

Lecture - Daniel Carpenter, Ph.D.

Introduction

Thank you for having me back to Guilford College. Being here to honor Sheridan is such an honor for me that I am not sure I can bring words to it. Sheridan and some other very powerful people set me on an educational course and an intellectual course, and a personal course that I am still on and I will be on thankfully forever. It is difficult to describe to you how important that was. I have thought of many different stories - you know, examples of the kind of impact being here had - but the main thing really was that I learned *how to think* and I learned *that I could think*. To put it another way, I learned how to use my mind and I learned that I was someone who had a mind to use. I don't know how you teach that. I don't know that I could teach that lesson if I were in your shoes. But you did and I thank you for that. Sheridan, in particular, was the quintessential mentor and teacher to all of us who were lucky enough to know him. I cannot imagine anyone doing it better. He was something, and I miss him terribly even after all this time. Tonight I have the honor of fulfilling one of his predictions. He once told me, "Dan, once you get your doctorate you will be able to speak at length, with great authority, on any topic you want, to anyone you want." It is in this context that I thank you for referring to me as a distinguished alumnus and I hope my talk supports the designation.

I work for a company that is, to be precise if you know the field, called a Behavioral Carve Out Company. The business of being a psychiatry managed care company, or being a managed care company for psychiatry services, is big and complicated enough in and of itself, and frankly enough of a pain in the neck, that a lot of HMO's and health care companies do what is called "carve it out." That is, they subcontract it out to us. Merit Behavioral Care was, up until it was recently acquired by a larger company, the biggest of this group, covering the behavioral healthcare for 23 million people. In its acquisition of Merit, Magellan will manage the mental health needs of over 60 million people. The backdrop of big consolidations and changes in the healthcare field is complicated and constantly changing itself. I hope to describe it in a way that makes some sense. During this talk, I will provide you with a way of conceptualizing health care reform. I will talk about one way of conceptualizing the quality of a particular instance of health care. Then, I will talk about the biggest problem that I think we now face: how to measure quality of care.

Health Care Reform

Health care has gone through massive reform in the last several years and I offer you the following analogy in which to understand some aspects of the reform process. Consider the automobile industry – and ask yourself what would happen if the people that buy automobiles come to a collective decision that they will not pay any more than \$10,000 for an automobile. They simply won't do it. Most individuals, rental car companies, and governments want a \$10,000 car so that the number of people who are willing to pay more than that now narrows maybe to 10% - 20% of the buying population. Of course, the automobile industry would face massive problems here with major job cuts and factory closings that occur because there has been a massive reduction in the

amount of dollars flowing into the industry itself. After a period of colossal and very painful change in the industry, some smart automobile maker would figure out a way to make a car that can be sold for \$9,999. When they put that car on the market, the previously unmet demand will make that cheaper car an incredibly successful product. That company will probably do extremely well in terms of profits and the person(s) who pioneered the technology for making the car cheaper will also become wealthy. Soon, the first company will publish their technology, or other companies will hire away their designers and technicians. The result will be that other companies will also be able to make a car to be sold for \$9,999. After that, someone will come along and make a car to be sold for \$9,995 and will capture some portion of the market. Eventually, and it may take a number of years for this to occur, the industry will stabilize in its ability to provide a car in the \$10,000 range. Once the industry stabilizes, someone will probably come out with a higher quality car that sells for \$11,000. The higher quality features will lure some buyers to spend the extra money, but the new car's features must give the owner \$1,000 worth of extra quality. If it doesn't, the new car will not do well.

Health care reform has taken a similar course as in the analogy above. I will talk about health care reform as having three phases or aspects: *cost*, *quality*, *access*. The cost phase is a pretty simple one if you have a checkbook at home. In any solvent financial entity, you must manage your costs so the amount of dollars coming in is roughly close to what you are paying out. Once you have a solid financial foundation, issues related to quality can be addressed. In addition, the converse of that statement is true. That is, if an organization is threatened because of financial insolvency, the quality of its product or service becomes secondary to the immediate concern of keeping the organization running. Many companies go bankrupt even though they provide a high quality product or service. Finally, once you have a solid financial operation and can provide a quality product, you can turn your attention to giving more people access to the product.

