Value-Driven Health Care—
Pipe Dream, Placebo or Prescription for Excellence?
by Ed Pudlowski

The Value-Driven Health Care initiative and the Executive Order (EO) that underpins it invert the cost/quality equation and proceed from the premise that improving quality first—in terms of both care and system management—will reduce costs and elevate value. Equally essential to the success of the initiative is transparency: access to information that will empower consumers to save on quality care. This article describes the four cornerstones of the EO and explains how they will translate into corporate action and value.

Every year, employers spend billions of dollars on health care for their employees, with limited means of assessing quality, comparing costs or evaluating performance. Ironically, this system, whose main objective is to heal and promote health, has been causing a certain level of pain—for the government, the private sector and the American citizenry.

Francis Bacon’s declaration that “knowledge is power” may be the motto for health care of the future as the federal government’s Value-Driven Health Care Initiative strives to put more information, more knowledge and, ultimately, more power into the hands of other than the healers’ (employers, employees, plan providers and patients). While this initiative is slowly gaining ground in state and local governments, the medical community and the workplace, there is one question that seems to overarch all discussions: Will it have any impact on health care cost inflation?

Cost, in fact, is one key driver of this federal initiative, an offshoot of President Bush’s 2006 Executive Order to help empower Americans to find better health care at better value. America today spends 16 cents of every dollar on health care goods and services; at the current rate of spending, that number is expected to increase to 20 cents over the next few years.1 As the name suggests, value is another driver. Compared to the 30 countries that comprise the Organization for Economic Cooperation and Development (OECD), similar in structure and economy to the United States, this country spends almost twice as much on health care and cannot show a result with commensurate value in increased longevity, improved quality of life or measurably consistent care.2 This puts America at a distinct disadvantage in a globally competitive marketplace.

While high cost is typically associated with high quality virtually throughout the U.S. market arena, health care is the notable exception. Not only have the high costs not delivered the desired standards of care but, until recently, very little price-shopping or value-demanding purchasing processes that typify the interaction between consumer and provider for most other goods and services has actually occurred.

The Value-Driven Health Care Initiative and the Executive Order that underpins it invert the cost/quality equation and proceed from the premise that improving quality first—in terms of both care and system management—will actually reduce costs and elevate value. Equally essential to the success of the initiative is transparency: access to the heretofore
“black box” information that will empower consumers to save on quality care.

The Executive Order (EO) signed by President Bush in August of 2006 was a solid step toward bringing the disparate and disjointed elements of health care together in an ordered system that, once operational, could drive value as well as quality across the spectrum of care. The order designated a portion of the government to be a “test-case-cum-precedent-setter” for other major consumers, instructing several federal agencies that provide subsidized health care for their employees to begin buying that care based upon specified principles of efficiency. The agencies tapped include the Veterans Administration, Department of Defense, Office of Personnel Management (health insurance for federal employees) and the Centers for Medicare and Medicaid Services (CMS) (collectively the biggest purchaser of health care in the nation, covering the 93 million people who comprise nearly 40% of America’s insured).

The principles of efficiency these agencies were directed to follow are known as the four cornerstones of the initiative:

1. The foundation of health information technology
2. Availability of information on the quality of care
3. Information on the price of care
4. Incentives to help providers and patients use available information wisely.

While these may seem to be fundamental requirements for packaging any system of service, the basic disconnect lies in the fact that “health care system” is something of a misnomer. Health-based facilities—from wellness through treatment—and the corresponding providers and funders are more “coincidentally connected,” practicing a common craft and engaging in or supporting similar activities. As such, they more closely resemble a business sector than an ordered structure or consistently applied system. The government believed that the 2006 Executive Order was needed to put more consistency in the approach.

**BENEATH THE CORNERSTONES**

Looking at what’s beneath the cornerstones not only describes the initiative, but also surfaces some of the challenges that both fuel and follow its drive to success.

