

# US Employers as Quality Drivers in the Health Sector

Peggy McNamara

September 2004





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IN THE HEALTH SECTOR**

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## Health, Nutrition and Population (HNP) Discussion Paper

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# Health, Nutrition and Population (HNP) Discussion Paper

## US Employers as Quality Drivers in the Health Sector

Peggy McNamara<sup>a</sup>

<sup>a</sup>Senior Policy Analyst, Center for Organization and Delivery Studies, U.S. Agency for Healthcare Research and Quality, Rockville, MD, USA

Paper prepared for the World Bank's Resource Allocation and Purchasing Project

**Abstract:** This review is one in a series of analytic efforts designed to inform the policy debate related to how the purchasing function is being used as an instrument for quality. The author reviews evidence on the extent of quality-based purchasing by U.S. employers, generally viewed as pivotal to the national push for value in health care, and summarizes key employer efforts underway. A typology for categorizing purchaser strategies is provided. The author examines what is known about the impact of employer strategies on care delivery and concludes with a broader discussion of quality approaches.

**Keywords:** resource allocation and purchasing, health care financing, purchasing, quality-based purchasing, performance-based purchasing, contracting, strategic contracting

**Disclaimer:** The findings, interpretations and conclusions expressed in the paper are entirely those of the authors, and do not represent the views of the World Bank, its Executive Directors, or the countries they represent.

**Correspondence Details:** Peggy McNamara, 2451 39<sup>th</sup> Street, Northwest, Washington, DC 20007. Phone: (301) 594-5880. Fax: (301) 594-2314. Email: <mailto:pmcnamar@ahrq.gov>. Web: <http://www.ahrq.gov/>



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## FOREWORD

Great progress has been made in recent years in securing better access and financial protection against the cost of illness through collective financing of health care. This publication – *US Employers as Quality Drivers in the Health Sector* by Peggy McNamara – is part of a series of Discussions Papers that review ways to make public spending on health care more efficient and equitable in developing countries through strategic purchasing and contracting services from nongovernmental providers.

Promoting health and confronting disease challenges requires action across a range of activities in the health system. This includes improvements in the policymaking and stewardship role of governments, better access to human resources, drugs, medical equipment, and consumables, and a greater engagement of both public and private providers of services.

Managing scarce resources and health care effectively and efficiently is an important part of this story. Experience has shown that, without strategic policies and focused spending mechanisms, the poor and other ordinary people are likely to get left out. The use of purchasing as a tool to enhance public sector performance is well documented in other sectors of the economy. Extension of this experience to the health sector is more recent and lessons learned are now being successfully applied to developing countries.

The shift from hiring staff in the public sector and producing services “in house” from non governmental providers has been at the center of a lively debate on collective financing of health care during recent years. Its underlying premise is that it is necessary to separate the functions of financing health services from the production process of service delivery to improve public sector accountability and performance.

In this Discussion Paper, McNamara emphasizes that the global health care debate increasingly recognizes the potential power of the purchasing function — whether led by national and regional governments, social insurance funds, community-based insurance organizations, employers, health plans, or consumers — to achieve not only efficiency and equity but also quality goals. Stakeholders from high-, middle-, and low-income countries are looking for the evidence base to guide future purchasing policies and practices. So, too, are representatives of the global health care community. No matter what it is called — quality-based purchasing, value-based purchasing, performance-based purchasing, responsible purchasing, or strategic contracting — the concept of leveraging payer clout to promote quality of care and improve health outcomes has a compelling logic and broad appeal.

*Alexander S. Preker*

Lead Economist  
Editor of HNP Publications



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## INTRODUCTION

*Health care purchasing* is the process by which funds are allocated to institutional or individual providers for the delivery of a specified or unspecified set of interventions (Murray and Frenk 2001). Increasingly, stakeholders in the global health care debate are recognizing the potential power of the purchasing function—whether led by national and regional governments, social insurance funds, community-based insurance organizations, employers, health plans, or consumers—to achieve quality goals. Stakeholders from high-, middle-, and low-income countries are looking for the evidence base to guide future purchasing policies and practices. So, too, are representatives of the global health care community.

