The Economist

Frugal health care in America

Quality, not quantity

Private firms are taking baby steps to curb soaring health costs

Jun 16th 2011 | DANVILLE, PENNSYLVANIA | From the print edition

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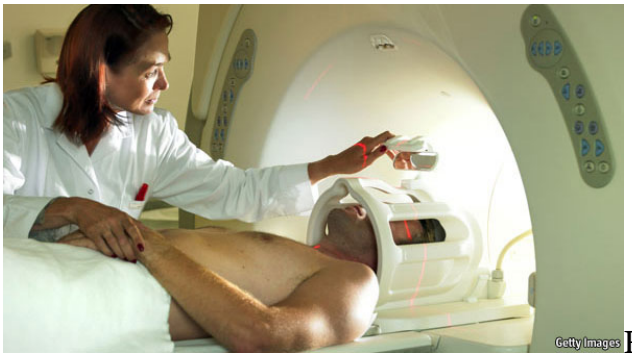


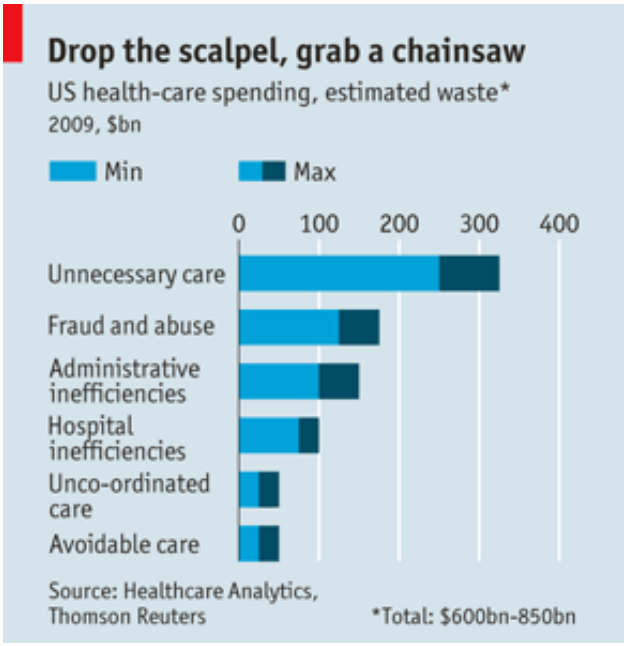
Relax, your grandchildren will pay

Pennsylvania sits an old hospital that gives an optimistic hint about the future of American health care. Geisinger Health Systems was founded in 1915 but is as adaptable and creative as a start-up. It has invented new ways to offer services: it provides heart surgery, for example, at a fixed price and with a warranty. (If there are complications within 90 days, you pay nothing to fix them.)

Geisinger is changing the way it delivers primary care, co-ordinating teams of doctors and nurses to keep more people healthy for less money. Barack Obama sometimes praises the organisation in speeches. His health reform includes a programme to promote a model much like it. Alas, Geisinger's chief executive, Glenn Steele, is one of many hospital bosses who think the new programme will not work.

America spends far more on health care than other countries, such as Britain (see article (/node/18834011)). The waste is staggering (see chart). The main problem is loopy incentives. Under “fee-for-service” arrangements, the more tests, scans and pokes with gloved hands a hospital or clinic provides, the more it is paid. Mr Obama's health reform included only a few small nudges to change this.

Topmost among them is a plan for Medicare to reward “accountable care organisations” (ACOs) for keeping people healthy, rather than lavishing treatment on them. The plan seems sensible enough. But it has provoked uproar in every corner of the health industry. This month the Centres for Medicare and Medicaid Services (CMS), the body that oversees government health schemes for the old and the poor, was barraged with irate letters about it.



An entrenched system is hard to change. Hospitals currently have little incentive to keep patients healthy. On the contrary, fitter patients would mean lower volumes and smaller margins, says Michael Nugent of Navigant Consulting, an expert on ACOs. Nevertheless, the current system is clearly unsustainable.

Wonks have buzzed about ACOs for years. In 2005 CMS began a pilot with ten health systems, including Geisinger, to reward them for improving the quality of care while lowering costs. America is dotted with examples of reform. Utah's Intermountain Healthcare is a hospital system with its own health plan. Clever use of data has helped to streamline care: a new protocol for delivering babies has reduced the number of unplanned caesarean sections and saved about $50m a year.

Insurers are experimenting with reform as well. Aetna, Humana and Wellpoint are testing new payment models. In Massachusetts, Blue Cross Blue Shield has created an “alternative quality contract” that gives hospitals a fixed budget for a patient, with additional rewards for improving the quality of care. In the programme's first year hospitals cut the number of unnecessary emergency-room visits by 22%.

“The train is moving in the right direction,” says Mark McClellan, a former head of CMS who has championed ACOs. Real progress, however, requires change in the public sector. Medicare, the public health programme for the old, provides a whopping 35% of American hospitals' revenue.

CMS's proposed rule for ACOs would allow doctors, hospitals and other health providers to form networks to co-ordinate Medicare patients' care. CMS would reward ACOs that save money, relative to a predetermined benchmark, while meeting certain standards of quality.

Alas, the regulations are a mess. “The ACO policy is an example of why the government is not always a great change agent,” sighs Chip Kahn, president of the Federation of American Hospitals. The insurance lobby frets that the rules will prompt hospitals to merge, reducing competition and driving up prices. The American Hospital Association says that the rewards for saving money are too low and the risks too high. The rules include 65 quality measures, more than twice the number in CMS's earlier, smaller pilot. “I was very disappointed with their over-specificity,” says Geisinger's Dr Steele. Advocates for ACOs, such as Dr McClellan, hope that the final rules will be different.

CMS is likely to make at least some changes to the programme. “I'm delighted to have the feedback,” says Donald Berwick, CMS's boss. Last month Dr Berwick unveiled a few new enticements for ACOs, such as more flexible rules for experienced hospitals such as Intermountain. But it is unlikely that the ACO programme will be in place by January, as originally planned.

Dr Berwick points to other efforts to spur reform, including a pilot scheme to improve primary care and new penalties for hospitals where too many patients acquire new diseases or are readmitted because their treatment failed. The trick will be aligning these programmes with one another—and with innovations in the private sector. Health-care reform is like brain surgery, only harder.

From the print edition: Business