tell you how much the international discussions have meant not only to American government, but one element of American government, the VA. It's been a great pleasure interacting and learning not only with international colleagues, but I want to take this moment also to acknowledge the Harkness Fellows, who are scholars in health policy, health services, research, coming from a variety of disciplines. And now, with the growth of the international program with the Commonwealth Fund, come from a number of countries, not just the English-speaking countries. They really work with us understanding the American health system, different elements of the American health system. And certainly in VA, I can't overstate how much I learned from the Harkness Fellows and from colleagues who were part of this international dialogue on health care quality and safety.

I think the slides that Robin just presented really outline that there are areas of excellence in each of the countries, and areas of opportunity in each of the countries, as well. So there is fertile ground for international learning. In a strange sense, VA is, if not an immunologically privileged zone, it is perhaps a little bit like a small country. It's an entity that provides service to 7.8 million veterans enrolled for care, 5.4 million of whom will seek care

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in any given year. And I mention this because over the past decade, it's an organization that I would hope would give you some optimism about the possibility for change, and change in a timely fashion.

Although I've recently stepped down, I'm still proud of the transformation that led VA to outperform the indicators that Beth McGlynn published, 294 indicators of quality in disease prevention and treatment, while increasing access by 350-percent while becoming a benchmark in patient satisfaction. Becoming a benchmark in patient restoration function, for example, having the national benchmark in age-adjusted amputation rates and diabetes in a remarkably vulnerable population – older, sicker, and poorer – adversely selected, all the while maintaining the nominal cost per patient or actually reducing the cost per patient by 32-percent over the ten year period of time. So I would hope this would reinforce what I know that many of you believe, and some of the speakers have expressed, that quality and safety are always the most efficient approach to health care.

In addition to efficiency, there's also the way in which one builds compassion into health care. And I use this word, compassion, as really a term to operationalize what we've been discussing a great deal, and that's the patient centeredness. And I think of compassion in four ways. First,

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as the ability to build inter-arc care, the capacity for patients and their caregivers, to use the American term, empowerment. Not just the activation in decision making, but empowerment in decision making. Two, with old new technologies, we move upstream from the hospital's ability to integrate care across the different environments where health services are delivered, including not only the patient's home, but with new technologies, actually the person them self may be the point of service of health care in the future. Three, the integration of care, not only across health and disease, but disease and disease. I look forward to the day when we get past disease management to really caring for the patient, so that the patient doesn't receive conflicting advice for heart failure and diabetes, perhaps even incompatible prescriptions. And fourth, health care that anticipates needs, rather than simply reacting to the needs. And what's interesting about that, it really tees up not only the promise of personalized health care genomic medicine, as we discussed yesterday, but it really identifies the need for progress in the two areas that we're going to discuss this morning. Care of chronic diseases and electronic health records. Without a systematic approach, without building systemness into our health care, we can't hope to deliver care that's safe and high quality, and

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compassionate, as defined by patient empowerment, integration, and anticipation of needs.

So it's in that regard that I very much look forward to the comments of our speakers this morning, and in the first panel we'll be discussing some national strategies to improve quality in health care, and look both to the U.K. as well as the Netherlands. And let me introduce, in order, the speakers. First, we'll be hearing this morning from Roger Boyle. And Dr. Boyle is a member of the Department of Health of the U.K., is a National Director for Heart Disease And Stroke. His stellar reputation in cardiology and, as in the United States we now are familiar with the term, a tsar [misspelled?], Dr. Boyle has been termed the "heart czar" in the U.K.

Following Dr. Boyle's comments, we're going to be hearing from Marc Berg. And Dr. Berg is a partner at Plexus Medical Group, which is a growing healthcare consultancy and affiliated with the Institute of Health Policy and Management of Erasmus Medical University Medical Center. And he's been doing a great deal of work on increasing quality in health care, and the structural form of Dutch hospitals, Dutch hospital redesign project, which now has touched 25 hospitals.

We're also very fortunate this morning to have David Fisher. David Fisher is one of the staff members who makes Congress run. David is the Republican Health Policy Director

for the Senate Budget Committee, he's worked not only in Congressman Gregg's office, but in the office of Jim Randstad and Congressman John Bethune. And as you might imagine, particularly those from abroad, you may have seen a few commercials on television. We have a very heated election going on, and in fact our voting day is next Tuesday. So it's really a particular delight and privilege to be able to be joined by David and later some of the colleagues to actually give a congressional reaction from a staff perspective to these approaches to improving quality, safety, and compassion of health care in each of our countries.

Let me then first turn to Roger Boyle, for your comments. Roger.

[Applause]

ROGER BOYLE, C.B.E., M.D.: Thank you very much indeed, and thank you very much for giving me the privilege of speaking to you this morning. And I'm going to invite you into my silo. I'm a cardiologist. Cardiologists, as you know, don't know very much other than cardiology, so welcome to heart disease. Please don't ask me about anything else.

I'm also going to talk to you about a national health service which may be unfamiliar to some of you. We have a state-funded system, services are free at the point of delivery, there is very little co-payment or out-of-pocket

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payment for individual patients. A small percentage of the population choose to have private health insurance and go down a different route. But I'm going to be talking to you about the National Health Service today, and particularly about heart disease.

The document which is our main policy document, the umbrella under which all our strategies have been developed is called a national service framework, and this one is for coronary heart disease. It was published in March of 2000, it was drawn up in a very grassroots fashion by clinicians, patients, carers, managers, epidemiologists, public health physicians, and civil servants. And its intention was to prioritize heart disease within the National Health Service. And to this extent, it was very useful to us. It was launched by the Prime Minister, Tony Blair one cold Monday morning. We are needed because we're at the wrong end of many lead [misspelled?] tables, and this one is just one showing mortality rates from heart disease in men and women for the nations that have been participating in this meeting over the last three days. And you'll see that we have high rates, both in men and women, from heart disease.

And we know that cardiovascular disease in general is the biggest cause of death in our nation. 37-percent of deaths are cardiovascular, more than all of cancer put together, that

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is in men. And in women, 36-percent of deaths are cardiovascular, again, more than the cancer deaths put together. And in fact, four times as many women in the United Kingdom die of coronary heart disease as die of breast cancer, but that is obviously not a [inaudible] section of the women in our nation. So we have high death rates, but we have other reasons for needing an improvement in quality of care. We had poor access to care, we had people waiting 12 months for a visit to a cardiologist, two years waiting to have heart surgery, we had low levels of prescriptions of effective drugs for people with cardiovascular disease, we had low uptake in new technologies, we had low levels of specialist staff, and we had inequity of access to care. So we had an awful lot to do.

So, what is a national service framework? Well, it is not a guideline. It is a higher level document than that. It really defines what a user might expect of a system, of a service, regardless of where he or she lives. It sets clinical standards, which they might expect of a service, in terms of delivery. It's evidence based. And in fact, we didn't realize it at the time, but in retrospect, it acted as a compact between government, local purchasers of care, and clinicians, in terms of expectations and delivery.

It is based on a twin track approach, which was based on health promotion and prevention, a whole range of

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interventions and national policies to improve lifestyle and better, and faster treatment for people who still were developing the disease. We are seeing an improving position, because here you'll see the death rates from all cardiovascular disease going back to 1996, and you'll see we've seen a 36-percent fall in the mortality rate. We will set a target to achieve a 10-percent reduction by 2010, it looks as though when the data comes in, we will have achieved that, probably four or five years early. So the rate of decline is about 4-percent a year, that's about as fast as anywhere in the world. So that's very encouraging.