The World Health Report 2000 identifies selective or “strategic” contracting as an important mechanism for improving or maximizing the performance of the global health care system. The report recommends that countries move from passive purchasing to strategic purchasing, choosing carefully what services should be purchased, how, and from whom (WHO 2000). In a January 2002 resolution, the World Health Organization recommends that member states develop contractual policies that maximize impact on the performance of health systems and share their experiences with contractual arrangements involving the public and private sector and nongovernmental organizations (WHO 2002).

As is evidenced by the publication of this book, the World Bank is committing significant resources to examine the technical design of resource allocation and purchasing (RAP) arrangements in low- and middle-income countries and to explore options for increasing the ability to serve poor and excluded groups through purchasing arrangements. The European Observatory on Health Care Systems has an initiative underway to deepen understanding of effective purchasing in countries of the European region (Figueras, et al. 2002).

No matter what it is called—quality-based purchasing, value-based purchasing, performance-based purchasing, responsible purchasing, or strategic contracting—the concept of leveraging payer clout to promote quality of care and improve health outcomes has a compelling logic and broad appeal.

## CALL TO ACTION FOR U.S. EMPLOYERS

In 2001, the Institute of Medicine called for a strategic redesign of health care in the United States, citing more than 70 reports, in peer-reviewed publications, documenting serious quality of care shortcomings. Report authors call on purchasers to use their leverage to support the development of an information infrastructure to facilitate quality measurement and evidence-based practice and to establish payment incentives that support and reward high-quality care (Committee on Quality of Health Care in America 2001). Employers are by far the largest purchaser of health care in the United States. In 2000, employers bought health coverage for nearly two thirds (64 percent) of the U.S. population (U.S. Bureau of Census 2001). Are employers heeding the call to arms and accepting the mantle of quality-based purchasing?<sup>1</sup>

<sup>1</sup> Access safeguards are generally commonplace in U.S. coverage policies and are not considered, for the purpose of this chapter, to be within the scope of quality-based purchasing. These safeguards include employer efforts to define

## QUALITY-BASED PURCHASING BY EMPLOYERS

Some employers are interested in some indicators of quality and are incorporating them in a variety of purchasing strategies (Fraser and McNamara 2000). The indicators most frequently used by employers, however, are not the ones clinical experts and policymakers would select as most reflective of clinical or technical quality. Instead, to the extent employers incorporate quality indicators, they reflect “amenities” such as patient waiting times. Fraser and McNamara conclude that employers as a group are not acting as quality drivers—with the exception of a few well-resourced outliers.

McLaughlin and Bernard (2001) report little evidence to suggest that employers use performance data to change plan behavior or influence employee plan choice. McLaughlin and Bernard find employers more likely to use measures of consumer satisfaction and preventive care access than measures of clinical or technical quality.

Some analysts believe that employers view quality as a given and that they assume it is constant from provider to provider (Kindig 2001). A focus group of employee benefits managers residing in the Washington, D.C. metropolitan area supports this view (Gabel 2001). The employee benefits managers interviewed were surprised to hear statistics about provider error rates and nonadherence to selected clinical practice guidelines. None considered provider quality or safety markers in selecting a health plan for their employees. None indicated they had negotiated performance guarantees related to satisfaction, quality, or safety. None indicated that quality or safety were ever a factor in terminating a health plan.

Some analysts believe that employers think quality is the responsibility of health plans (versus employers), which have access to provider performance data and are, after all, in the business of health care (Hibbard, et al. 1997). In particular managed care plans, which by definition selectively contract with a group of providers, are well-situated, compared to their fee-for-service counterparts, to influence quality of care by choosing to contract only with providers that meet their quality criteria.

Do health plans, as buyers of provider services, pursue quality-based purchasing? Health plans in New York State do not use data from the statewide cardiac surgery reporting system, which provides hospital-specific and surgeon-specific data on risk-adjusted mortality following coronary artery bypass graft (CABG) surgery, to direct their enrollees or otherwise reward higher performing providers (Chassin 2002). A broader review of the literature finds a lack of evidence that health plans shop for quality (Gold, et al. 1998).

