MEASURING QUALITY IN HEALTH CARE AND IN EDUCATION

Ted Kolderie's notes from a 1986 keynote talk given by Walter McClure, President of the Center for Policy Studies, to the Metropolitan Hospital Trustees Council.

Background

The discussions about system-change tend to go on pretty much within each of the major service areas. Transportation people talk to transportation people; educators talk to educators; health-care people talk to other health-care people.

Yet the similarities in problems -- and in strategies -- are often striking from service area to service area. So one of the things PSRP has done from time to time is to make some connections . . . mailing our memos about redesign to people in a variety of fields and inviting people from a variety of fields to meetings to talk about the problems in a particular field.

We have tried to do this especially in education, which is organized in Minnesota as in many states independent of general government; with its own institutions, its own facilities, its own elections, its own professional organizations and its own committees in the Legislature.

Mixing people from education with people from other fields has produced some fascinating meetings -- especially those in 1983 at which we brought together teachers with doctors, lawyers and consultants to talk about their different modes of practice, their different relationship to administrators and their different situations with respect to compensation and to professional autonomy.

Quality assessment is currently a subject of much discussion -- and controversy -- both in education and in health care. In both systems differences in cost are challenged with the same assertions: "My cases are tougher; my care is better". Policymakers wonder. But professionals resist comparisons. So nobody knows for sure.

The 1986 winter meeting of the Metropolitan Hospital Trustees Council focused on the problem of quality-assurance in health care. The keynote talk was given by the president of the Center for Policy Studies, Walter McClure. We thought his talk was full of implications for, and of echoes from, the debate about testing in education. Our notes follow.

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Notes of Walter McClure's talk to the hospital trustees

We want a health care system that assures high-quality care and covers all people at a cost that both the patient and the nation can afford. All elements of this -- universal access and coverage, quality, and efficiency -- are equally important.

Fifteen or 20 years ago we thought the way to do this was to governmentalize health care. That had solved the problem of coverage and the problem of equity in most industrial countries. But it did not solve the problem of quality. So in this country we have been looking for another solution.

Cost control is where we began. And cost control remains as important as ever: If we can't afford quality health care we can't provide quality health care.

There have been four ways to attack the cost problem. One is to shift costs from one group to another. This does not reduce costs in the aggregate: It simply moves them. So it is not a solution. The second is to reduce coverage . . . to exclude people from care. We have been doing this; and it is a shameful strategy. The third is to dilute the quality of what everybody gets. Equitable, perhaps, but also unacceptable. The fourth is to improve productivity . . . to get more health with fewer resources. This is what we are now trying to do.

Where do we stand today? We are moving away from regulation. We are trying now to create a soundly competitive system that everyone will be able to buy into. This can work. Markets -- if sound -- can be good at quality and efficiency, where adequate purchasing power is present.

There are three parts to this strategy.

The first is to introduce competitive arrangements among producers. Hospitals and doctors must be able to take patients away from each other based on the cost and quality of care.

The second is to get the people who pay for care to "buy right". We have got to reward producers for quality and efficiency if we want them to compete on quality and efficiency. If it works this will mean buyers will reward you with patients if your hospital is performing well on quality and efficiency but punish you with fewer patients if you perform poorly.

Overall there will be fewer patients for hospitals and less income per patient. That will be devastating for some hospitals. Some of you will be driven over the edge. But we have got to stop buying dumb -- as we traditionally did. We used to say to a patient, "Go anywhere -- regardless of quality and cost -- and we will pay the bill." That was dumb. Organizations selling to dumb buyers can always find ways to spend more more money. The Defense Department could. Schools could. Hospitals could, and did. Buying right will drive 20 to 30 per cent of you over the edge within the next 10 years. The question is: Which 30 per cent? If we do it right it will be the right 30 per cent, and we will have better health care.

We can do a lot better than we are at present. We used to say that perhaps 30 per cent of the surgery could be done on an outpatient basis. Today there are places doing 60 per cent of the surgery on an outpatient basis. If we provide the right incentives you and your medical staffs will find ways to improve that those of us on the outside have never thought-of. We should leave that professional job to you. The job of public policy is simply to give you those incentives to get better and better.

