

Quality, Economy, Transparency: A New Health Care Code

By Merrill Goozner

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Washington, D.C. – In 2003, most Wisconsin hospitals voluntarily began telling the public and their competitors the cost and the quality of the care delivered in their facilities. If you wanted to know how much treating a case of pneumonia or a heart attack cost at the local hospital and how well the hospital performed on a checklist of best practices for delivering that care, you could look it up on an easy-to-navigate [website](#) published by the Wisconsin Collaborative for Healthcare Quality.

The results on costs didn't surprise health care officials in the state. As had been long documented by the Dartmouth Atlas of Health Care using Medicare data, hospitals in different cities had wide variations in costs even after each case was adjusted for the severity of the illness and the age and health status of the patient.

For instance, treating a pneumonia case at the [Theda Clark Medical Center](#) in Neenah averaged \$10,435 in 2008. Sacred Heart Hospital in Eau Claire, on the other hand, charged the average pneumonia patient \$20,419, nearly twice as much.

What shocked hospital administrators most were the results for quality. Instead of higher cost hospitals delivering better care, the evidence pointed to just the opposite: The higher cost hospitals were less likely to meet benchmarks for quality. Theda Clark attained 95.5 percent of the quality goals outlined for treating a pneumonia case in 2008. Sacred Heart met just 90.5 percent of the standards.

Publishing the cost and quality data has had a far-reaching impact on the state, whose health care system is now considered among the best in the country. It gave hospitals with low quality ratings objective feedback for improving their performance. And the rankings motivated high cost hospitals to begin looking for ways to eliminate expensive but medically questionable procedures that didn't improve outcomes.

Most important of all, it created a constituency – informed consumers – who were now armed with data that allowed them to pressure local hospitals to improve their performance. "People make purchasing decisions for everything from banking to refrigerators based on cost and quality information, but that is not how it currently works in health care," said Walter Rugland,

chairman of [ThedaCare](#), at a House Energy & Commerce subcommittee on health hearing held last Thursday. "In Wisconsin, we believe we have fixed that problem."

At least three bills introduced in the House this session but not included in health care reform would make a start on replicating the [Wisconsin system](#) nationally. But they don't go far enough because they focus exclusively on price, and not on the quality side of the ledger.

Legislation sponsored by [Rep. Steve Kagen](#) (D-WI), a physician who represents the northeast part of that state, would go the farthest. [The Transparency in All Health Care Pricing Act](#) would require public reporting of price information for almost every entity that participates in the health care sector: hospitals, physicians, nursing services, pharmacies, drug manufacturers, dentists, health insurers, and any other health care-related provider, whether the service is wholesale, retail, subsidized or discounted.

Kagen told the subcommittee that publishing prices would foster competition between providers and begin to eliminate variability in pricing that gives big discounts to the well-insured and largest employers while charging the highest prices to those without coverage or stuck in small business and individual plans.

In a rare display of bipartisan support, most of the Republicans on the subcommittee agreed. "If you believe the market based system is the best approach to health care in America, you have to support these bills," said [Rep. Joe Barton](#) (R-TX). "Health care is one of the few areas in America where you simply have to take it on faith that you're going to get the quality of service. It's less information than what you get when you buy a used car.

"This would be a good first step that would show we're going to correct the flaws in the health care law," he said.

The only substantive complaint about the legislation came, ironically enough, from a former high-ranking official at the Federal Trade Commission. Michael Cowie, now an antitrust attorney at Howrey LLP, said "collusion among companies to raise prices is more likely in industries where pricing terms are known among competitors."

Pointing to the leverage large purchasers like pharmacy benefit managers have with drug companies, he argued that "the arms-length negotiation process will lead to the best pricing outcome for consumers." The Kagen bill, he said, "may well contribute to price stabilization and price increases."

Rugland, who spent 25 years as a life insurance actuary with Milliman before volunteering to chair the board of four non-profit hospitals in the ThedaCare network, scoffed at that assertion. "It's the government's job to monitor it and make sure collusion doesn't happen," he said. "Our experience shows that exposure drives efficiency and thoughtful culture change that produces better outcomes."

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