To better understand the nature of plan-provider contractual provisions relating to quality circa 1999–2001, Sutton and Milet (2002) reviewed a sample of standard contracts.<sup>2</sup> They report that

benefit packages (covered services) and require health plans to operate grievance and appeal programs (to arbitrate when care is denied). Developing countries lacking such safeguards, however, may wish to require them as part of a strategic purchasing effort.

<sup>2</sup> Though not necessarily representative of contracts in use nationwide, 116 standard contracts, on file in nine U.S. states were reviewed.

the most frequently used quality assurance mechanisms focus on nonclinical attributes, many of them required to comply with state licensing requirements. Additional provisions suggestive of employer influence are the exception.

Some analysts think expecting health plans to be guardians of quality is unrealistic. Hibbard and others (1997) make the point that, since health care costs are a dominant concern among employers and that employers hold plans accountable for costs, plans have insufficient incentive to selectively contract with high-quality hospitals and physicians.

We know that employers say that the cost of health plans matters to them, but do they send signals to plans that quality matters? After interviewing the leadership of 24 health plans, Scanlon and others (2000) conclude that employers exert only a minor influence on health plan activities to improve quality.

Some recent developments suggest a focus perhaps antithetical to quality-based purchasing. For example, a trend toward “tiered hospital plans,” urged by some employers in response to rising health care costs, encourages patients to use lower cost hospitals. Copayments vary by hospital according to the relative cost of the hospital care: higher copayments for higher cost hospitals. To the extent higher cost hospitals provide better care, employees’ quality of care suffers under tiered hospital plans. A number of the large plans offer tiered hospital care, and some analysts predict most will do so within the next two years.<sup>3</sup>

## **BARRIERS TO QUALITY-BASED PURCHASING**

Why is it that employers do not seem to be using their power in the health care market to demand high quality care? A number of barriers undermine quality-based purchasing by employers. These include challenges inherent in the technical nature of medicine as well as market characteristics.

- *There is no consensus on a definition of quality.* Thousands of measures, indicators of care, and performance benchmarks have been developed to quantify and compare health care quality (Kindig 2001). Some indicators focus on structure, some on process, and others assess outcomes of care. What employers deem an important indicator of quality may be viewed as irrelevant by their employees.
- *Technology in medicine changes swiftly,* with a constant stream of new devices, drugs, and procedures. For example, between 1990 and 2000, nearly 1,000 new drugs were introduced into the U.S. market (Newhouse 2002). A best practice in one year may be outmoded and considered inferior care in subsequent years. The pace of technological change poses significant problems for providers in keeping up; the challenge for purchasers is even more overwhelming.

<sup>3</sup> J. Bennet, “Insurers Push Higher Co-Payments for Treatment at Pricey Hospitals.” Wall Street Journal. June 6, 2002, p. D3.

- *The task of assessing a provider's performance is difficult*, even if there is a consensus on quality (Newhouse 2002). Development of valid data on how specific plans and providers perform is a daunting task, requiring sophisticated technical expertise and significant resources.
- *An undersupply of providers can undermine certain quality-based purchasing strategies*. For example, selective contracting is difficult in markets where a small pool of providers can call the shots.
- *Employer power is diffuse*. If no particular employer represents a threshold share of business in a particular market, health plans and providers may feel free to ignore them.
- *A lack of separation between the purchaser and provider functions results in role confusion*. In health care systems in which the same entity has responsibility for both purchaser and provider functions, because there is no purchaser independence, quality-based purchasing is difficult. While not relevant to employer purchasing and only relevant to a small portion of U.S. public sector purchasing, it is included here in the list of barriers because it can be a formidable challenge in certain developing countries.

