LETTERS

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An Open Letter To The President On Quality

To the Editor:

Restoring trust in the U.S. health care system needs presidential leadership, but, like most health issues, it is loaded. President Clinton will need to give some very specific directions to the Advisory Commission on Consumer Protection and Quality in the Health Care Industry if we are to preserve recent progress in containing health care cost inflation, while redirecting regressive legislation and settling irreconcilable conflicts among those who are committed to assuring high-quality health care.[1]

For the commission to be effective, its report ought to be available in six to seven months and should concentrate on a new, unambiguous institutional quality framework that matches the restructured health care industry. If the commission's deliberations take longer, while prescribing actual quality standards, the administration will experience Managed Competition II. As it is, a useful commission proposal for a quality framework will have to deal with hot topics like the federal regulation of insurance and the Employee Retirement Income Security Act (ERISA) preemption. Unfortunately, unlike the managed competition aftermath, there is no private-sector consensus or momentum to compel price-sensitive health plans to compete on quality.

My skepticism about the health care industry muddling through the quality issue should not be interpreted as demeaning new and superb consumer-driven outcome standard-setters like the Foundation for Accountability (FACCT). Any new quality framework will be judged by its ability to take advantage of programs like the FACCT approach and, for the first time, the opportunity to identify the impact of the routine workings of the new health care system on health. I believe that the ideal way to get a sound product from the commission is to start it off with a specific and circumscribed charge from the president. In no particular order, the following are some ideas on a charge to the commission.

■ **Accountable health care organizations.** The commission needs to do some redefining. What kinds of organizations have the appropriate mix of financial and medical care responsibility to be permitted to do business as independent accountable health care organizations? The commission will have to wrestle with a fluid health care industry in which the bulk of financial risk in the most advanced markets is shifting away from traditional health plans to increasingly large, risk-taking clinical enterprises that contract with health maintenance organizations (HMOs). It should avoid the trap of specifying "staff model this" and "point-of-service that," but organizations that are structurally incapable of following what they are doing to patients or demonstrating results are problematic as accountable sound sources of health care.

■ **Quality framework.** Creating a regulatory framework for restructuring the health care industry will be the commission's real challenge. I have not observed any real consensus on organizational hierarchy or associated processes to assure quality. Overseeing the health sector is as complex as and more dynamic than banking or securities, but health care has no real accepted quality accounting principles, no tradition of public disclosure of health outcomes, no methods of rewarding those whose high quality attracts the worst financial risks, and little evidence that consumers respond to comparative information on quality. But the president's charge can get things started by asking for a quality regulatory framework, however imperfect, that forces the health care system to improve

rather than locking in traditional criteria for assuring quality and selecting sources of medical care. The commission should be asked to devise a quality framework that describes organizational structures, responsibilities, processes, and financing for at least one national accrediting entity plus a hierarchy of others that enables the country to authorize accountable health care organizations to sell their product to the public.

The commission's quality framework proposals should describe a set of organizations and processes that (1) assure the public that federally qualified health plans are capable of providing high-quality health care; (2) health plans provide understandable standardized and valid information to consumers that will enable them to choose on the basis of health plans' ability to maintain health and to satisfy their enrollees; and (3) establish and operate a mechanism that identifies when health risks are inequitably distributed among health plans and a means for fairly redistributing revenues to those plans that are effectively serving the sickest patients. The need for this latter risk-adjustment mechanism demonstrates how critically interrelated the quality accountability mechanisms are to each other. We cannot have the best health care organizations going broke because they are good at helping the sickest patients.

"We cannot have the best health care organizations going broke because they are good at helping the sickest patients."

The institutional framework needs to be described by the commission in sufficient detail to draft presidential recommendations for establishing, in addition to the accrediting organizations, entities that might test and recommend measures that can be the basis for quality and risk adjustment. Finally, a system of independent auditing needs to be identified that confirms that the information from health plans is being accurately reported to the accrediting bodies and the public. Should the auditing and standards development activities be separated from the accreditation process?

■ **Prevailing authorities and other commission recommendations.** In recommending a quality framework, the commission should take into account the roles that should be assumed by prevailing authorities such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the National Committee for Quality Assurance (NCQA), and federal and state legislation and regulation. Should there be a federal preemption of state laws for health plans that agree to be federally qualified? Do ERISA plans escape the quality rules? What areas does the commission regard as the most urgent for standards development or application?

Then there are the patient-records confidentiality questions. The commission needs to clarify the public-interest importance of the quality assurance and market choice information, while also providing assurances against compromising privacy.

See what I mean about managed competition *deja vu*?

