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Citizens Research Council of Michigan

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CONSUMER PROTECTION AND QUALITY IN HEALTH CARE

On September 30, 1997, Gail L. Warden, President & CEO of Henry Ford Health System, addressed the 81st annual meeting of the Citizens Research Council of Michigan at the Westin Hotel in Detroit, Michigan. This is an edited version of his remarks:

It is a privilege to be invited to speak to the Citizens Research Council. I have been very interested in what this organization does ever since I came to Detroit, almost ten years ago. I've had the opportunity from time to time to look at a number of your studies, which I think have served the public and government well in the State of Michigan and Southeast Michigan. And I congratulate you also on the fact that you are now going to get serious about health care. I think that there is a need for an organization like yours that doesn't come with an agenda other than to try to look at difficult issues and educate the public about them. For that reason, I'm pleased that this is now on your radar screen and going to be part of your agenda.

The topic that I have chosen today might be viewed as not the most interesting one because people are more concerned about the cost of health care, about the impact of continued increase in cost upon the global market and upon the cost of their products. But I can tell you that another issue in health care worth talking about is quality and consumer protection. I think that I should begin by talking a little about what the symptoms are, then talk about the policy issues. Then, I want to talk a about your agenda and give you an example of what can happen if you get the right people around the table looking at some of these issues, as we did in Washington state. There, a group of individuals, who did not represent organizations, decided to sit down and look at some health policy issues in that state, which to a great extent is what you are proposing to do in your organization.

Symptoms of Problems in Health Care.

Perceptions of Bigness. As you look at the symptoms in health care that would make people be concerned about consumer protection and quality, all you have to do is look at the studies done during the last five years. A particularly significant one involved interviewing focus groups all over the country. It was conducted by the American Hospital Association with the help of two polling organizations to try to find out just what the public thought about their health care. The good news was that the public generally thought it was the best health care in the world, but the bad news was that it cost too much. It is perceived as big business and it is controlled too much by insurance companies. A feeling exists in every community across the country that freedom of choice of health care plan or provider is being lost because of the influence of large health plans.

Crisis of Trust. There is also a crisis of trust among the industry, its patients, and society as a whole. There is a feeling that the doctor-patient relationship, which has always been characterized as a "Marcus Welby" kind of relationship has suffered with the disclosure that some physicians may enhance personal income with unnecessary treatments and referrals. I can tell you that this behavior is really an exception, but all it takes is one or two stories like that to put questions in people's minds about just what is happening in health care. Patients also fear that their physicians might buckle under the pressure of the health plan and actually provide less than appropriate care because of policies of the health plan, and that they would not be able to talk about that to the patients. This is referred to as the "gag rule."

Limitation of choice arose from a system in which patients could go to anyone they wished and self-refer themselves to specialists, thereby driving up health care costs. The perception has been that limitation of choice is what managed care really means. In our organization, we refer to managed care as a style of practice focused on making sure that we provide access, good quality, and that we do the right thing, clinically. It has nothing to do with the financing or economic issues that so often are perceived by others.

There also has been a big change in consumers and their understanding of health care. As consumers become more sophisticated, as they know how to access information about their health and their particular diagnoses, they often know more about their disease and more about the symptoms and possible outcomes

than the physician because they've just focused on that one problem. They also become more informed because the pharmaceutical industry has now begun advertising particular drugs to persuade individuals to ask their physicians, "Why aren't you giving me this drug instead of the one that I'm on?" Quite often, the reason is that it is a generic equivalent of the very expensive drug advertised in *Good Housekeeping*, *Time*, or *Newsweek*.

Failure of Health Care Reform. So, consumers have questions about the health care system, about those of us that work in it, and also about individual physicians. This greatly concerns all of us in the health care industry. In 1993 and 1994, there was a very important debate about health care reform, introduced by the President and the First Lady. It heightened the public's interest in health care considerably, although as it turned out, very little happened at the time. The reasons nothing happened were: First, people were not excited about more government involvement in health care; second, they generally were quite happy with their own health care and any proposal that they read was probably not as good as what they perceived that they already had; and third, it was too complex.