## **EMPLOYER ACTIVISTS**

Despite the body of evidence suggesting that U.S. employers as a group are passive purchasers of health care, at least when it comes to clinical or technical attributes of quality, anecdotal evidence suggests this may be changing. To say that a quality-based purchasing movement is underfoot may be an overstatement, but a small and seemingly growing number of leaders in the employer community are committing tremendous resources to overcoming the barriers in the pursuit of a quality-based purchasing agenda.

Cutting-edge employer-led initiatives are happening at the national, local, and company-specific levels. Some employer activities are being spearheaded by the Leapfrog Group, which includes more than 110 Fortune 500 companies and other organizations and represents 32 million covered lives. The group was formed partly in response to an Institute of Medicine publication (Kohn, Corrigan, and Donaldson 2000) that reported up to 98,000 Americans die every year from preventable medical errors in hospitals. This statistic ranks medical errors as a leading cause of death in the United States. The Leapfrog Group's goal is to trigger giant "leaps" forward in the quality and safety of hospital care. The initial set of leaps calls for hospitals to: (1) install a computer system linked to software designed to prevent prescribing errors by physicians entering medication orders; (2) staff intensive care units (ICUs) with physicians who have credentials in critical care medicine; and (3) perform certain complex medical procedures (e.g., CABG) only if it performs a threshold number of the procedure.

These three leaps were selected partly because hospital performance on these indicators can be easily ascertained. Does the hospital have a computer system to prevent medication errors—yes or no? Is the ICU staffed by intensivists—yes or no? Does the volume of certain surgeries meet or exceed a certain threshold—yes or no? The Leapfrog Group asks all U.S. hospitals how they fare on these three criteria and their responses—and nonresponses—are made available to the

public via the Leapfrog Group's website. Not all hospitals participate and, at this point, few hospitals have fully implemented the three recommended practices (Leapfrog Group 2002). To encourage adoption, some employers pay bonuses to hospitals that employ intensivists in their ICUs and have installed or begun to install a computerized prescribing system.<sup>4</sup> Some individual employer members of the Leapfrog Group educate their employees about the three criteria and encourage use of the website.

Another national, multi-employer effort is underway, headed by the National Business Coalition for Health (NBCH) and a subset of its nearly 90 local, employer-led health coalitions. Employer coalitions began to take off in the early 1980s as a vehicle to leverage employer purchasing power, as few employers on their own can invest the resources required to become sophisticated purchasers of health care (Zelman 1996). And few employers, on their own, represent a large enough share of a geographic market to effectively command the market to act in any particular way. While the coalition movement initially focused on cost containment to curtail spiraling employer costs (Bergthold and Solomon 1997), NBCH activities now are guided by a set of principles that incorporate the concept of quality (National Business Coalition for Health 2002).

Since 1997, NBCH has been working with its employer community to develop a common set of health plan quality specifications covering patient safety, chronic care management practices, and physician performance. The product of this collaboration, referred to as the "standardized health plan request for information (RFI)" or the "common RFI," advances the national quality-based purchasing agenda in several important ways. First, to the extent individual employer members of coalitions opt to use the quality specifications in the common RFI instead of crafting their own, they will help deliver a single, loud market signal to health plans and the providers with which they contract about quality attributes employers consider important. Second, NBCH has developed a computer-based tool for its membership that presents the responses received from plans that accept the common RFI. Individual employers can compare health plan responses and select the plan that best meets their needs. NBCH in aggregate represents more than 34 million covered lives, nearly one fifth of the private U.S. insurance market. With this market clout, it is not surprising that more than a hundred plans responded to the common RFI in 2002 (National Business Coalition for Health 2002).

Local employer coalitions, most of them affiliated with NBCH, are independently breaking new ground in the area of quality-based purchasing. The Pacific Business Group on Health (PBGH), a coalition of 45 large employers based primarily in Northern California, uses both public reporting and payment incentives as strategies to promote quality of care. In terms of payment incentives, as part of the annual rate negotiation process, PBGH establishes performance targets with each participating plan. Performance targets span measures of clinical quality, customer service, and member satisfaction. Plans must set aside 2 percent of their annual payments from employers—more than \$10 million in 1996. If performance targets are not met, plans must repay employers from the funds set aside. The financial incentives are having an impact (see below).