Explaining this mortality reduction is quite political, the analysis that we have done, looking at the reductions between 1980 and 2000 suggested about a 60/40 split. Sixty percent of reduction due to alterations in lifestyle, and forty percent due to better treatment. But by far, the biggest impact was in smoking, almost 50-percent of the reduction has been brought about by reductions in smoking prevalence. So smoking has been very much a building block of the policy, with six strands to this, a ban on advertising, major campaigns, advertising campaigns, trying to link in the public minds smoking with heart disease. The link with cancer was already there, but not with heart disease. Pack health warnings, price increases, smoking cessation clinics, and for next year,

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following the lead from other nations, in fact, a ban on smoking in the workplace and in public places.

Smoking prevalence though, remains resistantly high at about 25-percent, although there's been a slight decline. We're now left, I think, with what we call the "hard to reach smokers," where we need different policies to bottom out this residual hardened group.

In schools, we've had a range of activities. Most of the schools' meals are fairly disgusting, and we've been working hard to try and improve that. One of our major successes, I think, has been the school fruit program, where children age four to six receive fruit every school day. Two million children in 14,000 schools, that's all the state schools across the country. Shows that an apple a day causes your teeth to fall out. But it is beginning now to influence dietary habits in the home, and some of these kids have never seen fruit in the home, so this is a real important step forward, I think.

And we work with our charitable partners here, the British Heart Foundation, again, to bring home the healthy diet messages, this suggesting that a packet of crisps a day is equivalent of swallowing a five-liter bottle of cooking oil. And these are very hard-hitting and certainly get the message home.

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One of our big issues, though, is the inequality of health across the country. And an index which we call DFL, that's distance from London, or the north-south divide, as it's conveniently put, and this plots on the vertical axis the mortality rate from circulatory disease. And the deprivation index across the bottom, you'll see that there's a very close correlation between the two, and that the deprivation is mostly in the north of England, and the deaths from cardiovascular disease are mostly in the north of England. But when you plot using program budgeting techniques to see how much money is spent on cardiovascular disease, you'll see that there is no correlation at all. In fact, there's more spending on cardiovascular disease in the south than there is in the north. So we have a real issue in terms of getting the resources into the right place.

Now, despite all this huge effort in terms of improving lifestyle and promoting good health, we still have the disease present. In fact, all the evidence suggests that the prevalence of heart disease is rising, if anything. So people are not dying of the disease, but surviving with it, perhaps less severe form. So we still have to tackle secondary prevention issues, and here we've learned from the United States, we've adopted a lot of the techniques espoused by Don Berwick, in terms of cycles of modernization, right along the

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patient pathway we have something like 300 people employed across the country facilitating pathway redesign and improving the efficiency of the system. We have registers in primary care for all patients with heart disease, we have primary care physicians and nurses with special interests in cardiovascular disease. And you've heard about the incentive scheme, the quality and outcomes framework in primary care, where our primary care physicians have made a huge impact, in terms of systematizing the management of cardiovascular disease.

We needed it, because our cholesterol levels are very high. You will see here the English and Scottish levels compared with American levels, which I think are not ideal themselves, as we've come from a worse starting point even than you in the United States. And here is a measure of some of the activity that has gone on in primary care. This is the number of prescriptions for statins each quarter in England, rising exponentially since our framework was published back in 2000. And you'll see here the cumulative spend reaching a peak of about 188 million pounds each quarter. A recent fall rising from the generic availability savings through generic prescribing. But in fact, if we switch, just did one simple switch, it would not please Pfizer very much, but from atorvastatin to simvastatin, which is generic and about a tenth of the price now in England, we would save 227 million pounds a

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year. And that could be done with the press of a button. So this is being actively pursued.

We've also been trying to tackle the rather neglected area of blood pressure, and many of the incentive points within the quality and outcomes framework relate to blood pressure. And you'll see here that the trend is downwards, particularly in women, the prevalence has actually fallen by 3-percent, but there's a long way to go if we're really going to maximize the benefits of normalizing blood pressure in our population. And against this, you'll see the spend on the drugs. We now spend 2.1 billion pounds, and that's roughly $4 billion, on cardiovascular drugs for our population of 48 million people.

All this activity in primary care has actually unearthed a lot of unmet need, and increased the number of referrals into the cardiology clinics, going from 66,000 referrals each quarter to nearly 120,000. It does seem now to have plateaued, thankfully. So this has put a huge load on the hospital system, and we've tackled this by setting up a network of rapid access clinics, so that people are seen very rapidly, within two weeks, often within the next working day. And this shows the outcome in each of the 154 hospitals that have one of these clinics. You'll see that the majority of them achieve this target. There are a few laggards at the wrong end of this

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graph, we know who they are and they know that we know who they are, and are working on that one.

We've also measured on the treatment of heart attack. We have a national registry for heart attack, 400,000 episodes of care already within it. They have an annual publication performance, and there's real-time benchmarking, so every hospital that contributes to this – and every hospital does – can see how they perform against the latest national position, on a daily basis. The ambulance service, we have set targets for them too, with currently 76-percent of calls, Category A calls, are responded to within eight minutes. That's quite an achievement, even in a small country like ours. We have ECGs on the vehicles and telemetry systems, so paramedic thrombolysis can be delivered. And we have pilots of primary angioplasty covering now about a fifth of the population. I'll come back to that in just a moment.

Again, learning from the United States, we've had a national defibrillator program, putting defibrillators into busy places, like our airports and railway stations. This slide shows 15 of the first 50 survivors to discharge from hospital, and there are three people on this slide who have not had an out of hospital arrest and been resuscitated by a layperson. One of them is our previous Secretary of State for Health, standing next to him is Ranulph Fiennes, described as

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the world's greatest living explorer. He has celebrated his recovery by running seven marathons in seven different continents in seven consecutive days. The man is completely mad.

We have improved the management of heart attacks substantially. This slide shows the improvements in door to needle time, so that something like 85-percent of patients are treated within half an hour of arrival at hospital, and over 50-percent of patients are treated within an hour of a call for help, looking at the whole system, which is, I think, quite a competitive level. And when we look at the comparative figures for thrombolysis, you'll see that our median time is 67 minutes, which I think takes a bit of beating. Angioplasty takes a little longer, at twice that time. We have increased the proportion of patients discharged on the effective quartet of drugs. This is important because it improves outcome. Here you see a dose-response curve, that the number of drugs you're on when you leave hospital after a heart attack is really vital, in terms of your likelihood of survival. And we've seen gradual improvement in the mortality rate at 30 days after heart attack in patients over time. So, we are improving the quality of care and have the data to show it.

We've invested heavily in capital schemes for the cardiac centers across the country. This is just one, showing

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that we even think of personalized parking spaces, this one for cardiac surgeons. They're having a hard time of it at the moment, only a small car. Waiting times have come down, so we have nobody now waiting more than three months for heart surgery. And we publish all the data about not only the units, but about individual surgeons. This data is on a public portal which anyone can visit. It describes procedures, it describes the outcomes, it describes the case mix for the surgeon that you're going to see, actually tackles and then shows his outcomes against the expected results and against the national norm. All risk-adjusted data, all done on a voluntary basis by our clinicians, and published through our relator, the Health Care Commission.