**Health Information Technology**

The first component the EO instructed its test agencies to implement was a standard of interoperability by which participants in the health care system could communicate with one another. As little as 15% of the health records in the United States today are electronic. An even smaller percentage is actually transportable and accessible. The information available that categorizes, measures or quantifies details on the quality and cost of care—information that could help consumers compare doctors and hospitals and, likewise, assist employers in designing appropriate and viable benefits packages—is still in its infancy when compared to other metrics businesses typically use to assess quality.

So while an individual can access his or her money, bank or loan balances from kiosks virtually anywhere in the world, and employers can call up extensive background information from their laptops, the same cannot be said for information that could mean the difference between profit and loss, even life and death. That access is unavailable to practitioner, provider and patient alike.

Meeting even the basic standard of interoperability will mean that data can be exchanged accurately, efficiently and securely. With electronic health records, patients will be able to access their medical histories and those managing chronic diseases will be able to coordinate their care from multiple providers; doctors will be able to cross-reference treatments and medications from other sources to improve patient care and substantially decrease medical errors. Electronic health records will have an impact on every step of the medical process, inpatient or outpatient, from admittance to release, with the potential for saving time and money while improving quality and value.
**Information on the Quality of Care**

The EO directed the federal agencies in its test program to share with beneficiaries information on the quality of services provided by doctors, hospitals and other health care providers. As in any other service, some health care providers and practitioners are better than others, but that information is neither easily measured nor tracked.

While measuring quality in health care is complex, it is vital to a coordinated system whose objective is to operate on value. Although still in the pilot stage, several organizations of insurers and health care providers have joined forces to create standards and measures for quality, beginning with a focus on ambulatory/physician care and hospital care.

One of the first steps taken as a result of the EO was the creation of the Hospital Compare site by CMS and the Hospital Quality Alliance (HQA). The site makes available quality information on more than 4,000 hospitals based upon an initial set of conditions and how often each hospital provides the recommended care to achieve the best results for most patients in those circumstances. Similar to the HQA, the AQA, formerly known as the Ambulatory Quality Care Alliance, compiles and publishes results from measuring physician performance. These and comparable alliances are gaining strength and support in response to the EO and the initiative, and they will continue to expand the parameters for collating and releasing information on quality and satisfaction.

Once quality-based information is available in a comprehensive and reliable form, it can assist employers in managing vendors, assessing market capabilities, demonstrating cost saving and moving to a consumer-driven health plan.

**Information on the Price of Care**

Rarely does anyone make a commitment to buy any kind of goods or service without knowing the price—except when it comes to health care. Apart from insurance premiums and copayments, many people know little or nothing about the total cost of the care they receive. By extension, expecting any positive impact on controlling health care costs is unlikely without a more transparent perspective on what those costs are and what they cover. And while a great deal of the money is certainly going to valuable treatments, a significant amount is not, which makes the overall cost of health care higher than it needs to be.

Price transparency is arguably as challenging to achieve as quality transparency. It requires information from a robust enough base of insurers and payers to make the information relevant and credible for driving any kind of price comparison that might change the buying behavior of consumers on a corporate or personal level. To achieve this “immediate critical mass,” CMS has posted the payment information involving such common procedures as hospital admissions, ambulatory surgery, hospital outpatient care and physician services. Additional coalitions, insurers and payers are also working to develop and implement standards that will enable consumers to have a clearer idea of their costs for treatment per episode of care and make the kinds of “informed decisions” that are otherwise demanded in this environment.

**Incentives**

How good these ideas are is in direct proportion to how widely they are implemented—And incentives can motivate acceptance, encourage competition and stimulate change. One of the fundamental incentives is that of the individual health care consumer’s vested interest—The patient will have a more personal stake in the choice of care, underscored by the information necessary to make that choice. Continuing further along the chain, doctors and hospitals will become part of the payment structure, with competitive bidding for services and pay-for-performance incentives that reward quality already part of several pilot programs between insurance plans and Medicare.