The early efforts toward health care reform were spent addressing issues of *cost*. In health care in general and behavioral health care in particular, the cost of providing care had become prohibitive and unpredictable. The chief buyers of health care, the nation's employers, were trying desperately to cut back on very quickly-rising health care expenditures. One of their main cost-cutting strategies was to reduce the benefits offered to employees such as raising the eligibility criteria, reducing benefits, and introducing "co-pays". By analogy, the nation's employers had begun to say, "we cannot afford these increasing costs, or we will no longer pay more than \$10,000 for a car".

A similar trend occurred within the state and federal governments. State governments, California in particular, began to say that they could not provide health care for everybody and decided to cut back. When the states cut back on their coverage, we began to see a large group of uninsured people that have no health care at all. Today, you can't walk into an emergency room without someone asking what health plan covers you. Twenty years ago this was not an issue because the system had enough dollars flowing that it wasn't that big a deal. Hospitals would treat a certain number of people without being paid and were able to absorb the loss because they could recover the funds on other cases that paid higher fees.

To illustrate the primacy of cost concerns, note that the rapidly rising *cost* of health care led employers and governments to restrict *access* to health care. To return to the automobile industry analogy, the purchasers of health care reached a point where they refused to pay more than \$10,000 for a care – or more than a certain amount for health coverage for their employees or citizens. At that point in time, there was no proven technology for reducing health care costs. Traditional health plans were simply unable to contain costs. The health care field was in a massive crisis with hospitals closing and good institutions having to layoff large portions of their staff in order to remain solvent. As in the automobile analogy, someone came along and developed a new technology for providing health care at a reduced cost. That technology was *managed care*. Managed care was the \$9,995 car. One could persuasively, if not controversially, argue that managed care, as a cost containment technology, brought the health care system back from the brink of financial ruin. The fact that health care costs have not risen as sharply as they did during the 1980's has contributed to our currently low rate of inflation and very strong economy. Now, employers are not cutting back like they were. They are back to providing fuller health benefits and including more people in the “covered” umbrella.

Now that we are no longer in a crisis, we must turn our attention to asking the *quality* question: Is this a good car? Is managed care a good system? In some cases, yes. In other cases, no. The task for us as an industry is evolve from managing health care based on cost to managing health care based on quality. The problem is that we do not really know how to do that yet, in large part because we have no generally accepted metric for quality as it pertains to health care. Remember that it took someone to come along and develop a technology for reducing health care cost from \$100 per member per month down to \$50 per member per month. Now our task is to figure out a way to provide quality care at that reduced cost. If we don't accomplish this task, then managed care is doomed to failure. In our free market economy, a cheaper but inferior product can do well for a while, but eventually its inferiority will be its undoing. Recall that the Yugo was a cheap car that did not last, largely because it wasn't a quality car - it was *too* cheap. Maybe health care is too cheap right now. If so, then we must make that decision based on a careful assessment of how much a certain level of health care quality *should cost* – rather than how much cost the market will bear. That is, we must continue to move from management based on cost to management based on quality. But in order to manage based on quality, we must be able to measure it.

Ah, measurement. Measurement brings me back to the beginning in some ways because how to measure things is one key thing I learned from Sheridan. The core of science is measurement. Without it, you know nothing about what you are doing. In an historical context, recall that it took us several centuries perfect the measurement of mass, or weight. Now the technology for measuring the weight of an object is so well understood and implemented worldwide (even universe-wide) that we take it for granted. But do not forget that it took a while. We are just beginning to measure things like the quality of health care. It is a huge task, but if we are going to move from managing based on costs to managing quality, we must agree on what the concept means and develop a scientifically valid technology for measuring it.

I will give you four different perspectives on why we need to measure quality.

From the Patient's Perspective: Choosing a Health Plan

As patients, we generally have no idea how to choose among the health plans offered by our employers. Which health plans are good? What does “good” mean in this context? Good for me as an individual? Good for my family? Do I choose a “point of service” plan from HMO #1 or do I choose the HMO plan from HMO #2? How would you go about characterizing differences between the plans. Based on their co-payments?...their deductibles?...their yearly limits? These may be standard approaches to comparing health plans but notice that these are financial, or cost-based, points of comparison. Must we assume that plans with smaller co-payments are *better*? Another way to compare plans is to examine the physician network. But how does one examine the physician network? By the number of physicians signed up? Or perhaps the number of physicians whose offices are near my house? These are, again, numeric or administrative kinds of measures that may have nothing to do with the quality of care that I will receive under the different plans.