This is just one of a number of audits and a number of systems that allow us to put this clinical data into the public domain, and is, I think, therefore important in terms of choice. And all these audit programs are linked together, so that we can not only track mortality, but also event-free survival across the domain.

Angioplasty is taking over as the major treatment care, and coronary bypass surgery, even from low levels of intervention falling, in terms of rates. And I'll skip that slid. And just to finish, just to look at some of the success factors behind this. I mentioned at the beginning that we've

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prioritized heart disease as part of this process, and unleashed a whole load of clinical enthusiasm to improve services. I think it's an underestimated lever for improvement. We've aligned government and clinical ambition in this regard. We have used performance management to target the key areas for improvement. There is less of that going on at the present time, but the targets that we have remain performance managed. We have had some financial investment, as I've indicated, we've modernized the process using collaborative techniques. We have had closer engagement between commissioners and clinicians within networks, regardless of the institution in which they worked, and our national audit program and registers, and our publication of the quality in measures has been a driver to progress, publishing that data.

So in conclusion, experience in England demonstrates that mortality and morbidity from coronary heart disease can be substantially modified by a national program, through prioritization at government level through modernization, through combining better prevention and better treatment, with investment and listening to patients, echoing Jonathan's point about trying to bring compassion into the process. And I'll leave you with this slide, which I think sums up some of what we've been trying to do. Thank you very much.

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[Applause]

JONATHAN PERLIN, M.D.: We'll take questions at the very end. Marc Berg.

MARC BERG, M.D.: Ladies and gentlemen, it's an honor to stand before you. I am not the heart czar of the Netherlands. If anything, I'd be called the Performance Management czar of the Netherlands, which is, for many, I can assure you, a much less flattering label than being the heart czar. I'll tell you a little bit about what we have been doing in the Netherlands. It'll be slightly more abstract than the talk we had just now, but I think it's very nicely balanced. And you'll hear a lot of complementariness, I think, in the talk.

I just wanted to start out briefly with talking about where we are coming from. Where we are coming from, and that means we, here, stands for the different countries, as we are here sitting around the table. And then I will try to talk about four or maybe five simple rules for a health care system that works. And the "simple" in this talk is not going to be that they're ready, the "simple" means that it's the kind of rule that if you keep your eye focused on it, and don't look too much at other things that might be happening around it, just focus on those rules, it actually might lead you very far.

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I will do that, telling you a little bit in the meantime about what's happening in the Netherlands. This is an interesting slide, it comes from OECD health data, and it shows not only what we all know, that costs are high, but it shows that the increase in costs every year is also higher than it used to be. Where, in an increase that we also saw in the '50s and the '60s in the international health care side. So there's a huge pressure, and actually the last two or three years you see a little bit of a flattening in some countries, except for the U.K., of course, because in the U.K., they're going through the roof right now. But this is one pressing issue, and it's very similar for many countries around.

At the same time, the quality of care, of course, delivered, leaves much to be desired. I'm not going to go into detail because we know this around the room. This is just one slide, I usually just take the slide that struck me the most in the last week. This one I came across, it's a study of hospital mortality in four [misspelled?] volume categories in the Netherlands. And so you have hospitals that do less than five pancreatectomies, which is the surgical removal of the pancreas because of cancer, and the hospitals that do many more, over 24. And you see a staggering difference in mortality rate. And what's equally staggering is that this has been going on for ten years now, and nothing is being done

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about it. This data is out in the open, and in the open is between brackets because it's known among doctors and hospitals, but patients are not aware.

In the [inaudible] sector, we have similar problems. We have a huge amount of pressure sores in nursing homes, and in the Netherlands, and it's not really clear why exactly, but it's especially a problem. Up to 25 to 30-percent in nursing homes have bed sores that they have achieved while staying in a nursing home. Over the last four to five years the average has gone down somewhat, but for example, we are still way worse than in Germany, which is a neighboring country. And we're still trying to figure out why that is. It has to do with attitudes at the bedside more than anything else.

Of course, there are also more on a comfort kind of level, which is equally important for this kind of care. The poor organization of work leads to insufficient time for clients. We have had accesses over the last few years which came into the paper, so that there were days that people didn't have time to dress the patients, so they had to stay in their pajamas in bed all day. They would be showered only once a week, and things like that. And then there's claims about how that is because there's not enough money. If you look into the detail, of course, it's a question of money, but it's also a question of how you organize the work.

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Now, we have poorly performing systems, and we've already talked about that this morning. We have increasing costs, we have – let's just use the word -- mediocre overall quality, and mediocre, just meaning by, it could be so much better. And we have high costs that are partly due to the mediocre overall quality. And we have estimates that are varied, and I'm just going to throw this one in the air here, we can talk about this at length, and I think we should. But if we would have more integration, less errors, more prevention, less overuse, more smart task [misspelled?] redesign, less administrative repetition, estimates are that we would be able to reduce 35-percent to 45-percent of overall costs. In the states, it's probably on the high end, and in most other European countries, in the low end. And sometimes I say this and I think it can't really be true, but then you hear the VA talking about what they have achieved, you see what's happening in the U.K. within this, and you can see that it's actually possible. These are not just academic calculations.

This is a lot of money, I don't have to explain that to you. What is interesting is that apparently, irrespective of the systems that we have, whether we're market-based, like in the U.S., or government-run, like in the U.K., or in the middle, like we are in the Netherlands, mixed systems, fundamental problems are all alike. It's a fascinating thing

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to think about. It does something to your – we have a lot of ideological, heated discussions about whether we need more market, or less market. And if you stay at that level, that's apparently not the point.

All of our systems have managed to fragment care delivery, have paid providers to do either too little, too much, or the wrong things, and have kept patients uninformed about all of this. All of our systems have done that.

Now, then, what are the sort of simple rules, again, for a health care system that works? And how does the Dutch system reform measures up? And I won't go into detail about the reform, because that might not be so interesting for many of the American people here, and many of the international crowd. The Commonwealth Group, they've heard already a lot about that. So I'll talk about the Dutch system as it is, but it's something that is in the making at this very moment.

Just to talk about those simple rules. The notion of simple rules – and you could go into this quite theoretically if you wanted – health care is a complex system with many historically and culturally determined differences between countries. But if a high performance system means that you deliver highly effective, safe, and patient-centered care as efficiently as you can, and in an equitable [misspelled?] way, then there are just a few simple rules that set the incentives

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just the right way. If you want the notion of simple rules, it's also used in the first IOM report on errors in medicine. But I take it a bit different. The simple rules are different. They're more about policy than they were used there, but it's a similar way of using the term.

And interestingly also, I would argue that these simple rules are irrespective of local differences or histories. And it means that getting them to work in every country, or in the U.S., or in the Netherlands might mean something completely different. But the aim would still be the same. Of course, I'll tell you a little bit of the Dutch health care system before I continue, because I'll be using that as an example.

Now, maybe just to start, where is the Netherlands anyway? How many people would vote that it's there? That's maybe putting the question wrong. Just say stop when you think you know where it is.

That's where the Netherlands is. It's a beautiful, small country, I don't even dare to project the map of the U.S. next to it, because the slide would be not big enough. What system does the Netherlands have? A very similar kind of problems. We have, as anywhere else – should tell you a little bit more in facts – we have a privately owned, non-profit providers and health care insurance companies, they are both profit and not-for-profit, the providers are not-for-profit.

