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Commentary

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The Way We Buy Care in this Country is Flawed, Dysfunctional, and Often Perverse

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Many of the biggest problems in American health care today are a direct result of the flawed, dysfunctional, and often perverse business model we use to buy care. The Berkeley Forum Report addresses one of the most serious problems: fee-for-service payments to providers. Every industry aligns and organizes around its cash flow. No industry produces products that have no customers, and every industry produces large volumes of the products their customers actually purchase. Health care is no exception.

Knowing that to be true, no one should be surprised that the health care industry produces the array of products and services it does. That business model leads us to spend $2.8 trillion a year for health care, much of which we spend for care we should not be buying Centers for Medicare & Medicaid Services (2014).

We do not buy health, and we do not buy packages of care. We buy care by the piece. That is the American business model. For almost all care, we have a piece-work reimbursement model that is not linked in any way to either the outcome or the quality of the care we get for our $2.8 trillion.

Our piecework-purchasing model is massively and fundamentally flawed in four fundamental ways. The first is that a piecework-purchasing model has only two incentives and two financial leverage points – volume levels and price hikes.

There are few quality payments or effectiveness rewards when we pay for care by the piece. The piecework model rewards increasing the volume of units sold and/or the price charged for each unit of care. Not surprisingly, in areas like MRI exams and CT scans, where the providers of care set the price and determine the unit volume consumed, we have more exams and scans per capita than almost

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any country in the world Organisation for Economic Co-operation and Development (2013) – and our price per scan is two to five times higher than the price other countries charge for the same exact scan International Federation of Health Plans (2012). We have the highest scan prices in the world for no economic reason other than to increase revenue to the providers.

The prices for delivering a baby or for removing an appendix are three to four times higher in the US than in other Western countries (International Federation of Health Plans 2012). Our piecework charges for doing a basic coronary graft heart surgery average over $70,000 per heart. Other countries charge $10,000 to $45,000 to perform the same surgery, and their outcomes and safety levels equal or exceed US outcomes and safety levels (International Federation of Health Plans 2012).

Since we do more of these surgeries than many other countries Organisation for Economic Co-operation and Development (2013). Higher volume should reduce prices in a normal economic functionality situation. That does not happen in our purchasing model. Indeed, in America volume can increase prices.

But these obviously problematic issues are not the biggest problems or the most egregious flaws in our payment model. The second and much bigger flaw in our system is the fact that the piecework model we use to buy care cripples reengineering and process improvement for care delivery. For basic medical issues and procedures like asthma attacks or congestive heart failure (CHF) crises, it is clearly possible to reengineer care delivery and intervene with patients in systemic and proactive ways to reduce these kinds of painful and expensive patient crises by half or more.

That reengineering work is seldom done in this country. It is seldom done because each CHF crisis and each asthma crisis generates large amounts of money for care sites. Preventing such crises generates no revenue and can directly damage the cash flow for our fee-based care sites. The same holds true for just about every chronic care delivery process. Making care better reduces piecework revenue.

So care reengineering almost never happens. A given patient might have three separate CT scans in three separate care sites. In a reengineered and process-focused world, the patient might have one scan and that same scan would be used three times. That basic and logical process improvement does not happen in this country because the three care sites that scan the patient each charge for each scan – and each charge is highly profitable for each site.

Thus, in a piecework payment model, reengineering seldom happens and process improvement is rare. And that is a much bigger problem than the economic volume incentives inherent in a piecework payment model.

A third and even bigger flaw in our current piecework care purchase model is that it actually rewards poor care outcomes and rewards bad outcomes very

directly. There is no reward or payment for preventing a stroke or a heart attack, but care sites are paid hundreds of billions of dollars when people do have strokes and heart attacks. The financial model we currently use to buy care richly rewards those bad outcomes.

Fourth, and this might be the most perverse part of the way we buy care, the current model rewards bad care. Other industries tend to have financial models that penalize products that damage people. The payment model we use can actually increase revenue for care sites when mistakes occur and bad care is delivered to people. In 2011, one in 25 Americans cared for in hospitals, or 648,000 patients, ended up with an infection they did not have when they were admitted (Magill et al. 2014). Most of these infections increased revenue for the sites that were caring for the patients.

No care site ever deliberately infects a patient. That absolutely does not happen. No care site ever intentionally harms a patient. But it is also true that not enough care sites do the things that need to be done to keep infections from happening in the first place. Some payers are beginning to stop paying for bad care that should "never" happen – but that is not the model used by all payers; as such, bad outcomes far too often actually generate additional revenue for care sites.

It is hard to imagine a more perverse payment model when you look at the overall financial reality for care delivery. The current piecework payment approach rewards price increases, unnecessary volume, bad care outcomes, and care screw-ups, while it penalizes process improvement and reengineering.

We spend more money on care than any country in the world by a significant margin, and our outcomes are not better than the outcomes in countries that spend a lot less money on care.

When you consider how we buy care, that high cost and those less than adequate outcomes are easier to understand. We get what we pay for.

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