Recently, several national magazines have published ratings of the larger HMO's and managed care organizations based on readers surveys and investigative research. The Consumer's Union has conducted several reader's polls, going back to 1994, regarding their experiences with different health plans and published the findings in Consumer Reports. Newsweek, Time, and US News and World Report have also published extensive research and ratings on the larger health plans. These organizations are actually pushing the cutting edge of science by helping to develop a technology for measuring the quality of health plans. Yes – let us give them credit. Consumer Reports has long been an innovator in ways to measure the performance of various consumer products, such as lawn mowers, and many Americans have come to trust and rely on their findings. It seems natural for them to turn their attention to health care. In a separate, but related reader's survey, CU turned their attention to measuring psychotherapy effectiveness a few years ago. The findings indicated that readers reported that psychotherapy was effective and, in fact, those who were in psychotherapy longer said it helped them more. Was the study a perfect example of scientific rigor? No, it was not perfect. There were certainly problems with the study and with some of the conclusions that were reached in its publication. But the study was better in some ways than what had been done before it. And, perhaps more importantly, because of the broad readership of Consumer Reports, the findings were more widely distributed than most other psychotherapy studies.

Another exciting point is that these organizations are pushing the technological envelope by developing metrics on which different health plans can be compared. I believe their efforts are paying off. The US News and World Report study was able to measure the rate of immunization among children enrolled in the plans. Now that is an excellent performance measure: the extent to which a health plan exercises preventive health practices by ensuring that its child enrollees are immunized? Preventive health practices are particularly difficult because it requires HMO's to go out and find individuals who are not currently being treated for a particular condition but who need or may soon need such treatment, and then offering them some kind of preventive intervention that reduces the likelihood that they will ultimately need the treatment. This is called “case finding” and is not an easy task to take on. The point is that the US News & World Report ratings of health plans included a metric of how well plans carried out this particular task. Good for them.

The Employer's Perspective: Purchasing Health Care

Most health care in this country is purchased by companies for their employees. Someone here at Guilford College went out and purchased health care for the faculty and staff. That person made a very complex series of decisions about which plans and which benefits to offer the faculty and staff. This person probably took sealed bids from several different companies and may have decided to offer a range of benefit structures to different people in the faculty/staff community. The problem that this person faced is actually huge and is similar to the one faced by the individual consumer who has to choose among plans. How do you know which plans are good, better, best? Do you give senior faculty an excellent health plan while offering the junior faculty a lesser plan? How would you even tell the difference? The way we usually consider this issue is to say that one plan or benefit structure is more expensive so it is better. The more generous the limits are, the better it is. As I noted above, this is a process of evaluating a health plan based on financial metrics – not based on quality. It is based on administrative kinds of questions, not based on quality. The biggest, most difficult question is: How much *should* health care cost? Right now, that question is asked and answered by the market economy. Much like the old saying, “a product or service is worth what you can get for it”, we operate on the principle that “health care is worth what you can get it for”. But let us suppose that you are buying health care for Guilford College faculty and staff and that among the bids you receive, HMO#1 submits the lowest. It is certainly possible that HMO#1 will be able to provide the same service as the other bidders for less cost. Perhaps they have a more efficient organization or a lower profit margin and can operate with less profit. But it is also possible that HMO #1 submitted a “low-ball” bid in order to get the contract and there is no way they will even break even on your contract. In the long run, losing money on a contract is usually bad for everyone involved. Without some metric of quality for a health plan, we will always have difficulty knowing how much quality health care *should* cost and we will have trouble buying quality health care.

Before I leave the employer's perspective, I will raise an important issue that people outside of managed care tend not to know about. As I have argued above, if you want to understand health care reform, you have to go back to who is paying the money. Where is the money coming from? It is mostly coming from employers – not from the managed care plans. And where there is money, there is power. People often do not realize the power of the employer/client. At Merit, our client list is extremely varied. We have some clients who demand that we never deny a claim for psychiatric service. They demand that we allow employees to stay in the hospital as long as they want and that we never cut off benefits. We have other employers who allow ten inpatient days a year. That's it, no more. We do it because the contract says we are going to do it. Which employees get higher quality care? I would argue that you certainly cannot tell based on the number of days they get in the hospital each year. That, again, is an administrative and financial factor that may not be related to quality. The reason I bring up this issue is to say that the purchaser has great power in the system. If you have a complaint, go see your Director of Human Resources or whoever interfaces with the HMO.