<sup>4</sup> M. Freudenheim, "Quality Goals in Incentives for Hospitals," *New York Times*, June 26, 2002, <http://www.nytimes.com>.

Another local coalition, the Central Florida Health Care Coalition (CFHCC), representing 120 employers, has a somewhat different emphasis and strategy. Recognizing that, to consider practice changes, providers need comparative information on their own and their peers' performance, CFHCC has supported the development of a comprehensive data system of profiles and comparisons. Hospitals and physicians receive data on how they compare to the national average, for example, in terms of cesarean deliveries, pediatric asthma treatment, hysterectomies, and coronary artery bypass grafts. The provider profiling strategy is having an effect (see below). Though not yet operational, the next phase of CFHCC's initiative will categorize physicians into one of three groups (platinum, gold, or silver), based on their performance compared to national standards. Physicians in the platinum category will receive higher payments than those in the gold and silver groups. "Platinum" physicians also will benefit from some nonfinancial rewards such as special dispensation from using formularies or adhering to precertification requirements (Bailit 2002; Milbank Memorial Fund 2001).

Another 20 local employer coalitions—nearly one fourth of NBCH's membership—are working with hospital performance data to develop comparative reports. Some are tapping existing administrative datasets available to the general public or purchased from a vendor, some are surveying hospitals about care processes and outcomes, others are surveying employees about their satisfaction with hospital care, and some are doing a mix of these. The target audience for the hospital performance data varies by coalition. Some performance reports are intended as a quality assessment and benchmarking tool exclusively for a provider audience; often these are referred to as *provider profiles*. Some are intended for employees' use in selecting providers; often these are referred to as *provider report cards*. In addition, hospital data are used by the employer group itself as part of the provider selection and contracting process.

Some very large employers devote significant resources to advance quality of care to tailor their own purchasing strategy. In 1996 the General Electric Corporation (GE) decided to apply the same quality-control processes it uses in its design of its new products and services to its health care purchasing practices. GE developed a health plan scorecard to assess performance in four areas, two of them member satisfaction and quality of care. If performance is not satisfactory, plan enrollment may be frozen or a plan contract may not be renewed. Portions of the scorecard are shared with employees during enrollment periods to influence their plan selection (Bailit 2002; Milbank Memorial Fund 2001).

## **GENERIC EMPLOYER STRATEGIES TO PROMOTE HEALTH ACCOUNTABILITY FOR QUALITY**

Several typologies have been advanced to help define and distinguish employers' efforts to promote quality (Fraser and McNamara 2000; Midwest Business Group on Health 2002; Bailit Health Purchasing 2002).

Perhaps the most basic distinction among employer approaches is whether the employer or employer group sees itself as an arbiter of quality on behalf of employees, or whether the employer sees its role as a purveyor of information to enable employees to act as their own arbiters. Said another way, employers can seek to influence quality of care by focusing their efforts on the supply side (i.e., directly affecting health plan and provider behavior) or by

focusing on the demand side (i.e., directly affecting employee decision-making and indirectly affecting health plan and provider behavior). Employers who opt for the latter might not feel qualified to ascertain quality and might lack the resources to hire the necessary expertise, or they may have liability concerns associated with inserting themselves into the delivery paradigm (Fraser and McNamara 2000).

**Table 1. Framework for Conceptualizing Employer Quality-Based Purchasing Strategies**

<i>Generic employer strategies</i>
1. Identify good and bad quality, a prerequisite to all other strategies (2 and 3, below).
2. Focus on supply side and seek to directly influence quality attributes of plans and providers available to employees. <ul style="list-style-type: none"> <li>• Reward good quality and penalize bad quality such as by selective contracting, varying payment according to performance, offering non-financial incentives for high-quality care, dropping poor performers.</li> <li>• Make resources available explicitly for quality improvement (i.e., apart from care-payment scheme) such as grants, technical assistance, training funds.</li> </ul>
3. Focus on demand side by encouraging, enabling, and empowering employees—through the provision of comparative performance data -- to become quality-based purchasers of health care.