The third part of the strategy is to get government to use the 'buy right' strategy as a major purchaser for the poor, the old and the uninsured who need subsidy.

How are we coming?

The first part of the strategy is now a done deal. The shift to a competitive marketplace for producers is now obvious to anyone reading the papers, and certainly to those of you in hospitals. I would say the second effort, to get purchasers to buy right, is about halfway along. But we are only beginning to get at the problem of the poor and

uninsured. (We do do pretty well for the elderly.) The poor are a difficult problem. Finding the money is only a part of the answer. We have also got to spend it right, or the poor will end up again with low-quality and costly care.

How will we complete this job over the next 10 years, given the forces presently at work?

Let's look first at those 'forces at work'. Two are of major importance. One is the oversupply of doctors and hospitals. The other is the new determination of purchasers to control their costs. This is now very strong. We always knew it would appear when costs got high enough. The question has been what form it would take.

Basically we can respond in three ways. We can let all hospitals and doctors starve equally -- which seems both unwise and unlikely. We can let the bad producers drive out the good. Or we can arrange for the good hospitals and doctors to drive out the bad.

Remember: Closing hospitals and dropping doctors out of the system is not itself bad. It will be a sign of success -- if those leaving are the ones that ought to be leaving.

'Buying right' means that purchasers will have the ability to identify the quality and efficiency of producers, and that there will be strategies and 'technologies' to give consumers both the means and the incentives to choose the better over the poorer producers.

Identifying the quality is a challenge, to be sure. But an even bigger challenge is to design the benefit programs that will actually shift patient volume to the superior producers once they are identified. Meeting that challenge will be in the interest of every hospital and doctor that is a superior producer. You will have to help the purchasers . . . by helping them deal with the powerful pressures that exist today not to buy right.

Quality-assessment is not being done today. The techniques in use today in health care are primitive. No other business would spend so little and know so little about the quality of its product. The reason is that today you are punished as a hospital if you do quality assessment, and punished as a buyer if you try to use it. Thus what is holding us up is not the lack of technology for quality assessment but the lack of structurally-entrenched incentives to use or to improve the technology.

We will not change this situation except by changing the underlying structure of rewards and incentives.

Three things need to be done.

The first is simply to introduce the technology of quality assessment. We do need numbers. Numbers are not all that is needed, to know quality. No college would admit just on SAT scores. But no college would admit without them. In health care, too, we need to begin with the numbers -- and then go on to the other information that is needed to understand them.

I want to talk about one of the most sophisticated quality-assessment systems available today.

The first chart compares nine hospitals on elective gall-bladder surgery. The costs have been reported for some time. Hospital A charges $4,900, Hospital B $2,900, Hospital F $2,700, Hospital E $6,000. So there's a range of more than 2:1.

We all know what hospitals say when confronted with numbers like this. Those with higher costs say, "But my patients are sicker." Or: "My care is better." They will question whether buyers are really concerned about quality, or just about cost. (Equally, someone might ask whether sellers are really concerned about quality, or just about income.)

Not surprisingly, we have seen no significant shift in patient-volume as a result of this sort of discussion. Buyers wonder whether the lower price might indicate lower quality. Until now there has been no way to tell.

The new technology answers this 'quality' question. It simply goes to the medical record. It looks at the clinical findings: at the blood counts; at the pathology reports. It is factual. So it is medically and politically credible -- unlike the DRG classifications, which have no clinical basis whatever. It produces a 'severity rating' for a patient, both when the patient arrives and when the patient leaves. It makes it possible to construct an index with which you can compare complication rates and fatality rates.

So we can now answer the question of what's quality. That's not a simple question. Three things go into quality. One is patient satisfaction -- which has nothing to do with the technical effectiveness of the care. It has to do with the humaneness and responsiveness with which the patient is treated. That is important. Your success may depend on that. But it is not enough: Sometimes you can keep a patient smiling all the way to the grave. The second ingredient of quality is precisely the technical effectiveness of care. The third is improvement from year to year in that technical effectiveness as well as in efficiency.