From the Managed Care Company's Perspective: Managing a Network of Physicians

To summarize one of managed care's biggest problems, when you have a huge system of twenty thousand primary care physicians, how do you know which of them are good? Let's pause for a moment and ask, from a logical viewpoint, are all of them good? Probably not. But before we can even answer the question, we must seek further clarification: *good at what?* Good at treating my particular condition? Good at geriatric medicine? Good at recognizing depression? We know from the research literature that most primary care doctors are, in fact, not very good at recognizing and treating depression. At a recent meeting I attended at the headquarters of a national HMO with several million enrollees, it was a firm consensus of the medical leadership that their primary care physicians were actually very poor at recognizing and treating depression. I was at the meeting to help develop a technology for identifying doctors who need additional education about depression and then providing that education in a form that they would use in their practice. The big problem is that when you have twenty thousand physicians on your panel, how on earth are you supposed to know which ones are doing a good job? Which ones need further education? Which ones should be left alone and allowed to practice medicine unfettered? And which ones should be taken off of the panel entirely? Part of the reason we do not know how to evaluate physicians is that we have no way of measuring physician performance. What is a good doctor? What does *good* mean in this context? As it stands currently, the primary measures we use to evaluate physicians involve the submission of credentials, many of which were obtained many years ago and simply establish that the doctor has a license to practice. In psychiatry, we may ask whether the doctor has had special training with, for example, cognitive-behavioral psychotherapy, but we rarely go out and verify that information because the question is too broad to verify. A more valid way to evaluate a doctor is to ask his/her patients whether they are satisfied? Well, we do measure patient satisfaction. Is patient satisfaction a reasonable measurement of physician performance? Actually, it is not. Research tells us that satisfaction is not the same as outcome. People are satisfied with care for a variety of reasons, only one of which is that the care was actually good. Just because you feel good when you walk out of a doctor's office does not mean that you were given the right treatment. I am not saying that patient satisfaction is not important – it is important. But it is not the same as physician performance.

The Physician's View: Caring for patients in the face of increasing intrusion from payors

The way in which physicians and health care providers currently practice their trade is dramatically different than it was only a few years ago. Physicians are spending more time filling out claim forms and arguing with managed care for reimbursement of services that would have been covered without question. Physicians are, to a large extent, very upset because they feel that managed care takes them away from their patients and intrudes into a process that had been, for a very long time, a sacrosanct relationship: that between doctor and patient. Every major study that I have seen of how health care providers spend their time shows a significant reduction in direct patient care with an accompanying increase in time spent on administrative duties. These latter duties are largely associated with advocating on behalf of patients for payment of services. My particular professional organization, The American Psychological Association, has been extremely active in suing individual managed care companies and seeking legislation that holds these companies

responsible for their benefit decisions. There is no doubt that the practice of medicine in general, and psychological medicine in particular, has changed a great deal in the past several years and continues to evolve as we speak. We desperately need to find a way to allow good doctors more time and freedom to do what they do best: treat patients.

The Role of Government

What can legislation do? What can a government do to improve health care? Well, now I get to give you my view of how the government can most effectively help. First of all, I believe that everyone should have health care. Whatever it takes to get through the issues of *cost* and *quality*, we must do it quickly so that everyone can have *access* to health care. The second thing that the government can do is facilitate the success of companies that provide high quality health care. I do not believe that creating some legislation that forces managed care companies to conduct business in a certain way will be effective. At our most wise and well-read, we simply do not know how managed care companies *should* conduct business. The best we can do is make some very simplistic statements about what should happen and I believe that legislators should confine themselves to this very narrow range of policies. In this category, I include simplistic statements such as “people *should* not be dropped from coverage because of excessive claims” and “managed care companies *should* be forced to honor the benefits they offer in a particular contract”.