**BEYOND EXECUTIVE ORDER—SPREADING THE MESSAGE TO MAKE CHANGE REAL**

While the 93 million people covered under the blanket of the federal government seems a significant enough sample to set a precedent, reaching the tipping point means leveraging the catalytic effect of

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the Executive Order and taking its cornerstones to the state and local levels and the marketplace of the private sector. After all, the initiative is a voluntary effort outside the federal programs, not a government mandate. It also is a program that is considerably less than common knowledge among potential corporate consumers. In a quick poll of 300 human resources professionals conducted in the context of an Ernst & Young Webcast in April 2007, 77% of these participants had never heard of the initiative.

Casting a wider net with the message designed to change buyer behavior means rolling out the initiative to corporate enterprises and provider organizations as well. The “go-to-market” strategy centers on a revised version of the president’s Executive Order—a corporate executive request, if you will, that would generate a shared vision, “sign-on” support and a public commitment from governors, corporate executives and other large-scale buyers to apply the standards that strive for the transparency that will enable value-driven health care to spread nationwide.

Ongoing federal support and real-world demonstrations of the Value-Driven Health Care Initiative at work are invaluable for the business community. With government as both the creator of the infrastructure and one of the nation’s largest health care purchasers, there is a vested interest in successfully creating a workable scenario for both “buy and sell” sides of the initiative. Additionally, the byproducts of government-funded research can be leveraged throughout the corporate world to the long-term benefit of any purchaser or provider on the health care continuum.

To kick-start the initiative in the business arena, the U.S. Department of Health and Human Services tailored the EO cornerstones into a request for information (RFI) that would provide guidelines to help employers assess how well their vendors, health plans and contract physicians are already measuring up to the prescribed standards. The standardized framework for RFIs and RFPs makes it simpler for governments and businesses to elicit competitive bids from plan providers and communicate a consistent message and standard. HHS leaders say that about a dozen governors and 100 of the country’s top 200 companies initially signed the statement of support.8 Though this isn’t a legal document, some companies are already evaluating their providers according to these standards and formats. Finding a vendor who is even somewhat knowledgeable about the initiative and its increased transparency can separate that provider from the pack with an advantage over less-informed competitors.

Complementing government efforts are the alliances and consortiums of small and large employers that recognize the need for a uniquely designed infrastructure that will support “comparison shopping” and value-based decisions relative to health care. Some, such as the Leapfrog Group, a consortium of 500 of the top employers in the country, had established their own set of standards and conducted their own surveys even before the value cornerstones were cemented in the EO.9 One voluntary survey of hospitals, designed to measure the impact of implementing certain patient safety practices, revealed that errors could be reduced by as much as 40-50%,10 and many thousands of lives and millions of dollars could be saved.

**Taking Cornerstones From Concept to Corporate Action to Value**

An arguably essential element of the employer/employee covenant is selecting a vendor that helps a company direct its people to good health care. Using the EO cornerstones to standardize both the collection and evaluation of information, then making the findings transparent and available to employers enables companies to challenge their health care vendors to provide the most comprehensive, value-based plans. They also help human resources (HR) executives hone in on their company’s particular challenges and encourage additional conversations with their vendors to explore how transparency and health care information technology (IT) can translate into solutions. This example of utilizing transparency in quality of care information would seem to have a significant impact on the quality and cost of care provided to its employees. Likewise, the affected facility will probably begin to review its procedures for treating heart patients to win back the employer’s business. Transparency can truly make a difference.

**Prescription for Long-Term Treatment**

The objective of the EO and its corresponding value-driven initiative is quality health care delivered with appropriate and improved value. But like many remedies for chronic conditions, the prescription that gets this result requires consistent application, even after the desired effects are first visible.

**Connectivity**

Quite simply, connectivity improves efficiency. The interoperability that comes from an efficient IT infrastructure not only enables employers to make comparisons between health care providers and services, it also helps reduce errors from both the clerical and the care perspectives. An efficient IT infra-
structure can mitigate or prevent errors that stem from the misapplication of funding, as well as the misapplication of treatment stemming from wrong diagnosis or non-evidence-based medicine. As the cost of errors such as these has been borne historically by corporate and individual consumers, so will the savings from minimizing these errors be passed along to them, too. Costs go down; quality goes up.