There is no way a patient can know the quality of care. Quality is a measure of what the hospital does in the aggregate: It does not turn on what happens in any particular case. Think about baseball: A player's getting a hit the day you happen to go to the game is no measure of that player's performance. Performance is an average -- important both as an absolute figure and in relation to other players' averages. So quality in health care is something not for patients but for producers and for purchasers: How good is the best, and how close to it does this producer's 'batting average' come?

How many of you have seen these figures? (Virtually no hands are raised.) This is available now. And you are legally responsible for the quality of care in your hospital!

Look at the implications. The hospital charging $4,900 would, under the old arrangements, have been the winner -- getting the most dollars. We want to change that. But we do not want the dollars to go simply to the cheapest hospital. So we look at quality. We see that Hospital A has the sickest patients -- and a 4.7% complication rate. Hospital B charges less and has the next-sickest cases, but its outcomes are better: only 2.5% complication rate. Hospital C charges $5,400 for less severe cases and has a high complication rate: almost 10%! It is expensive and gives lousy care. "Come to our hospital," it might advertise: "There is a 10 per cent chance we can make you sick." Hospital D charges $,3,500 and has good outcomes. E's quality is good, but it charges $6,000: It's pretty effective, but not efficient. F charges $2,700 and its outcomes are good, but its patients are less sick. G is expensive and gets lousy results. H charges $3,300 for healthy people and gets good results. Hospital I gets healthy people and makes 'em sick -- but cheap.

DRGs are a symptom of purchasers' determination to impose some kind of cost control -- with no adjustment for severity and no adjustment for outcomes. It offers no rewards to a hospital like B which gets good results on sick patients for $2,900. Medicare would pay that hospital, say, $3,500. Why shouldn't it pay the hospital $2,900 dollars and send it patients? That would be buying right, instead of buying dumb. We have got to get Medicare to do that. If 40 per cent of the market buys dumb we have a big problem.

You can also make these comparisons doctor by doctor. Doctors too will say, "My cases are tougher" and "My quality is better". But look at these numbers. Doctor D gets less sick patients -- and 35 per cent of them die! Another 10 per cent have complications. And that doctor is out there now, in your hospitals. What are you doing about it? Do you even know who he is? Other doctors are working with really sick patients and having morbidity and mortality rates of about 15 per cent.

How can you not get this kind of report on quality . . . just as you get reports on financial performance?

Finally, let me talk about the other two things that must be done, to make sure the new technology is used.

Understand first why it is not used. It is not that people are stupid. Somewhere there are powerful punishments for people who use it. In hospitals these have to do with:

* Cost. If you put in a quality-assurance system your costs would rise. You'd be at a disadvantage against others.

* Professional divisiveness. The medical staff would be up in arms. They would challenge the validity of the figures. They would challenge your right to know the numbers. ("This is a professional matter" . . . etc.) And the medical staff can punish a hospital like nobody else.

* Malpractice risk. The figures will show you are not perfect. That could cost you patients. You could get sued.

* Management. Such a system would take people, and a system, to run it and really to act on what it tells you -- for example, to remove or to retrain doctors not performing well.

And what would be your rewards for doing this? Zero. Except for your own conscience.

There have got to be rewards. We can turn the whole system's incentives around by buying right, so that a hospital that does not assess quality will not get patients. Then everybody uniformly will have to bear the cost of quality assessment. Professional objections will be muted (as more patients come to the better hospitals), liability problems will decline (as it becomes clear the system reduces risk) and the management systems will appear.

Incentives will have to be turned-around for the purchasers as well. Their employees will initially be unhappy at having incentives to go to other doctors and hospitals. Doctors and hospitals will have to be educated not to lean on their corporate-executive friends who serve on hospital boards. Management systems will have to be set up in the companies, too.

This is your challenge: to decide that you will measure quality; to help others make the same decision, and to help persuade the purchasers to buy right. If we do this we will get high quality health care, for everybody, at a price they and the nation can afford.