Supply-directed efforts can take several forms. Some employers prescreen plans according to their quality priorities and make only the subset that meets their criteria available to their employees. Some employers use financial bonuses to reward good performance or withhold payment to penalize bad performance (Fraser, et al. 1999). Financial incentives for quality can be incorporated into any type of payment system—salary, budget, per case, or per unit. Or employers may reward good performance by using nonfinancial incentives such as exemptions from certain administratively burdensome requirements such as drug formulary compliance (Bailit Health Purchasing 2002). In the words of Newhouse (2002, p. 21), “if purchasers do not reward higher quality...we should not be surprised to see quality problems.” Employer attempts to promote provider quality can fall outside the traditional conception of a “purchase transaction.” For example, an employer could develop a provider-specific profiling system that tells providers how their performance compares to others—the hallmark of the Central Florida Health Care Coalition’s effort—or provide funds for a provider training program.

Strategies that focus on the demand side seek to enable and empower employees in their own health care decision-making. These efforts aim to make plan or provider-specific data available to employees and educate them about markers for good quality. Some employers even offer their employees financial incentives to encourage selection of high-quality plans and providers.

Some employers pursue multiple strategies. Leapfrog Group activities, for example, span both supply- and demand-directed strategies (table 2).

**Table 2. Leapfrog Group Strategies**

<i>Generic employer strategies</i>	<i>Leapfrog Group Strategies</i>
<p>1. Identify good and bad quality, a prerequisite to all other strategies (2. and 3, below).</p>	<p>All U.S. hospitals are asked how they fare on Leapfrog’s three criteria [i.e., (1) install computer system linked to software designed to prevent prescribing errors by physicians entering medication orders; (2) staff intensive care units (ICUs) with physicians who have credentials in critical care medicine; and (3) perform certain complex medical procedures (e.g., cardiac artery bypass graft) only if it performs a threshold number of the procedure] and the responses—and nonresponses—are available to the public on the Leapfrog Group’s website.</p> <p>The National Business Coalition for Health, influenced in part by overlapping membership with the Leapfrog Group, solicits plan-specific information related to the three criteria in the “common request for information” and incorporates the responses into their computer-based clearinghouse of plan attributes.</p>
<p>2. Focus on supply side and seek to directly influence quality attributes of plans and providers available to employees.</p> <ul style="list-style-type: none"> <li>• Reward good quality and penalize bad quality.</li> <li>• Make resources available explicitly for quality improvement (i.e., apart from care-reimbursement scheme).</li> </ul>	<p>Some participating employers pay bonuses to hospitals that employ intensivists in their intensive care units and have installed, or begun to install, a computerized prescribing system.</p>
<p>3. Focus on demand side by encouraging, enabling, and empowering employees—through the provision of comparative performance data—to become quality-based purchasers of health care.</p>	<p>Some participating members of the Leapfrog Group work with their employees and others in their geographic area to spread the word about their three criteria and encourage use of the website, which presents hospital-specific information.</p>

Regardless of the particular strategy or package of strategies an employer or group of employers may pursue, the most basic strategy—a prerequisite to any other employer strategy—is an effort to collect data or information to help tease out and identify high-performing providers according to the quality markers important to the employer. Some quality markers or indicators can be gleaned relatively easily from health plan self-assessments (perhaps in response to a request for information issued by employers) or from a government-sponsored plan report card. More sophisticated measures require more resource-intensive data collection, for example, a survey of employee satisfaction or a customized analysis of claims data or medical records.

## IMPACT OF EMPLOYER STRATEGIES ON QUALITY

While there is some evidence about the extent of quality-based purchasing, we know little about the effectiveness of specific purchasing strategies—what works and under what circumstances it works—and what the unintended consequences are. We know even less about the overall feasibility of relying on purchasers as a force for quality improvement (Fraser and McNamara 2000; Kindig 2001; Goldfarb, et al. 2002).