Connectivity itself, however, costs, and the question inevitably arises as to who will pay. Since hospitals are the principal source of the information and therefore of health IT, the onus of investment logically falls on them. Those that have successfully implemented advanced systems with the capacity for real interoperability—e.g., computerized physician order entry systems with end-to-end patient records—almost universally say that they recoup their investment in three years or less. Rather than waiting for hospitals to both make and finance the first move, some corporate health care purchasers are offering up-front grants to help them invest in the appropriate infrastructure that will work along the whole health care continuum and over the long haul.

Convergence and Collaboration

A quest for better, more cost-efficient health care and standards for measuring it has led to interesting and unusual collaborations among companies that would otherwise compete. And health care reform leaders say this is a key factor in the success of the value-driven initiative. Employers have been coming together by way of such multistakeholder groups as the American Benefits Council, the National Quality Forum and others. These organizations have a mandate to make sure the voices of all participants are heard—providers, purchasers, consumers and vendors—as they try to reach consensus on what constitutes quality and identify places where quality already exists or where it’s a standard yet to be met.

Some leading-edge companies are working to establish “premium networks,” based upon the voluntary sharing of measurement results of hospitals and doctors with a third-party administrator. This information helps to identify where the best outcomes are taking place and what practices are driving them.

Centralized Communication

Interoperability is the outcome of connectivity and one that both enables and relies upon communication. One of the primary challenges for effective communication to improve the health care environment is for employers to send a cohesive and consistent message to plan vendors and care providers—an inextricable element of collaboration. Forming ad hoc coalitions can provide a forum for raising issues that affect companies across the board and consolidating them into a shared mission and common plat-
business units are accountable for their own profitability, they need to be provided with appropriate ways to get control of their costs. While corporate HR may have a better perspective on the broad range of plan possibilities, the business units are more likely to be in touch with the challenges and solutions that are unique to their particular employees. They must identify the highest health care drivers in their locales; share them with appropriate C-suite executives; and work together to develop plans and programs that factor in the complete span of the company’s demographics. This extended approach to ownership and shared responsibility has a much higher potential for changing the behavior of consumers and providers.

When communication isn’t enough to effect change, companies must underscore their commitment via the buying decisions they make. As information becomes increasingly available, leveragable and comprehensive, health care purchasers have a clearer idea of their choices and will be more likely to make them as much on the value equation as on the cost equation.

A Word of Caution

Corporations and consumers tend to implement a few quality standards as a way of getting things moving in the right direction. On the other end of the pendulum, hospitals and physicians generally wait for a full set of standards to be fully developed and vetted. Hospitals and physicians tend to weigh in on the latter while corporations and consumers are impatient to begin even the former. One thing, however, is clear and immutable: The message must be consistent. There is exponential power in communicating a common message—and exponential failure when the message is fragmented, waffled on or watered down to the extent that the concept of quality is open to many interpretations rather than based on well-defined metrics. Credibility will suffer and so will the march toward a value-driven health care system.

WHAT PRICE HEALTH CARE?

Another topic for debate relative to value-driven health care is how to measure price. These are the most common options:

- The price paid by a health plan to health care providers in keeping with a discount arrangement
- The price paid by an individual consumer for one service or another from one provider or another
- The average price in a given region, to serve as a point of comparison.

Whatever the metrics, consistency is as important here as in any of the cornerstones, and so is transparency. It bears repeating that health care is the only service arena in which it is said service is provided with little or no up-front knowledge about, or discussion of, price. This lack of information will hopefully be the first casualty of the value-driven initiative.

Take, for example, a growing health care procedure that is considered to have both price and quality transparency. Lasik eye surgery is not typically covered by an employer-sponsored health plan and therefore must operate outside the health care system typically encountered for other procedures—In other words, it is marketed much like any other product or service in our economy. Providers of Lasik surgery routinely advertise the price of the surgery and affirm its quality in relation to the number of procedures performed or the clientele that feel comfortable using the surgeon. As a result, there has been a dramatic decrease in the cost of Lasik surgery—much the same marketplace dynamic that occurs as any new technology becomes more widely used and its quality more commonly understood and appreciated. For example, in 2000 the standard prices for Lasik surgery ranged from $1,800 to $2,500 per eye. Today the same standard procedures can range from $500 to $2,500 per eye. The current initiatives are designed to move the services in the employer-sponsored environment into a market arena more like that of Lasik eye care.