The problem with legislating rules about how businesses should be run is that such legislation often produces undesired effects. I will give an example of some pending legislation and how the effect will be disastrous if passed. Consumer’s Union has pressed for legislation that requires that doctors be able to discuss a range of treatment options with their patients, regardless of the cost of the different procedures and whether the covering HMO will pay for them. The intent of the legislation is to prevent HMO’s from restricting a doctor to discussing only covered treatment options and leaving out more expensive options that are not covered by the plan. This will presumably provide consumers with more information about their options. The problem with this legislation will be in its implementation. One fundamental point to keep in mind in considering HMO business practices is that HMO’s do not see patients (except for Kaiser, which I will exclude from this discussion). Doctors see the patients and send the bill to the HMO. Asking the HMO to be responsible for ensuring that a certain kind of interaction occurs between the doctor and the patient puts the HMO in a difficult position. Since the HMO is not in the room at the time, this law will end up requiring that HMO’s contractually require that doctors document the range of options that was discussed with the patient. From a systems view, the law will pass the administrative responsibility for documenting compliance from the HMO to the doctor. Doctors are already overloaded with just this sort of paperwork. In addition, the HMO will have to put together an “approved” list of treatment options to be discussed. Every type of procedure that might come up will need its own list. Because this would be legislated, the HMO will need an entire compliance system to document that it created, distributed, and updated each of the “approved” lists of reasonable treatment options, with particular attention to ensuring that more expensive treatment options are included. This would become an administrative nightmare for both the HMO and the doctors and would force HMO’s to focus their efforts toward compliance with regulations rather than on improving patient

care. I strongly believe that much of the HMO-reform legislation currently being considered will push the industry into being *compliance-driven* rather than *quality-driven*.

Instead of plunging the managed care industry into these kinds of compliance-drive business practices, the governments (state and federal) should fund projects to 1) improve the identification of ways to compare HMO's and managed care techniques on a range of quality measures; and 2) improve ways of disseminating this information to consumers and purchasers (the employers and state governments). Under the first category, I am referring to projects to develop better measures of the quality of different aspects of health care as it relates to outcome. Does raising the number of allowable psychotherapy visits from 8 to 16 per year increase the quality of care? Does it even raise the system-wide cost of care to any extent? Or better yet, are there ways to identify health plan members that really need the extra coverage versus some other members who do not need it but are using it just because it is available? The second category involves state-wide and nationwide efforts to inform consumers about the different plans that are available, the different benefit structures that are offered, and the different concomitant costs associated with different options. The state of Indiana has a very nice report card for all of the mental health facilities in the state. The report is called the Hoosier Plan Report Card, and was the result of several years of diligent health services research that examined the aspects of facility importance that were important to patients, family members, doctors, policy-makers, etc.

The point I am trying to make is that legislating the way HMO's and managed care companies do business will backfire. It will create a business culture focused on compliance with legislation rather than on quality of care. The best way for the government to help is to figure out how to determine which companies have practices that lead to better care and how to inform consumers about plans have adopted these practices and which plans are still using less effective practices. This will lead us all to the next phase of health care reform where we think about health care in terms of its quality – not just its financial or administrative aspects. It will result in public vilification of companies with poor quality services and will provide those companies with explicit ways of improving quality. Employees who see their HMO rated poorly in a national comparison of quality will contact their Human Resources offices immediately and demand better quality. Doctors who have a demonstrated track record of providing quality care can obtain a lower level of scrutiny from HMO's so that claims are paid with fewer contentious interactions.

Summary

I will close with a quote from Lord Kelvin that sums things in a way that Sheridan certainly appreciated. "If you can measure that of which you speak, you know something of your subject. But if you cannot measure it your knowledge is meager and unsatisfactory." Since we cannot measure quality we don't even know what we are talking about. We don't know what it means to be a good doctor. We don't know what it means to be a good psychotherapist. Until we know these things, our efforts to reform the health care system will be greatly hampered. The fundamental principle of science is that you've got to start with a good measurement system.

So it seems appropriate to answer the question that many have asked me to day. That is whether there are things you students can learn here at Guilford that will equip you to go out and make a contribution to solving these problems. I would urge you to learn how to think, learn how to evaluate what you hear and learn how to measure things. Get in there and think about the issues beyond the superficial coverage the media offer. Learn how to think.