If the President and the First Lady and their task force had taken the 13 principles espoused the night the President put the wrong tape in the machine before a joint session of Congress, and had stuck to those principles instead of trying to sell the public on a 1,300 page document, we might have actually had something happen in health care reform. But, they didn't do that and health care reform went nowhere.

Lack of Statement of Purpose. Another symptom is that there is no unifying statement that articulates a purpose for the health care system in this country. We need something that addresses the need to continually reduce the impact and burden of illness and improve the health status of the population we serve. Most of us, when we think about health status, think about those "other people" whose health we would like to see improved. We don't think about the need for a policy that really focuses on how to raise the health status of everyone in this room and every individual in the country. Most government policy has basically been budget driven, and will probably continue to be for some time.

These health care issues create some paradoxes for the public. For example, do we really want higher quality of health care and greater value if it's going to cost more? Do we want government to decide our coverage and select our provider network, or do we want to make that choice ourselves? Do we want to renegotiate our social contract with physicians if it means we have to become more accountable for our own health status? In other words, do I really want to have to listen to the physician who tells me to lose weight so I can lower my blood pressure; tells me that I should drink moderately, or tells me to stop smoking? Then the real question is whether we are really concerned about clinical quality outcomes. In other words, is the patient better, or are we just concerned about convenient and accessible health care? All of those questions are going to have to be answered if we want the health care system that we would like to have in this country.

We have to recognize that health care is a function of the interplay among 1) the individual consumer; 2) the care givers; 3) the system that organizes the services, like the Henry Ford Health System; and 4) the purchasers (in other words, the employers and the government) who decide what kind of coverage is going to be available to people who work for them or who are covered by them. On top of this are the private and public oversight agencies; the accrediting agencies; the state licensing agencies and others that bring about compliance in the health care system.

We need policies that are going to strengthen the consumer's knowledge about health care, what constitutes good quality, and what their rights are. We have to talk about how we can facilitate better choice of coverage, choice of provider, choice of health plan. We have to talk about how we can optimize access and how we can foster total quality management in health care.

Social Contract Between Physician and Patient. We also need to revisit the social contract between patient and physician and patient and health system. A lot of people perceive that the hospitals and physicians are too definite about what they think should happen with the patient instead of providing the kind of open communication that many patients are seeking. They want open communication, they want faith, they want trust in their physician and that's what we have

got to foster if we are going to have good policy. We also must recognize that the caregiver and the patient have got to be honest with each other. If I don't tell my physician really what I am worried about, we're going to have a problem. The physician is not going to know how to treat me. Likewise, if the physician withholds information and doesn't really tell me just exactly what my health status is, I am not being well served. We must improve that communication.

We also, in this social contract, have got to support the patient's right to know and the caregiver's right to fair review when an error or misjudgment is made. All of us recognize that there is nothing more complex than the covenant of accountability in health care. In no other area of human relations and commerce do two individuals surrender so completely to each other. In no other relationship is so much trust routinely asked for and so freely given as between physician and patient.

Confidentiality Issues. Another policy issue is the security and confidentiality of the patient's identifiable health information. What information should be controlled by the consumer? What are the boundaries in terms of release of information? What is the accountability of those keeping the records? What can be shared and what cannot be shared? What rights do patients have to withhold information from their physicians? These are all huge issues and are now being debated in Congress.

ERISA. The last policy issue is the question of the rights of employees who work for small self-insured employers. This involves ERISA (the Employer Retirement and Income Security Act), which says very little about health care, but protects the employees of small self-insured employers. The issue, in a nut shell, is this: Is there going to be more protection provided for those who are covered under ERISA and, if so, how tough can consumer protection be before small employers can no longer afford to offer a health plan?

