Measuring Quality in Health Care and Its Implications for Pay-For-Performance Initiatives

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KEYWORDS

• Quality • Health care • Pay-for-performance
• Hand surgery • Outcomes

Health care is a decisive issue in the 2008 United States presidential election. Over the past months, the candidates' visions for future health care policies have been discussed, debated, and dissected. In a December 2007 poll by the Kaiser Family Foundation, health care ranked second on a list of voters' most important issues.[1] It is so important that 21% of Americans named health care as the single most important issue in their choice for president in this election.[1] In contrast, in 2004, health care ranked only fourth among decisive issues, with only 14% of those polled considering it the most important.[2] The issue of health care has remained a major concern because restrictions and lack of access to affordable care have eroded the standard of living expected by many Americans.

Any discussion of health care is likely to touch on a trio of topics: cost, access, and quality. These topics weigh on the minds of health care consumers. A September 2007 CBS News poll found that 66% of registered voters reported that they were unsatisfied with the quality of health care in the United States.[3] Another recent poll by the Kaiser Family Foundation found that 80% of respondents were worried about the worsening of the quality of the health care services they receive.[4] Furthermore, 81% of Americans reported that they were dissatisfied with the cost of health care in the United States, up from 62% in 2004 (**Fig. 1**).[2,3]

There is much about which to be dissatisfied. United States health care spending is among the highest in the world, averaging $7026 per person, or $2.1 trillion in 2006, and is growing at a rate of over 6.7% per year.[5–7] Despite continually increasing expenditures, the United States has not enjoyed the quality that should be accompanied by this enormous investment (**Fig. 2**).[6] The stakes are high for various special interests groups to protect their ''turfs'' in this battle for health care allocations. These interest groups, which include the government, insurance companies, health maintenance organizations, consumer groups (eg, the American Association of Retired Persons), employees of corporations, and ordinary consumers, have competing interests that conflict with hospitals and physician organizations in their efforts to extract as much as possible from a fixed pie of health care expenditure.

The current system of United States medical care is based on the free-market economic model

This article is supported in part by a grant from the National Institute of Arthritis and Musculoskeletal and Skin Diseases (R01 AR047328) and a Midcareer Investigator Award in Patient-Oriented Research (K24 AR053120) (to K.C. Chung).
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Hand Clin 25 (2009) 71–81
doi:10.1016/j.hcl.2008.09.001
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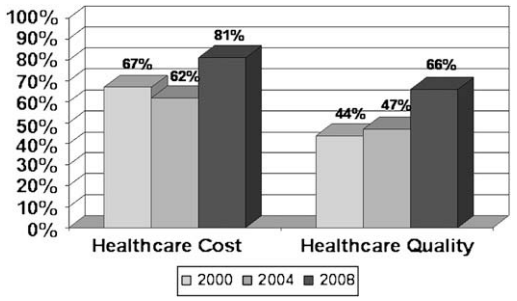

Fig. 1. Percent of Americans dissatisfied with United States health care costs and United States health care quality. (*Data from* Kaiser health tracking poll: election 2008. Menlo Park (CA): The Henry J. Kaiser Family Foundation; 2007; and Health care and the Democratic presidential campaign: CBS News; September 17, 2007; and Kaiser Family Foundation poll. Storrs (CT): Roper Center for Public Opinion Research; 2007.)

in which supply and demand create a mutually beneficial market for both buyers and sellers. Noted Princeton University health economist Uwe Reinhardt supports this free-market model. He believes that competition in medicine is healthy and has the potential to give consumers the ability to choose among various providers for the highest quality of care.[8] He also realizes, however, that medicine is a unique field, influenced by government regulation, consumer norms, and market prices.[8] In addition to not holding price in check, the existing United States provider reimbursement system does not pay much attention to quality, but bases payment instead on volume and intensity of services provided.[9,10] As the United States moves toward a single-payor system like those that have been adopted by many industrialized nations, quality metrics will be instituted to improve efficiency of service delivery by focusing on preventive care measures and minimizing costly complications.[11]

EVOLUTION OF THE UNITED STATES HEALTH CARE SYSTEM

Before the 1970s, private and public payors reimbursed physicians and hospitals customary fees for their services. Charges were submitted to the insurance carriers, who typically paid the full amount. As the cost of health care continued to rise, however, Medicare and private insurers adopted the diagnostic-related groups, which introduced the concept of fixed case-rate payment. Rather than paying hospitals for each test and procedure individually, specific payment rates were given to hospitals based on diagnosis.[10] The diagnostic-related groups introduced the concept of capitation, which shifted the financial burden to the hospitals. The aim of the diagnostic-related group system is to encourage hospitals to discharge patients earlier and to curb the ordering of expensive, often optional, tests. Because hospitals are paid a set amount, if they can practice medicine more cost-effectively, they will retain more of their reimbursement. The diagnostic-related group model had a great effect in reducing the length-of-stay in hospitals. For example, in

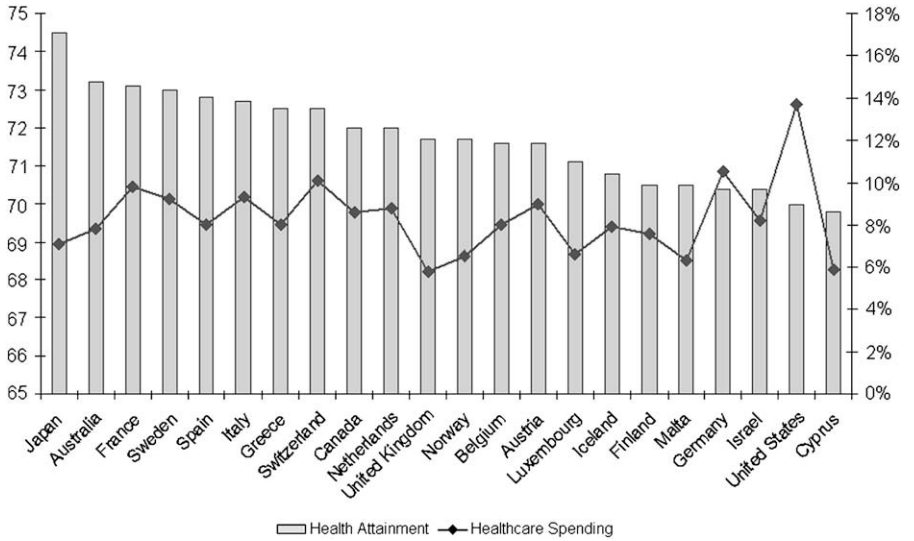

Fig. 2. Health attainment (disability-adjusted life expectancy) and health care spending (percent of GDP). (*Data from* The world health report 2000. Health systems: improving performance. Available at: http://www.who.int/whr/2000/en/whr00_en.pdf. Accessed March 3, 2008.)