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And some of the insurance companies are for profit. But they operate in the playing field that is heavily regulated by government. And this strong government rule stems from two interrelated considerations. First, we have a strong focus on solidarity and acuity, and on health care as a public good, which, for everybody who knows a little bit about that, it's a very European tradition. In Europe, health care is a public good, it's not something that you can describe in pure market terms, it seemed to be something that the government will arrange for you. But yet, of course, within that saying, you can have a zillion different ways of filling it in, and so that's why we often talk about the mix system, because we have a private providers and insurance companies that are actually doing, and playing out the game of creating that.

Of course, very importantly, and in daily life, much more importantly, the strong government rule comes from the need to cost control, because the cost of health care, because health care insurance is obligatory, it is seen as a public cost and so it's measured with all the measures of what public costs and taxes are doing to your population. So it's a crucial political aim to keep that cost down.

So what is rule one? And again, you'll see these are rules that are easy to say, crucial to focus on, but not always easy to achieve. Rule one simply is about insuring solidarity

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on one way, so it's sort of a no-brainer for a European to say this. But even for somebody that might not want to go along with the argument of solidarity, if you have universal access, you reduce the huge failure costs otherwise born by other actors in the system. This is something that is a well-known, discussed situation in the U.S., in the Netherlands, that argument you would never even hear. The gist about solidarity, the core thing you need, universal access. This has been achieved, this was already in place. The way we do it now is we have obligatory health care insurance, and you have to have a health care insurance, and it's a private insurance where you cannot not have it, it's like car insurance, it's the same thing.

That everybody has access to an extensive standard benefit package, and the insurance company has to accept everybody. So the insurance company cannot say no, they cannot do a risk profile of you, they'll have to accept you as you are, even if you have cancer in a progressed state. They have to accept you. They're not allowed to differentiate prices according to risk. So if you have a policy for a standard benefit package, and the standard benefit package, as I said, is the same for all insurance companies, they can set their prices because they hope to contract in a smarter way, they're to be more efficient in handling the policy claims. And if

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they have a policy, they have to accept everybody for that same price. So even somebody with cancer, or a 20-year old person, same price goes there.

The health insurance companies are not tempted to risk select, because there's a very well developed – and this has been developed over the last 15 years – risk equation system that operates behind the back of the insurance company. And basically what it does is it looks at the attributes of patients, and it says, for example if a patient has diabetes or is very old, or has AIDS, for example, it looks at all these parameters, and it will give an extra sum of money to the insurance company that holds that person in the risk pool. Which actually is fascinating, because what it does, is that it makes it actually interesting for insurance companies to think about, "Well, you know, I get so much more money for a patient with diabetes if I can take care of that patient in a better way, it actually is profitable to create a special policy with people with diabetes. It's an insurance world that's sort of fascinating. You like to sell insurances to burning houses, and that's what it is. If anything, this is one of the best developed, and smartest and innovative things of the Dutch system, and in Germany, they're partly taking this over. If you're interested, check it out. There's a lot of literature, also in English, available on how this has developed. It's a

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spectacular system. Of course what happens, because everybody has to have the insurance, people with low income get a tax benefit in order to be able to pay for the premium, and the level of co-pays that we have is relatively low, so there's no limit to access. This is the way we have implemented rule number one.

Rule number two – and you'll recognize the terminology of Porter and Teisberg's work, if you're familiar with that, but it's not because of their work that we have done this, you can say. The product or service in health care, or the level of competition, has to be played out. In the Netherlands, this was a core purpose of the reform. Moving from a focus on budgets linked on beds and the number of professionals in a hospital that you pay, moving from there, to a system where you would say, you pay for an integrated pair [misspelled?] trajectory. So a person with a hip replacement, for example, goes to a hospital, has atherosclerosis in his hip, a diagnosis is made that it's necessary to replace the hip. The hip gets replaced, and you get discharged. And that whole episode of care is what you buy. In fact, at this moment, it's not possible to go to a hospital and buy an x-ray. You buy the integrated care package. It's a little bit like the DRG, but then, it's the only way of paying we have for health care in hospitals. Diabetic care is now being worked on in the same

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way. You buy – and it's a chronic care – so you buy one year of integrated diabetes care, and you have one price for that whole care, a year. So you cannot buy a single part of that care, you buy the whole thing. You cannot buy the medication that goes into the hip replacement set, it's part of the package.

And it's crucial to do that for many different reasons. It's this level, it's this sort of unit in health care, it's not the hospital, not the individual doctor, what patients look for or need. And certainly not the health plan, I would argue, although a health plan can be crucial in organizing this. But this is what patients look for. If you have something you want to go to a place that gives you a good hip, that takes care of your diabetes, that can help you deliver a healthy baby, et cetera. This is the level at which health care providers can differentiate themselves from one another meaningfully, because you can say, I've got this great doctor or that great doctor, fantastic hospital, but there's always differences between. And a great doctor can be superb, but if the nursing staff in the same hospital is not as good, it's the integrated care trajectory around that patient that works. And it's the level at which quality is delivered, also. And this is also the only level at which you can truly measure quality.

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Now pricing is core, as well. So there's no more price setting per day, or per x-ray or medication prescriptions filled, no more fee for service, in that sense. And hospitals now are working with a DRG-like system, but then it's very inclusive. Because it includes the physician's fees, which is very interesting and important. And it includes, also, outpatient care. Not primary care, but it does include outpatient care. It includes the medication you get in the hospital. So a hospital has a stake in using generic medication rather than, for example, non-generics.

In long-term care, it's the same idea. Similar pricing system, but then it's based on the intensity of the care you require, which is set by the moment you go in. So you have the integrated care trajectory, and you have the price listed to [misspelled?] it, and in the long-term care, you have the care products differentiated by severity of care, and you have prices listed with every care product.

That's the crucial way to set the proper incentive to deliver care efficiently, at the level of the integrated care product. This will simulate doctors, and the hospitals and the integrated providers to prevent failure costs for injury admissions, et cetera.

The fourth rule is to enforce public presentation of comparable performance information per product. This is

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crucial, this is happening in many countries. We are actually only starting to do this very well. There's some great examples happening in the States, and to have the price and the quality together, is what creates the proper incentive to deliver high-value care. And in this way, you will get a rapidly freeing the failure costs that are now frozen in the system. If you look at the quality that is being used in this, we look at patient centeredness, effectiveness in patient safety, and I'll tell you a little bit more about that in a second.

What we're trying to do now in the Netherlands also, is trying to move to a situation that we can then free up prices. If you have this in place, you can start to free prices, because there is so much overcapacity in the system in the Netherlands, I would even argue in the U.K., but in the U.S., I don't even have to talk about how much overcapacity there is, and prices will fall downward very, very fast. But you need to have these rules in place, otherwise that's never going to happen.

And in the Netherlands, to talk a little bit more about rule four, you have the situation that's at this moment, in long-term care, we have had the agreement that all providers will publicly [misspelled?] present realized quality of care. Safety, patient-centeredness, and effectiveness, so that

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consumers and patients have concrete information to base their choices on, so that the health care inspector can monitor delivered quality, and so the insurance companies can contract care and negotiate price. And we worked hard, it was a collective effort to get there. We had different provider organizations, professional organizations, patients, and insurance companies coming together. They jointly set the overall aims, deciding what is quality of care for clients in long-term care. What do we call that? And it's a highly normative process, you can say. Because, of course if you say, there's cost qualifications implied in long-term care also, but what patients prefer or not prefer, so it's not a technical process, it's a very normative one with financial consequences.

