The Future of Healthcare

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The world did not change overnight with the passage of the Patient Protection and Affordable Care Act ("Health Reform") in March of last year. The Health Reform legislation is, however, the latest and broadest effort by policymakers to improve the quality and reduce the total cost ("value," when taken together) of American health care. Unlike the reform effort put forth in the 1990s under President Clinton, which advanced the notion that insurance companies were best positioned to control costs by "managing" care, President Obama's Health Reform legislation creates mechanisms that aim to shift "accountability" for the cost, volume, and quality of care to doctors and hospitals. Although it is not yet clear which of the many initiatives in the Health Reform legislation will ultimately take root and which will be discarded, it is clear that the ascendant concept of "value" in health care delivery will continue to gain traction. Knowing this, the University of Pennsylvania Health System (UPHS) will continue to develop and grow highly differentiated services and to constantly improve outcomes and costs on a longitudinal basis, as opposed to the event-driven nature that dominates the current payment system.

The history of health care delivery in America is such that, with the notable exceptions of group practices and teaching hospitals, physicians traditionally viewed themselves as independent operators and viewed hospitals as their "workshop." This arrangement was, and largely still is, reinforced by separate payments to hospitals (the facility, or "technical," fee) and to doctors (the "professional fee"). In addition, payments were historically made for all services rendered ("fee for service"), with only weak measures, rules or processes in place to regulate the cost or volume of the provided services.

Beginning in the 1950s, a series of legal decisions established hospital liability for physician behavior, leading to the first substantive efforts at collaboration between the two groups. Although the establishment of Medicare and Medicaid vastly expanded access to care in the 1960s, they did not change the fundamental nature of the relationship between hospitals and doctors. It wasn't until 1983, when Medicare introduced the prospective payment system through "diagnostic-related groups" (DRGs), which paid a fixed amount to a hospital for an entire hospitalization (but preserved separate payments to physicians), that policymakers more aggressively attempted to reign in cost and utilization, yet even that effort was focused on a procedural basis. Later, in the 1990s, the specter of "Hillarycare" and the rise of managed care companies drove a wave of consolidation and integration as doctors and hospitals sought to build their market power and to reduce financial risk.

In this context, President Obama's Health Reform legislation can be seen as the latest in a long series of initiatives to more closely align doctors and hospitals, thereby improving cost, quality, and access. The trend (if not the timing) in this direction is quite clear. Some of the names for the mechanisms in Obama's Health Reform legislation have already entered the lexicon of health care professionals; "ACOs" (for Accountable Care Organizations), "Medical Homes," "Value-Based Purchasing." Avoiding the specifics, these mechanisms can be thought of broadly as efforts to increase "payment risk" and/or "utilization risk" for doctors and hospitals. Examples of payment risk include non-payment for "health care-acquired conditions" or preventable readmissions. Utilization risk examples include "bundling" around an episode of care and accepting a fixed payment for managing the health of a particular population (capitation). In many ways, such as the formal integration of its hospitals, practice plan, and School of Medicine, as well as a sophisticated "funds flow" model, UPHS is prepared to thrive in an environment that rewards integration and accountability. Like most others, however, we have opportunities to be more transparent with quality data and to improve coordination across the care continuum.

Many aspects of orthopaedic care are well-defined and episodic, at least when compared to medical services. As such, orthopaedics is viewed as an attractive proving ground for some of the progressive ideas that are in the Health Reform legislation. For example, UPHS anticipates that increased outcomes reporting, and "bundled payments" (a lump sum reimbursement that covers both hospitals and physicians for a procedure, and also for care provided several days before and several weeks after the procedure) will come to pass in orthopaedics earlier and more broadly than they will in many medical services. As mentioned previously, much of the infrastructure is already in place to support success in operating under these frameworks. In addition to the alignment described above, recent investments in facilities, information technology, and programmatic development make it possible to coordinate efforts across clinical services and along the care continuum to render the high "value" (improved outcomes and/or reduced cost) orthopaedics care that is the primary driver of UPHS' position as the preeminent provider of advanced care in this region.