From a few employer self-evaluations, we know that some of their efforts seem to be having a positive impact. PBGH found that cervical cancer screening rates increased by three percentage points over a two-year period after implementing clinical targets. Testing rates (hemoglobin A1c) for patients with diabetes increased by three percentage points over a one-year period (Bailit 2002). The Central Florida Health Care Coalition (CFHCC) found that cesarean sections went from 36 percent of deliveries in 1989 to 18 percent by 1998 after its provider profiling system was put into place (Bailit 2002). Though helpful, these descriptive statistics do not consider other causal factors that may be at work, and do not allow for generalizing the findings to other employers that reside in different markets, each with its own particular dynamic.

There is additional evidence that provider profiling and public disclosure influences quality. While the following effort was not created at the instigation of employers, it easily could have been. New York State developed a cardiac surgery reporting system in 1989, publishing annually hospital-specific and surgeon-specific data on risk-adjusted mortality following coronary artery bypass graft surgery. The initial report showed wide variation in mortality rates. Poorly performing hospitals responded constructively and improved their cardiac surgery programs; statewide mortality fell substantially as a result. One of the poorest performing hospitals responded by recruiting its first full-time cardiac surgery chief, concentrating cardiac surgery on a single floor of the hospital, hiring nurse specialists, and installing a dedicated cardiac anesthesia service. This hospital now has the lowest risk-adjusted mortality of any hospital in the state. Overall, risk-adjusted CABG mortality fell 41 percent statewide in the first three years of the reporting system. Interestingly, while hospitals and physicians paid close attention to the ratings, health plans and consumers did not. Health plans in New York State did not use data from the statewide cardiac surgery reporting system to direct their enrollees or otherwise reward higher performing providers, nor did patients avoid high-mortality hospitals (Chassin 2002).

These findings of consumer lack of interest in, and provider responsiveness to, quality measures seem to resonate. According to a recent national poll, ratings and rankings that purport to measure the quality of care provided by individual hospitals, physicians, and health plans have almost no impact on the choices consumers make.<sup>5</sup> Researchers other than Chassin have noted that provider profiling does have a direct impact on provider performance. Hibbard (2002) tracks hospital quality improvement activities across three scenarios: hospitals whose performance is profiled and publicly reported; hospitals whose performance is profiled but not publicly reported; and hospitals that are not part of any externally generated profiling or public reporting effort. Preliminary findings suggest that hospital quality improvement activities are most frequent

<sup>5</sup> Wall Street Journal, “Most Consumers Ignore Health Ratings,” October 11, 2002. p.B2 .

among hospitals whose performance is publicly reported, and least frequent among those that are not part of any profiling or public reporting effort.

Until now, the research community has given scant attention to the subject of quality-based purchasing by employers, but that is starting to change. The US Agency for Healthcare Research and Quality (AHRQ) convened a meeting in 2001 of purchasers, researchers and private foundations to develop an agenda related to value-based purchasing. Subsequent to this meeting, AHRQ incorporated part of the agenda into one of its 2001 program announcements, which is how Agency priorities are communicated to the research community (U.S. Agency for Healthcare Research and Quality 2003).

Private foundations also responded to the need for evidence on quality-based purchasing strategies. The Commonwealth Fund announced in 2002 that it is funding an evaluation of the Leapfrog Group's initiative to encourage use of physicians who have credentials in critical care medicine to staff intensive care units. The research project will survey top management in 105 hospitals along with health plans to determine the financial and nonfinancial factors that influence a hospital's decision to adopt the Leapfrog ICU staffing standard (Commonwealth Fund 2002). The Commonwealth also has funded a study on dissolving the barriers to value-based purchasing.<sup>6</sup> (Goldfarb 2003).

The Robert Wood Johnson Foundation (RWJF) is funding an evaluation of a hospital report card initiative underway by the Employer Health Care Alliance Cooperative, a local employer coalition that represents employers in south-central Wisconsin (Hibbard 2002). RWJF also has funded a study of employers' quality interventions to see if they are having an impact.<sup>7</sup> (Scanlon 2003).