And we put the patients in the lead where it was about defining what they find important for the things that are more easily developed by them, patient experience. And we put professionals and providers in the lead where it was more about safety and effectiveness indicators. Now, I won't go into detail over [misspelled?] this, this is just an image that was made during the process and that people sort of liked. The Health Inspector at this government organization oversaw the process, all these different groups were involved. They had a patient questionnaire based on the U.S. CAPS methodology on the one hand, they've had professional quality indicators on the

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other hand, and working together, they created this integrated set. These are the quality themes, I won't go into detail. We had 30 indicators in total. For example, care-related safety, talked about outcomes, of pressure sores, of earring [misspelled?] infections, of falls out of the bed. But a lot of it was questionnaires about living conditions, how they were treated, if they had a meaningful daily life, et cetera. And we used two instruments, the CAPS patient questionnaire on the one hand, and the quality indicator instrument having to be filled in by the providers, on the other hand.

This is now done yearly, and in 2007, all the providers will have to publicly, on the website, present how well they're doing with that. And what will happen, then, is that we will get national rankings of nursing homes. And you can drill down to where you want to be, in the case of special care needs. And they will be comparable and measurable and transparent. It will get a fierce upward quality trend there, because ranking low hurts. And we're really seeing that in other sectors in the Netherlands, and you see that here too, in some instances. And interestingly enough, insurance companies at that point will no longer be able to accept poor value. They might want to do that for financial ways, if there are still places where low cost and low quality go hand in hand. But they won't be able to do so, because it will be publicized widely that that

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insurance company is actually contracting really high-cost, low-quality care. So they will quickly work against them very hard.

We have some instances, and in the discussion we might go in, in that we have already some instances of free price setting in part of hospital care in home care situations, et cetera, so we're seeing that work too, and you're actually starting to see this price quality waiting and at work. Now, I would argue this is beyond pay-for-performance, because this goes one step further than pay-for-performance, you're actually paying for the value of the care you're getting. Not on top of a system that is fundamentally broken, but it's a new way of regulating health care.

So these are the simple rules. I would argue that it's very important for policy makers to focus on those simple rules to – and they can be put into different ways, in different instances in different countries, they will look differently. But it's crucial to look at those simple rules and other issues that might be important that are very often in policy agenda, in my view, are much more secondary, like information technology. It's crucial. It's [inaudible] for all this to work, but if you focus on that first it's never going to work, and we've seen many instances of that.

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An interesting discussion we will have after the coffee break about IT, but IT without a focus on system and the incentives in the system, focus on IT and IT stimulation is bound to fail and has done so over the last 20 years. And I'm not going to see it work without focusing squarely on those simple rules first.

Just to give you a hint for the discussion, and you have many questions to ask. One of the questions we're struggling with is – these are crucial rules, they're very important, but how are we going to get the patient to start to act on all this information? There's a lot of people [who] are not very optimistic about that patient who actually starts to use this quality information. And since, in many countries, we have very high insurance percentages, people are also a bit worried that they won't have the financial pressure to start to look at the quality of information and the cost information, because it doesn't really impact them very much. Of course, in the U.S., you can have a system in which very large co-pays, or deductibles. In many European countries, that's not acceptable. In the Netherlands, it's almost politically impossible to have that.

So, there might actually be a fifth rule necessary in order to incentivize patients in some sort of a way to go to high value care providers without hampering access through high

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co-pays or deductibles. And I think this is something that's not Dutch policy. This is my personal opinion, and I think this might be the next step that will really, truly turn around the perverse incentives that have plagued all our systems around 180 degrees, finishing off the first four. And that is that you would have some sort of a value, a metric. This could be, for example, a health plan that does this, that offers a policy that says okay, you can have a policy that is just about 20-percent or 30-percent lower in price than other policies. Because you make the deal with the insurance health plan that you go to a high value provider. The high value providers that are in the lower right box, high quality, low price. It's possible, we all know that, that in fact, most of the time the higher quality providers are the lower priced providers. And if you, as a patient sign up to a policy like that, and you make the deal with the health plan that you actually go only to providers that deliver that on the product of care. We're talking still about the competition with the product of care. Not the whole hospital, but heart failure care, or diabetes care, or complex chronic care. And you have a co-pay going up for higher costs, which is sort of self-evident, but also for lower quality, which is a bit of a counterintuitive first thing but is not so difficult to explain why that is.

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We see first insurance companies in the Netherlands trying to start to do this, my feeling is that we're actually going to go there in a quite strong way. Because this is ultimately probably the only way that an insurance company will have a way I which to truly start to change the behavior of patients of selecting providers, where you'd want, as an insurance company, but also as a health care system, to get there. Thank you.

[Applause]

JONATHAN PERLIN, M.D.: Thank you, Marc, and Roger. Two very interesting conversations about improvements in quality and improvements in the conceptualization of value. And here then, from Senator Judd Gregg's office, now the Republican Health Policy Director for the Senate Budget Committee, a pleasure to reintroduce [misspelled?] David Fisher.

DAVID FISHER: Good morning. A very odd podium, I won't have any place to put my stuff here. Hold on for a second, see if I can work this out. A little bit like Gilroy, I can look over to see people in the front.

I'm very excited to be here today. Over the course of the last couple of weeks, I had the opportunity to attend events for some international symposium discussions on health care. Attended them now, didn't participate. And I've been

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very interested to sort of see that the, just like Mr. Berg said, a lot of similar problems across these different types of health care systems. It's interesting at the least, it gives us, I think, a little bit of hope. We're all in the same boat together, regardless of how we pay for these systems, how we pay and how we provide care. So I'm interested to do that.

You all must be thinking, "What is a budget committee person doing here?" The budget committee here, they make the budget resolutions, or to set the parameters for debate for the year for the Congress. I happen to work for Chairman Gregg, who was the chairman of the health committee, Health, Education, Labor and Pensions Committee, last Congress. And he was nice enough to keep me and a few of my colleagues on board when he switched to become chairman of the budget committee. And so, we have a little health policy shop with the budget committee, where we think about health policy, write bills, but also have an obligation to think about the budget a lot. And I will get to that in a moment, because it clearly is one of the more important things that our health care system faces, is the growing, quickly growing price of health care. And that's particularly true for the federal government.

I will take a quick second to just say I am not a heart czar, I am not a Program Management czar. And in fact, I can

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only tell you I'm the czar of my home, but only because my wife's not here to contradict me.

So, what I think we've heard today is sort of a broad-based, theoretical discussion about what are the rules that we can put into place across the world, sort of help our health care systems improve, both from a quality perspective and a price perspective. And the previous speaker spent time drilling down more, giving an analytical perspective of how have we improved in England in cardiac care. What I'm going to try to do is combine that a little bit, sort of take the over arcing policy discussion as well as incorporate my budget committee bias, now that I have one, to talk about where I think we need to go here in the U.S.

But first I want to say a couple of things about previous discussion, our previous speakers. First is that the four rules are simple, which I think is great for someone like me, who's not one of these czars. Being simple, I think, helps to understand them. And I think that while I would say them in a slightly different way, for example, minimize the uninsured. Rule two, integration of care. Rule three, a total perspective payment system akin to our inpatient system in Medicare. And then, quality transparency. And I think what's interesting is that over the course of the last year we've certainly seen a huge emphasis on, particularly, price transparency from the

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administration, but at least in our office, a lot of interest in quality transparency as well. And I'm going to talk about a bill that Senator Gregg has introduced in just a minute, that tries to achieve some of those goals.