Role of the President's Advisory Commission on Consumer Protection and Quality

Consumer Bill of Rights. I am a member of the President's Advisory Commission on Consumer Protection and Quality, a commission that has been asked to advise the President on the kinds of issues that I have just been talking about. It has 29 members that represent the various perspectives in health care. It is bi-partisan and the members are really serious about doing the right thing. They are focusing on four areas: First is the consumer bill of rights; what the consumer's rights and responsibilities are in relation to access and choice of plan and choice of provider and availability of information and grievance rights. That will be the first product of the commission and will come out for public discussion probably in November.

Performance Measurement. The second area is performance measurement. Those of you who are employers and who pay attention to what's really going on in health care are very much aware of the fact that there are now 10,000 different plans for measuring health care. They have been created by employers, by state government, and by federal government agencies; by health care providers who developed their own report card. There are all kinds of overlap, creating a tremendous burden on everyone and still the right information is not always available. The commission will be assessing the priorities for measurement, how measurement can be made more uniform and how we can move away from so many different measurement plans, which aren't that useful either to the public or to the people who are paying for the health care.

Total Quality Management. Those of you who live here in Southeast Michigan are very familiar with the third item, that is how can we improve the quality environment in health care; how do we introduce total quality management into the health care system; how can we improve the infrastructure of the health care system in such a way that it can improve the clinical process and in so doing improve patient satisfaction and outcomes?

Oversight Agencies. The final set of issues that the Commission is looking at is that of the oversight agencies, both public and private; what role they play; what kind of duplication exists. We will also concentrate on the ERISA issue that I mentioned. The Commission meets two days a month, although those of us that chair the four sub-committees (I happen to chair the oversight committee) sometimes meet three days a month. The report of the commission is due in March. Probably not much legislation will come out of it, but it is going to heighten the public's knowledge of these issues.

A Role for CRC.

In the CRC white paper on health care policy, you acknowledge the different roles the state government plays in health care. The state directly provides care, such as in mental health institutions and medical care in correctional facilities; it subsidizes care, for instance in correctional facilities; it regulates through such activities as professional licensing, certificate of need, and health insurance regulations. It also purchases services through the Medicaid program and through community mental health programs. The role that CRC can play is to make sure that there is good fact-based research going on and that the answers are not just those promoted by one organization or another that has a particular agenda.

In the past year there was a lot of discussion about the 24-hour delivery, sometimes referred to as "drive-thru delivery." The facts are in and, now that the study has been done, it really was not a very big issue. There are very few cases in which there was a problem, but it was a perception that people had because of anecdotal data. The gag rule issue, which I raised earlier, was analyzed in a study of all the health plans in the country. It found only two of 450 organizations actually had gag rules, but there was a perception that everybody had gag rules. Another recent study shows that people enrolled in Medicare managed care plans actually get better care because the care is much more organized than that delivered to those not in such a plan. That kind of fact-based research, which could be done by CRC, could really make a difference here in Michigan and in Southeast Michigan.

Secondly, I think that you could conduct forums and bring the right people together to talk about tough issues. You could educate the public and the media. As I said in the beginning, I had an experience in Washington state with a Committee on Affordable Health Care, which was a group of individuals representing the various interest groups from consumer to insurer to provider to state government who came together to talk about policy issues. What grew out of that was a study that showed that there was a very high percentage of people in the state of Washington who were uninsured. We got a better understanding of who they were. We conducted hearings in a number of communities around the state. We went to legislative sessions and raised questions with state legislators, when they were running for office, to get them involved in really understanding the health care issues. The outcome was that we ended up passing the first basic health plan in the country. It brought about some real health care reform in the state of Washington and is still serving that state very well.

It's been a pleasure to be with you. I hope I've raised some questions that you will want to pursue as you move forward. If the people in this room and the organizations they represent are willing to work together, we can improve quality, we can reduce cost, and we can make Southeast Michigan a healthier, happier community.