The Robert Wood Johnson Foundation, the California HealthCare Foundation, and the Agency for Healthcare Research and Quality are supporting a multimillion-dollar, multi-site demonstration and evaluation project on "rewarding quality." Grants and technical assistance will be offered to employers and other payers to design, implement, and evaluate alternative payment innovations and nonfinancial incentives for physicians and hospitals to improve the quality of care (National Health Care Purchasing Institute 2002).

<sup>6</sup> Goldfarb, N.I. 2003. Email correspondence to P. McNamara., January 30, 2003.

<sup>7</sup> Scanlon, D.P. 2003. Email correspondence to P. McNamara., January 30, 2003.

## CONCLUSIONS

Given the dearth of evidence about the effectiveness of U.S. employers' quality-based purchasing strategies, few lessons can be drawn for other U.S. employers let alone for purchasers in other countries. As is the case for low- and middle-income countries (Gauri 2001; Dixon, Langenbrunner, and Mossialos 2002; Mills 1998; Palmer 2000), the United States-specific body of research is especially lacking in the area of purchasing strategies' impact on health gains. Until the next wave of research is completed, we are left mainly with a sense of the prevalence of quality-based purchasing, a small but growing set of frameworks to help organize the component strategies and with a rough understanding of barriers that might impede a quality-based purchasing agenda.

We are also left with a small body of evidence to suggest that providers, when presented with credible information about their performance relative to their peers, do in fact make improvements—particularly when this information is made available to the public (Chassin 2002; Hibbard 2002; Newhouse 2002). Perhaps that is because previously—in the absence of comparative data to the contrary—providers presumed that their performance was state of the art. Or perhaps they instituted quality improvement initiatives out of fear of losing patients. Regardless, purchaser efforts to collect and disseminate comparative performance data on hospitals and physicians seem to have promise in as a quality improvement strategy and may well have applications to purchasing in lower and middle-income countries.

While the findings on impact are relatively recent, the concept of provider-specific reports has been around for a while.

I am fain to sum up with an urgent appeal for adopting this or some uniform system of publishing the statistical records of hospitals. If they could be obtained...they would show subscribers how their money was being spent, what amount of good was really being done with it, or whether the money was doing mischief rather than good.—Florence Nightingale 1863

As governments, social insurance funds, community-based insurance organizations, and employers consider their own paths to improve the quality of care, broadening the context beyond purchasing might be helpful. Informed purchasing is one societal approach to pursuing quality of care. The Institute of Medicine (Donaldson 1998) identifies two other broad policy strategies to address health care quality apart from the purchasing or market-based strategy. One rests on voluntary, self-regulated relationships among physician and other provider groups, based on ethical and professional norms. An example of this is the development and sponsorship of practice guidelines by a national professional society. The second approach relies on a government or regulatory remedy, for example, a legal requirement that physicians be licensed in order to practice.

Each of the three approaches stems from a different philosophical premise and relies on a different set of system stakeholders. And each can be—and often is—used in combination with the other two. The actual as well as optimal balance among the three approaches varies over time, however, and is influenced by contextual factors. These factors, all in a constant state of

change, include the political environment, economic circumstances, health care market attributes, cultural characteristics (including literacy rates, corruption indices), and the extent of unison or discord among the lender and donor community. The dynamic nature of these contextual factors suggests that there is no such thing as a generic template for improving quality.

We look to the research community to embrace a broad research agenda<sup>8</sup> that ultimately will provide guidance to a wide range of countries, each characterized by its own unique set of contextual factors, on how best to craft an effective, synergistic mix of purchasing, professional development, and regulatory approaches in the pursuit of quality.

<sup>8</sup> In 2003 the Center for Health Affairs at Project Hope, with support from the Agency for Healthcare Research and Quality, convened a small group of experts to develop a detailed research agenda to guide future research investments (e.g., surveys, case studies, demonstration evaluations) that would improve our collective understanding of the current and potential role of purchasers in improving the quality of health care services specifically in developing countries. For further information contact Project Hope investigators Janet Sutton and Gail Wilensky or visit [www.projecthope.org](http://www.projecthope.org).

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