And then with regard to Dr. Boyle, I think I was really struck by the value of measuring and publishing, or making public, this information, this analytical information, to help us understand how is a hospital performing. Are they that 10-percent of hospitals that aren't giving their heart pain patients into appointments during the first two weeks? That information is critically important to patients, I think critically important to the public, just generally. And it's something that's sorely lacking, at least here in the U.S., and I think the value is clearly there.

But then, the other thing, I think, that I took away from that was the issue of hope. As I looked at those charts, it struck me how quickly improvements were able to be made, once these national roles were said. And I think that is helpful to see, in sort of an optimistic way of looking at some of that information, because for those of us who are extremely worried about the quality of care here in the U.S. – it's obviously very good, but it needs improvement – that gives me hope and optimism about how we can get from here to there.

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A lot of folks have talked today already about our health care system. We have wrap [misspelled?] innovation, it's fragmented. We have lots of variations in the quality of care, both regionally and locally. We spend 60-percent of GEP on health care, and 45-percent of that is paid for by government. The thing that I focus on a lot myself happens to be the cost of that care is rising at a rate that's 2-percent above GDP. Which, at the end of the day, is a non-sustainable rate. For example, without changes, just Medicare and Medicaid by themselves will consume 20-percent of U.S. GDP in 2050. For those of you who don't follow these sorts of things, our historical tax level is 18.3-percent of GDP. So those two programs alone would take up more than our historical level of taxation. Clearly, we're in a position where we have to start thinking about how do we bend that growth curve to use sort of a budge committee or economist's point of view. And this is something that Senator Gregg is intensely interested in.

But it's not just about the money. I think it's also about the quality. And I was struck – I was asked to speak in this panel a couple of weeks ago. But then on Sunday, by happenstance, I happened to open up the paper and there in Parade magazine, which has a circulation of, I think, 33 million or so people, and they claim to be read by nearly 80 million Americans. The title on the front page was, "How to

Survive Your Local ER." It's astonishing to me that a story like that appears in a U.S. publication. How to survive your local ER. I was taken aback by it, and I think we all should be. That is a tragic headline, if nothing else, about the state of health care here in the United States.

But then on Monday, I read in the New York Times an interesting article. It was entitled, "What Pilots Can Teach Hospitals About Patient Safety." It's a very interesting article, I think there's a lot of value to many of the ideas [it lists] [misspelled?], and the walking to procedures that you sort of go through to make sure you do something right, every time. Make sure you do it the same way every time, make sure you do it right every time. That's very interesting, but what was even more interesting was a couple of quotes in the piece, in which one physician said health care is 30 years behind the FAA, or pilots, or airline safety. Thirty years behind. And then another quote by a physician from Texas who said, "Checklists are for the lame and for the weak." How terrible, how tragic is it that we have a culture, at least with some in our health care system, where a comment like that would be made. It's not about the safety of the patient or the quality of the care they receive, but whether or not it's about me and whether or not I can remember and I'm strong enough to make this work.

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My boss has been interested in this for years. He worked very hard as the Chairman of the Health Committee on a patient safety bill, which was enacted last year on regulations to come, but was, we thought, an important bill offered by Senator Jeffords to improve patient safety here in the United States. This year, he has introduced a bill called the Medicare Quality Enhancement Act, that's 3900, which does a few things. And the purpose of the bill is to improve the transparency in health care. And again, when I talk about transparency, primarily, I'm talking about quality transparency, not price transparency. I certainly believe that price transparency is very important, but when I'm talking about transparency from this point forward, it will generally be about quality.

The MQEA, Medicare Quality Enhancement Act, creates what are called Medicare quality reporting organizations, whose purpose is to analyze data, plains data, primarily, at this point, for quality and efficiency on behalf of the public. The second and most important part of this is it requires CMS to share their data with these organizations so that this, I believe, treasure trove of information gets out into the public domain in a way that the privacy of the beneficiary is completely protected. So, parenthetical, we don't want to violate any beneficiary privacy here. That's obviously

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critically important. However, getting this information out, particularly on issues of quality and efficiency is critically important.

Now, how do these things work? The NQRO sits there, a repository of information and analysis, and then we have private sector organizations, whether it be a health care plan, a physician group, a city, a business, like GM, a provider organization, hospital, asks the organization for a report. "Rank order for us the hospitals in Bon Air California, the number of cardiac stents placed in the last year." Or alternatively, "Rank order of the number of cardiologists in Bon Air, California who have done these procedures." A little bit similar to Dr. Boyle's – the picture you saw was of Dr. Owen, I think, from the U.K. who, he'd done 140 of these procedures and ranked in the 93rd percentile, or something like that. Similar information, that I think is very important to help people, the public understand where things stand quality-wise here in the U.S.

But one of the things that I think is also important about this bill is, all of the information, the requests, made the MQRO, as well as the data that comes out and the methodology that was used to generate that data. All of it is made public. None of this is private. We believe fully in transparency, and believe that anybody who's trying to skew

results in a particular way, that's going to become obvious. It's going to be open. If a physician group, or if, for example, cardiologists in Bon Air, California don't think that the hospital, or the plan asks the right questions to rank them, they can do their own version of this study with their methodology, which would then be, again, open to the public for everyone to see.

So why is this important? We've talked a lot about value over the course of the last hour. I think that value is really the focus of where we need to be. The lack of transparency that we have allows poor providers to sort of hide, to get away with performing poorly, or to say that checklists are for the lame and the weak. That's not what we should be about. I think also that we have sort of a Lake Woebegone syndrome here in the United States with regard to health care. In Lake Woebegone, the fictional place, all the kids are above average. Well, here in the United States, everybody thinks their physician is just the best. And we need to make sure – we need to figure out if that's true or not. The public needs to know whether or not their physician is the best, or in the top 50 percentile, or maybe in the worst tenth. That's important information.

Making this information available to consumers and to payers is a strong motivator to providers to improve, I think

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there's no question about that. And the release of the claims will provide valuable data today on quality, it will also motivate providers to develop additional clinical performance measures to supplement and enhance the claims measures, the claims data that we're talking about today. And we all would agree that clinical data is the best way to measure performance. We don't have that today. However, we need to stat, and there is value to the claims data that we can use to get a lot of this information. But then also, there's an issue of cost. I can't leave, as a budget committee staff, and not talk about cost for a moment and refer back to the Dartmouth Atlas projects from earlier this year. They released their study illustrating that variations in the intensity of care across the country was not related to improved outcomes, which I think is powerful information. And in fact, for chronic diseases, high utilizing regions had worse outcomes. Just astonishing, astonishing information, and backwards from the way Americans tend to think about health care. And what the Atlas then estimated is that 30-percent of costs in Medicare could be for – I want to make sure I get this right – that you conclude from that, therefore their significant waste, inefficiency at a high utilizing regions that could be reduced, and the Atlas estimated that it's 30-percent. Thirty percent in Medicare. That is a huge amount of money.

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So, that's all I have. I'm very interested to hear from you, hear your questions. S3900, let's talk about it. And again, thank you for your time and attention.