Incentives—What, Who and How?

CMS is currently participating in what is called “the Premier hospital quality incentive demonstration.” Premier is an organization working with more than 250 hospitals around the country and with CMS to apply specific standards of measurement to five areas of patient care in each of these hospitals. The goals are to increase patient quality outcome, decrease mortality rates and decrease hospital-acquired infections, which can cost an average of $150,000 for any and every such infection. Once the measures are collated and the results evaluated, those hospitals that fall within the top 10% of this peer group receive a 2% bonus on top of the normal payment that CMS makes against their claims. Those that fall into the second 10% receive a 1% bonus. While the percentages appear small, given the number of procedures and the dollars of CMS reimbursement involved, high performance can make a significant
impact on the margins of these hospital systems. In fact, in its first year of implementation, the program has paid out close to $9 million in bonuses for the first round of assessments.

The Leapfrog version of the CMS incentive plan also factors in measures of efficiency and price transparency, reimbursing those hospitals that rank in the top 10%. Both are examples of how the public and private sectors can work together to reset the performance bar for a number of levels of patient care and service.

Incentives also apply with respect to changing the health care-based behavior of employees. More transparency in plan facts and costs may empower employees to make more proactive decisions about their health care. By seeking appropriate health care sooner rather than later and focusing on wellness rather than health disaster response, this change in employee behavior will keep risk factors down and productivity up.

**BOTTOM LINE—IS QUALITY MORE EXPENSIVE?**

On the surface it may seem counterintuitive for an initiative to be contemporaneously successful at cutting cost, increasing efficiency and improving quality. Or, as a hackneyed production triangle would have us believe—*Good. Fast. Cheap. Pick any two.*

To the contrary, a recurring theme of the examples posited in this discussion is that quality and cost are neither inversely proportional nor mutually exclusive. In fact, a 2005 Rand Corporation study showed that the cash outlay required to properly implement health information technology would ultimately save money in the long term and significantly improve health care quality by reducing costly mistakes. Even without changing the cost structure of health care and simply improving and monitoring the quality at which it’s delivered, the upside potential is considerable. This is possible since the health care system does not operate like any other component of the economy. Essentially, those concepts that govern economics when we want to make changes within the current health care system must be abandoned.

Given the vast array of issues that must be addressed in search of the ultimate cure for the ills of the health care system, it’s unlikely to find a single magic prescription for making all health care costs go down and quality and value go up. In this area as well, all the participants in the health care supply chain have their own responsibilities supported by the infrastructure of the four cornerstones and the common commitment to connectivity, collaboration and communication.

Quality and cost are linked. The leading groups in the transparency and quality revolution will be able to sustain an acceptable level of inflation in health care expenses without having to place a significant burden of the cost on their employees. Organizations that fail to consider programs to improve quality or support quality-based initiatives are not likely to experience the cost impact of proactive organizations. In short, while chasing the cost equation can yield short-term results that may be evident to the bottom line for a year or two, committing to and pursuing the quality equation can yield long-term, sustainable results that are evident in both monetary and mortality improvements. As more measures are put out on the table and more information made available, the evolution will likely tend toward an all-new reimbursement system that doesn’t just pay the same amount for good care or bad care, but differentiates and rewards all those who do it right, just like any other component of this consumer-driven economy.

*The views expressed herein are those of the author and do not necessarily reflect the views of Ernst & Young LLP.*

**Endnotes**

1. Andrew Cronshaw, U.S. Department of Health and Human Services senior executive advisor and project leader for the Value-Driven Health Care Initiative.
4. See note 1.
13. www.cms.hhs.gov/HospitalQualityInits/35_HospitalPremier.asp.