If the administration has second thoughts about involving itself in the quality morass or wants to do a sure thing for quality in parallel to the commission's work, it can make a huge difference as a consistent quality purchaser. By combining forces in buying only from high-quality health plans that report their health outcomes to the public and by establishing a risk-adjustment mechanism, the federal government will be in a better position to drive the health care system than the private sector will be. The Health Care Financing Administration (through Medicare) and the Office of Personnel Management (through the Federal Employees Health Benefits Program) are already establishing some good precedents in cooperating on quality purchasing of health care. It would further strengthen the federal government's leverage if the Veterans Administration, the Department of Defense, and the Indian Health

Service pursued the same health care quality policies.

PAUL M. ELLWOOD
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NOTE

1. The Advisory Commission on Consumer Protection and Quality in the Health Care Industry was created by Executive Order on 26 March 1997. Its purpose is to advise the president on how changes in the health care delivery system are affecting quality, consumer protection, and the availability of needed services. Through a series of public meetings, the commission will collect and evaluate information and develop recommendations on improving quality in the health care system. A final report is due March 1998, with an interim report due at the end of 1997.

   The commission will be cochaired by the secretary of health and human services and the secretary of labor. The commission has broad-based representation from consumers, business, labor, health care providers, insurers, and quality and financing experts.

   The following persons have been named to the commission thus far: Donald Berwick, Institute for Healthcare Improvement; Christine K. Cassel, Mt. Sinai Medical Center (New York, NY); James Chao, Metro Provider Service Corporation; Robert Georgine, AFL-CIO; S. Diane Graham, STRATCO, Inc.; Val J. Halamandaris, National Association of Home Care; Sandra Hernandez, San Francisco Department of Health; Nan Hunter, Brooklyn Law School; Sylvia Drew Ivie, T.H.E. Clinic for Women (Los Angeles, CA); Risa J. Lavizzo-Mourey, Institute of Aging, University of Pennsylvania; Sheila Leatherman, United Health Care Corporation; L. Ben Lytle, Anthem, Inc.; Beverly Malone, American Nurses Association; Gerald McEntee, Association of Federal, State, County, and Municipal Employees; Paul Montrone, Fisher Scientific International, Inc.; Phillip Nudelman, Group Health Cooperative of Puget Sound; Herbert Pardes, Columbia University College of Physicians and Surgeons; Ron Pollack, Families USA; Marta Prado, InPhyNet Medical Management; Robert Ray, National Leadership Coalition on Health Care; Thomas Reardon, Portland Adventist Medical Group; Kathleen Sebelius, insurance commissioner, State of Kansas; Steven S. Sharfstein, Sheppard Pratt; Peter Thomas, Powers, Pylers, Sutter, and Verville, P.C. (Washington, D.C.); Mary Wakefield, Center for Health Policy, George Mason University; Gail Warden, Henry Ford Health Systems; Alan Weil, Assessing the New Federalism Project, The Urban Institute; Sheldon Weinhaus, attorney representing workers in health care litigation (St. Louis, MO); and Stephen F. Wiggins, Oxford Health Plans, Inc. Janet Corrigan, of the Center for Studying Health System Change, will serve as the commission's executive director.

Hospital Conversions And Uncompensated Care

To the Editor:

In their paper "Does the Sale of Nonprofit Hospitals Threaten Health Care for the Poor?" (*Health Affairs*, January/February 1997), Gary Young, Kamal Desai, and Carol VanDeusen Lukas assert that concerns about reductions in the provision of uncompensated care as a result of hospital conversions from nonprofit to for-profit status are "unwarranted." We have some concerns about the validity of this conclusion and serious reservations about the applicability of this study outside of California.

For-profit hospitals are located chiefly in thirteen states. Compared with national averages, those states have relatively few public hospitals and stricter rules for Medicaid eligibility. California, however, has an extensive system of public hospitals. The indigent care provided by those public hospitals, in addition to the services provided by MediCal (California Medicaid), has resulted in a relatively low demand for uncompensated care in private California hospitals. As a result, there has been little difference historically in the provision of such care between private nonprofit and for-profit hospitals.

Lawrence Lewin and colleagues, in a 1988 report cited by Young and colleagues, studied the provision of uncompensated care in five states where both nonprofit and for-profit hospitals were prevalent (California, Florida, North Carolina, Tennessee, and Virginia).[1] They found that in comparison to for-profit hospitals, nonprofits provided 50–90 percent more uncompensated care in Florida, Virginia, and North Carolina; twice as much in Tennessee; but nearly the same in California. In regard to California they stated, "Neither investor-owned or not-for-profit hospitals as a group bear a cost burden of more than 3% on average, as compared with up to 10% in other states." The U.S. General Accounting Office (GAO) had similar