[Applause]

JONATHAN PERLIN, M.D.: Let me thank each of the speakers for terrific visions for improvement. First we heard about a service framework trend [misspelled?], spending guidelines and really helping to advance the quality of cardiac care very rapidly. We heard about a value matrix, framing a perspective for informed purchasing at a variety of levels. And David very nicely framed a real challenge in the United States, and a potential response introduction of Medicare quality review organizations and the transparency initiative to again, allow informed purchasing at a variety of levels.

I think there's a theme here that has recurred throughout our entire conference the last couple days, the issue of value for money. And there's a subtext, which is really, what are the tools, or do we have the appropriate tools to really elucidate the quality of care, create transparency around that for informed decision making, elucidate the cost, or the value, ultimately the relationship, of the quality to cost. And do we have the right tools to do that? And then, I think Marc quite rightly analyzed this with the question, "Will patients as consumers, will purchasers, aggregates of

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businesses, employers, governments, use those data for informed purchasing decision making?

I think David put a marker on the table. The combination of Social Security plus federal health programs, Medicare, and Medicaid equals about 18.3-percent of GDP in 2015. One can see that there is a zero sum at that point, and I think all of us interested in quality and safety realize that quality is more efficient. So rather than being depressed by that, I'm actually very optimistic. It means that we have to change. So I'd be interested in your questions to each of our presenters on how these approaches might interlapse [misspelled?], energize, apply in different contexts, and allow us to really realize the aspirations and improve safety, effectiveness, efficiency, transparency, and value.

[inaudible] take the first, come to the mic. There's a mic in the front, we do have some time. To Marc, you put the question out there, "Will purchasers, consumers, use the data to make decisions?" So, in short, what would be your answer to that? Have you had enough experience with that, for consumers to use that data for decision making?

MARC BERG, M.D.: I think if you look at the literature at this point, there has been quite a lack of uptake by consumers of this type of information to them. And basically, if you just look at the literature, you'd have to come to the

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conclusion that they don't. I think, though, that if you look at that same literature, that you have to realize that much of the information as presented to consumers or patients in those studies is at the wrong level. If you have information at the level of the condition of the issue that the patient actually is struggling with, I think you'd find that the outcomes might be a little different. At least we have seen in the Netherlands some very concrete examples of it. We've had a cardiology center that had some really bad news in the paper about their quality. They have seen their patient load drop by 50-percent. So I think it's a matter of having information at the right level, it's also a matter of people having to break down this Lake Woebegone illusion that their doctor is always the best and that all health care quality should be the same, or is the same.

And people are realizing that it's not the case, so I think that you'll see a change there. But nevertheless, I still think you ultimately will need some additional stimulation to make people move to the health care providers that are the best.

JONATHAN PERLIN, M.D. I'll ask that question in a slightly different perspective and Roger, feel free to comment either at the patient as consumer perspective or from an administrative perspective, in terms of decision making about

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how one resources better or worse performers. Two competing schools of thought. One, reward the best performers. The other, reinforce where you need to improve. I'd appreciate your thoughts on that.

ROGER BOYLE, C.B.E., M.D.: Well, I think there is a real challenge here in rating the patient's awareness, or the potential patient awareness. I think that many people need help to do this. I was impressed with the talk yesterday from Cologne on oncology services, where the system navigator was helping patients through the system. And I think that if you are going to get into looking at disease specific things which may not be relevant for everything, but for big operations like coronary bypass surgery, may be relevant. But you probably do need some form of navigator to help you do that, so that when the time comes for you to make your choice, you can actually make the choice on social grounds, depending on where you might live and where your relatives might be, but also on the basis of the published data. So I think there needs to be a facilitation step in this, as well as good publishing of the broader issues, which you, Marc, have demonstrated. Which can, perhaps, take them in the first step, into which bit of the system are they going to go before they make the specialized decisions. So I think help is needed. And also, the way the data is presented, I think we need to work on very

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substantially. When we did this public portal for the heart surgery project, we did a lot of testing with patient groups to see whether it met their requirements. And we made sure it was in a language that they could understand, explained the procedures so there was more in it for them than just making a choice as to which surgeon or which hospital they might go to, but actually begin to understand their condition at the same time, through the website.

JONATHAN PERLIN, M.D.: Thank you. I think the other night we heard Secretary Azar turn and describe Secretary Leavitt's vision for an orbit, or something of that sort, where you could actually look at this quality, and David, I imagine that's the ultimate playout. So let's take some questions now. We've asked people to introduce themselves to the larger group. We'll start with Dr. Leatherman.

SHEILA LEATHERMAN: I'm Sheila Leatherman, I'm at the School of Public Health University of North Carolina. And I have a question about the role of markets and competition, and would like to address this specifically to Roger, and also in you role in the VA, Jonathan. Throughout these three days, we've heard from several countries that the direction of travel is strongly towards competition as the lever to improved quality and performance. However, in the very compelling presentation by Roger Boyle, I note that on his slide

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explaining the success factors for reducing morbidity and mortality, there are eight interventions, few, or even none of which are the usual set of what we call markets or competition. Rather, they are setting national priorities, performance management, clinical audit, reporting of data, et cetera. So what I'd like to do is ask the question of Roger and Jonathan as well, are we moving too strongly in the direction of thinking that competition is the magic bullet?

ROGER BOYLE, C.B.E., M.D.: Well, our institutions have competed vastly for many years without any policy help to do so. So competition has been, in some form or another, already. And I think it is probably an overrated product. I think they all wish to see, all these institutions wish to see themselves performing well, and certainly, poor performance is a great incentive for them to change. And quite often, when we've seen poor performance – I've been directed to go and sort it out – which has been usually something very simple to do. Because normally, poor performance relates to poor management arrangements, poor relationships, and all those sorts of issues. I think that what we really need is the proper benchmarking and making sure that that's properly done. And that needs to be very carefully done, and we only use the risk-adjusted data. Basic things that you think would be good markers, such as mortality after heart attack, are very, very

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tricky to sort out. And so I think that the role of competition there needs to be carefully harnessed, and then part of the process. I think the important thing is to build on the professional ethic of wanting to do a good job. People do not go to work in the health system to do a bad job, they all want to do well. And we've got to create a system that allows them to do that, and remove the bureaucratic obstacles that get in the way of it.

JONATHAN PERLIN, M.D.: I thought the moderator got off the hook from hard questions. But let me respond to that, because a lot of what created transformation in VA, first, a burning platform of a need to change would be rendered obsolete. Second, really, a compelling mission, a noble mission of serving America's veterans, create an incredible burning platform in which the status quo is far less comfortable than the specter of change. It happened that a good vision for change could be created, one for health promotion, disease prevention, and creation of systemness from, really, episodic intervention for catastrophe. End-stage disease. And in support of that, there were a number of things, a couple of which I've mentioned before. Specified outcomes to help reinforce health promotion, disease prevention as opposed to the traditional markers of performance in the hospital alone. Accelerating tools, such as the electronic

health record. But there's an important structural one that, in a sense, created an internal market. And the currency was, in part, money, but the rest of it was public display of data. And that was the creation of networks within the country, dividing into entities where the funding unit became, essentially, as network states that said, "Okay, use your dollars wisely to achieve the ultimate outcomes. And while at one level you might say, "Well, VA's not really competing in the broader markets of the United States healthcare," that's true. There was an interesting internal dynamic, where essentially, a market was created. Reinforced by funds flow, but also, reinforced, perhaps, most strongly by performance measures, where the different states, or in this instance, networks, actually competed. And the currency was the public, very public display of performance data. So, a bit of an unusual conceptualization of market, but a very real sense of creating a market competition to drive performance from an internal perspective. I think we saw an individual over there. Yes, sir.

