If Federal Policy Can't Improve Health Care, What's Next? 5 Trends to Track

written by Theresa Hush | October 12, 2017

Health care has been extraordinarily resistant to change. Escalating costs have been at issue since the early 1980s—think about it!—but continue to rise unabated. Ask anyone participating in the system, be they physicians or other health care providers, payers or patients, and you will be inundated with complaints about health care economics, outcomes or processes. If you ask most health care executives about the future, chances are you'll be met with a shrug.

The fact is, however, that an undercurrent of change is already beginning to transform health care. It is gaining momentum, but the health care system and providers are still behaving as if the status quo is immutable. Nothing could be farther from the truth.

Here are five trends emerging throughout health care delivery and health care financing that are reshaping both economics and treatment.

1. Consumers will assume a greater and greater financial responsibility for health care.

With revived proposals of vouchers for health care, limitations on benefits, as well as outright loss of coverage and restrictions in access from everyday to only catastrophic health care coverage, the cost for consumers will continue to rise sharply. This is significant not only because the cost burden is shifting to those who may be less likely or able to pay, but also because it sets up a quid pro quo: if I'm responsible for paying, I should have more say in it.

Health care systems, which have consolidated into huge bureaucracies, should not be surprised by a consumer revolt on pricing, nor by millenials avoiding health care institutions altogether. They should prepare by understanding, first of all, what costs consumers are facing, and then by establishing solutions for consumers who cannot afford services they need to purchase in order to stay healthy. The time for simply verifying coverage of patients is gone.

2. Consumer-patients will demand more information and shared decisions.

Shared decision-making has become a new buzzword in health care, replacing "patient engagement"—outdated code for providers' desires that patients comply with physician directives. Patients are pressuring for facts about effectiveness, for price transparency and for access to information. They are motivated by financial vulnerability as well as a reliance on Internet-based information. They are willing to challenge bureaucracies and are taking more personal responsibility for health.

Health systems are not used to sassy consumers, especially younger adults, but they should pay attention. Insurance plans that constantly change provider networks have killed patient loyalty. Providers must engage patients with better customer service, helping them make intelligent choices, and giving them the tools to do it.

3. Individualized care will take precedence over population health.

At its best, population health is only a way of making sure that patients with chronic disease receive essential health services. Measurement of outcomes using populations or treatment of patients in a population, however, will always fall short.

Research and genetics have already clarified that people do not respond the same to drugs,

treatments or other interventions. Population-based health care may help keep track of the overall status of health and of general processes, but it is not magic. It cannot identify how an individual will get better. Individualized care is emerging as patient data become richer and more specific, and intervention results are evaluated against those patient characteristics.

Providers should prepare by working with a clinical data registry or other technology to capture and evaluate patient information, garner patient feedback and create opportunities for broad based research on interventions.

4. Cost measures will be essential tools for health care management.

Most health care organizations are focused on prices and revenues, not cost. They are not tracking what it costs for an intervention or the overall cost of care per patient. In part they are limited by the data inside their walls, but the larger issue is this: As long as providers are paid fee-for-service, they won't perceive a need to know about cost.

Medicare introduced types of cost measures a few years ago for primary care, and episodes of care for specialists. As data becomes shared more widely (as under MACRA plans) for all payers, measures of cost will become more universal and shared publicly.

Health systems need to prepare by establishing programs to calculate and create ongoing measurement of their costs—pronto. They can then strategically plan how to use their resources in a market that measures cost comparatively and address cost outliers collaboratively with their providers.

5. Performance improvement will take the place of quality measurement.

Measuring quality through standardized measures has many flaws. Measurement problems, missing data, measure limitations such as annual outcomes—for all these reasons, quality measurement fails the test of accuracy and fairness. That's why physicians never bought into the concept, but health systems have found it difficult to move away from the simplicity of scores.

Performance improvement, however, is beginning to take hold through discrete initiatives that focus not on annual measurement, but on outcomes over time. This is how measurement will occur in the future. As quality measurement becomes "streamlined" and deregulated, but data becomes more available, payers and consumers will demand better measures of quality. That

test will be one of effectiveness, measured over time.

Performance improvement in the future will be less generally applied and more condition- and outcome-specific. Old “disease management” programs are beginning to re-emerge and may well replace generalized process improvement.

To succeed in the future, health systems should focus on real performance improvement over quality scores. Performance improvement must differentiate process improvement from outcome improvement. Health systems have historically focused on process rather than outcomes. Outcomes improvement, however, will be of greater interest to clinicians and engage them, and will have greater value to patients. A trend line of patient health status provides the basis for asking why variation occurs and why improvement is or is not happening. It creates curiosity and engagement.

The Federal Government Will Not Fix Health Care

The most comprehensive plans for changing the health care system in recent years have come from the federal government and, to a lesser extent, from private health plans. Change did not come from inside the system. That is an important point, because federal policy inadvertently fostered passivity for creating solutions to the health care system itself; instead it put a premium on compliance.

It was federal policy that proposed major solutions for measuring quality and controlling cost, building on private insurers’ quality incentives for primary care. The Affordable Care Act, various budget bills and, later, MACRA attempted to engineer deep changes in the system. Providers got into action to comply with regulations but largely did not adopt initiatives that would change the health care system’s profit center—fee-for-service reimbursement.

Expect to see continued action by Medicare and private health plans to take down fee-for-service and replace it with some kind of fixed fee. That could mean risk models like Alternative Payment Models or risk-based ACOs, Medicare Advantage and various capitation and episodic payment models, or a blend.

Regardless, there will be no solution for a new, effective health care system that emerges from Washington. Instead, we will face one of two realities: a system that implodes under increasing consumer debt or failure to pay, or a system where most providers begin to engineer change and improvement. The choice is obvious. The question is whether providers have the will to take the initiative.

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