View from the United States

The American health reforms seemed to promise much but then came to nothing. Those in Europe may be wondering what has happened, but Americans too remain bewildered and want more information. Dr David B Nash, a director of health policy and clinical outcomes here publishes a memorandum on the health reforms he would like the 104th American Congress to read.

MEMORANDUM

To: The 104th Congress
 From: David B Nash, MD, MBA
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 Re: Autopsy report on health reform: future mistakes to avoid

I am a practising primary care general internist (the kind of doctor that the president and first lady like), and I'd like to give the incoming congress some free advice about health reform. Three things that I didn't see addressed by any of the healthcare reform proposals include technology, intensity of service per case, and the composition of specialists. These in my view, are the real drivers of cost, and they will complicate the process of improving medical quality, no matter what tools we use.

The missing elements

Technology is a runaway engine which needs taming. Doctors like their "toys." More importantly, consumers enjoy access to those toys. When you practise in a major urban environment like Philadelphia and patients have to walk more than one and a half blocks to receive cardiac catheterisation, they believe their satisfaction level is low.

Intensity of service per case, especially with regard to the Medicare population, is another forgotten component and major cost driver. The government can impose financial caps and global budgets galore. But the point at which the doctor lays his or her hands on the patient – and all of the evidence from the Medicare program as best as I can tell supports this – is where intensity of service per case goes to the ceiling.

Let's not kid ourselves. It is not the greying of America that is

important, it's intensity of service per case that has been the driving force. When you examine today's medical school environment to see how we are training the doctors of the future, you will see how important intensity of service per case really is in the day to day fabric of medical school and residency education.

The third and final element, also related to the training environment, is the composition of specialists. To put that into perspective, the United Kingdom averages one cardiologist per million citizens. In the United States there is one cardiologist per 10 000 citizens and in Philadelphia it seems like there is one cardiologist per 400 people. Outcomes from cardiac care are better in most of the coronary care units in the United Kingdom because of their home healthcare connections.

Some tools and their limits

Consumer report cards, practice guidelines, and total quality management – this is what those of us who are concerned with medical quality assessment and improvement have in our toolkit at the moment. Are these the right tools to do what we want? Are they the right tools for the future?

Firstly, let's look at consumer report cards. For the past four years Pennsylvania hospitals have been required by law to submit performance information on their top 50 diagnoses. These are then evaluated, adjusted for severity, and published by a state agency as part of its quarterly hospital effectiveness report. There is little information out there about how the public views these report cards and no studies to indicate what impact the cards have!

Practice guidelines, as they apply to day to day patient care, do not seem to be a real concern for the average well trained, good doctor at the 700 bed hospital where I practise. The question for practising physicians is: Do practice guidelines make a difference to the outcomes of my patients? I will follow a guideline if it will help me to do a better job, but I'll be damned if I'll follow one just because I'm told. We face a major educational challenge in taking those guidelines and putting them to work.

Many of us have missed the boat with the third tool – total quality management, continuous quality improvement, or "re-engineering." We have been concentrating on the hotel/motel functions of what we do. Is the food good? Was the parking attendant nice? What the hospitals and health maintenance organisations have not tackled are the detailed "rubber meets the road" clinical questions. How do we improve the delivery of drugs so that we can assure that the right patient gets the right drug at the right time? How can we agree on which preoperative antibiotic, at which dose and at what time, should be given before a major surgical procedure? These are the questions that deserve our attention.

Facing the challenges

If we are going to improve the quality of health care in some future delivery system we face three principal challenges in education, research, and operations.

Our nation's 127 medical schools reform their curriculums at glacial speed. Every day, I interact with interns, residents, and medical students, most of whom cannot spell health maintenance organisation, let alone understand the differences in capitation between the various managed care models. That's the educational challenge. We need to think about dramatic changes in our approach to educating doctors, not just in the exigencies of the reform process but in teaching them about doctor-patient interaction and making primary care a worthy career for the future.

The research challenge stems from a need for just that. We have done a lot of good work, but it is not enough. We need to figure out how we get from professional journal articles to changing aspects of behaviour that we think are important for doctors in the future. The answer lies in a better understanding of how we organise care and the impact of that organisation on the outcomes of care. I would bet the rent that a hospital with a full time intensive care unit director who meets regularly with the staff of the unit will have more successful clinical outcomes than a unit where there is no full time leadership,

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coordination, or continuing education, despite all the “toys.”

Finally, the operations challenge. How will we organise and structure the quality measurement and improvement process? This is no mean feat. Health care is delivered locally by various competing interests. It

follows that independent, state based organisations, providing physicians with good, non-punitive feedback about their performance relative to local peers, are the most logical guardians of quality. Remember – high quality care must cost less. Let’s hope our elected

representatives don’t forget this law.

Nationally, autopsies are on the decline. Health reform is one patient who really needs a thorough and detailed one. Maybe next time we’ll learn from our mistakes. That’s what medicine is *really* all about.