CRAIG TANIO: Craig Tanio with McKenzie. A question for Dr. Berg. You had mentioned the benefits of unfreezing prices once the four rules had been met. I was wondering if you can comment a little bit on the mechanism in which prices are effectively unfrozen, and how that contrasts with maybe

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traditional contracting arrangements from insurance companies and providers?

MARC BERG, M.D.: Basically, what I'm saying there is that the provider sets the price. So an individual provider, basically, then, comes down to saying, "This is my service. This is the –" and again, this is very crucial, and I would argue for the overall system goals that you have to have the definitions of the services and the definitions of the quality indicators sort of agreed upon. Those are the regulatory framework within the game is played, otherwise it doesn't work. In other words, you don't have transparency. But then, if you have that, then the provider can say, this is, for example, for integrated diabetic care, or hip replacement, or for – let's just keep it at those examples. They set their price, and they have the quality information next to it. And basically, then you have almost an ordinary market type of situation, because other providers will set their price and will have to perform with their quality in linkage to that, or better. And then you'll have insurance companies having to contract from that. Or, for example, individuals could choose directly, and insurance companies would just have to refund them. And there are different ways you can play that out. But basically it comes down to there's this impossibility for government, or for other consensus groups to try to set prices for these complex

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entities. And having providers set them gives an incredible stimulus for trying to constantly improve the value of the care they're creating. Does that answer your question?

CRAIG TANIO: Yes. Thanks.

JONATHAN PERLIN, M.D.: Yes, sir.

STEPHEN McKERNAN: Thank you. Jonathan, my name is Stephen McKernan, I'm the Director General of Health with the New Zealand Ministry of Health. My question really builds on a theme that Sheila kicked off, and that's really under the headings of system performance and value for money. Roger, you had a very powerful chart, which was explaining mortality reduction between 1980 and 2000, where 60-percent came from risk factor modification and 40-percent from direct treatment. Under those headings, I'd be keen on your, or any information you may have on the relative spend to achieve those outcomes in each of those quadrants.

ROGER BOYLE, C.B.E., M.D.: Yes. In percentage terms, very much less on the lifestyle issues than on the treatment costs. The big costs are the primary care prescribing and the hospital costs. But we, I think, made a deliberate decision that we would spend money on the high-tech end, at least in the initial phases, merely to prove to our cardiology community that we're only just beginning to realize that we're treating a

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preventable condition. That we're taking this whole business seriously.

I think, in retrospect, we would have liked to have preserved more of the revenue that we have actually spent in the public awareness area, which is extremely expensive to do per project, but has really high impact factor. So the television advertisements, particularly around the smoking project, have been the highest impact of any advertising campaign that has been run in the last decade in the United Kingdom, for example. We would like to do more of that, and find ourselves short of the cash to do it at the moment, because of our financial position at the present time. But that is where we would like to redress the balance. So it is something in the order of 8-percent of the total spend has been on the primary prevention element. Of course, there is a treatment element to the prevention side of it, which is all within the prescribing cost [inaudible].

STEPHEN McKERNAN: Thanks.

JONATHAN PERLIN, M.D.: Question over here?

JOHN RING: John Ring, Director for Policy Development and Research at the American Heart Association. My question is for Dr. Boyle. If I understood you correctly, the public reporting of physician performance is voluntary? What percent

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of providers choose to report, and can you link any outcomes or changes yet to that public reporting?

ROGER BOYLE, C.B.E., M.D.: All but one of our cardiac centers report, and the one that does not, does not report because they do not have the data systems to handle it. And it's more about a level of competence than an unwillingness to do it. Sixty percent of the surgeons are allowing their individual performance data to be included in this website, but we do have the individual performance for every surgeon. Is it impacting on quality? Well, we're seeing a gradual reduction on our already very low mortality rates, and I think, actually, mortality rate may be, although it's the one that attracts all the attention, is probably not the best indicator of quality. Because it's very difficult to distinguish not only between individual surgeons, but between individual institutions, even, in terms of those rates, to really make a choice as to whether they're good or bad. And really, it's more of an alerting mechanism to tell us if they're going off track. We would like to look at other markers, and we are certainly, as we develop the audit program and build in quality of life measures, would like to look at that as a marker of the quality of the care. But also, as I mentioned briefly, because we've got all that's going on in registers for the whole range of the cardiovascular activities, being able to monitor event-free survival after an

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intervention, I think, will be, in the end, a much better marker of quality that we would also wish to publish.

JONATHAN PERLIN, M.D.: The central tool for transparency is measurement. And you may recall that Albert Einstein has a wonderful quote on measurement. He once quipped that, "Not everything that's measured counts, and not everything that counts is measured." And we're going to be able to begin to develop some transparency on some things. And there's the old image, as well, of looking for the lost keys under the light of the lamppost. So my question to all three of the presenters is this: Do measures lead to better care overall, or will we just see improvements in the area that we measure? What are your thoughts on how we move from improvements in the focal areas, be they in clinical care services, in improving value... And let me start with David, in terms of your thoughts on that one.

DAVID FISHER: I hope. Yes, I think that they will. To me – as I think I said when I was speaking – making public information about providers about their relative rank amongst their peers is a very, very powerful motivator. And at the end of the day, that's what's going to improve quality.

JONATHAN PERLIN, M.D.: Marc?

MARC BERG, M.D.: I agree that measures – and I think it's crucial to constantly emphasize how measures are always

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imperfect and always partial, and the points that you made are completely true. For me, I always emphasize the point that we have a system now that has the incentives for quality and cost in the most perverse way, almost, as possible. Still, we see health care systems that provide relatively okay care, and it's because of the professional motivation of professionals, and the motivation of managers, et cetera. If we turn around those incentives so that they point into the right direction – although they're not perfect, but they'll point in the right direction – I cannot think of a reason why, then, suddenly motivations of professionals which are then aligned, will start to become disaligned and start to try to become perversely reacting to something that is innately pointing in the right direction. So, I'm actually quite positive about that, although I see the limitations of it.

JONATHAN PERLIN, M.D.: Roger, your comments on the space between the measures.

ROGER BOYLE, C.B.E., M.D.: Well, I think we've got a long way to go before this really takes hold in the public imagination. I think that in our experience, that all of the public wish is local service. And it'll take quite a deal of publication of unfavorable data to dissuade them to really seek alternatives. But I think that it's more actually about incentivizing the institutions to be regarding quality as a key

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issue. I think we've been slow in developing this process in the United Kingdom, although we have a lot of measures there that can be used for measuring quality. But to do it systematically and to do it in the context of the contracting and the financial flows, so that quality is part of the contractual arrangements in the way that the tariff is set for each individual disease area, I think is something that really does need to be developed if quality is to be driven up, and for us to still get the value for money that the big investment demands.

JONATHAN PERLIN, M.D.: And I'd add my vote that measures are the appropriate beginning, and Beth McGlynn's work, in fact, when she and Steve Asch looked at the VA, what was interesting to me was not just what was measured, but it was interesting that there was a halo effect, there was a bystander effect. And when one measured unmeasured things that were related to the things that were measured, the care also improved. And I think that was the most important finding. So in terms of creating systemness and coherence, other tool sets are needed. The next panel focuses on electronic health records.

Please join me in thanking this panel for a terrific presentation.

[Applause]

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