**PYRAMID SCHEME: Dartmouth's Dr. Joseph O'Donnell was one of eight U.S. oncologists invited to Egypt by the National Cancer Institute of Egypt to advise the nation on its graduate medical education programs in cancer.**

## Coming to grips with the money-medicine mess

The rising cost of health care in the U.S. has become a universal rallying point. Politicians, pundits, patients, and even many doctors agree that Americans spend too much on health care—and that the current payment system is largely to blame.

But no similar consensus exists on how to remedy the problem. That's why a group of 47 representatives from academia, private practice, patient advocacy groups, health plans, and large corporations gathered recently at Dartmouth to evaluate and rate the potential of alternative payment models.

**Consensus:** "We're actually not looking to say, 'Well, here's the one payment system we should move to for the entire United States,'" Robert Smoldt said at the start of the forum. Smoldt, executive director of the Mayo Clinic Health Policy Center, and the other organizers of the session were instead looking for "a consensus on some assumptions and principles about how we pay for care."

**First, the group agreed on some major flaws of the current system.**

One of a series of forums organized by the Mayo Health Policy Center, this meeting was cohosted by DMS's Dr. John Wennberg. He founded Dartmouth's Center for the Evaluative Clinical Sciences (recently renamed the Dartmouth Institute for Health Policy and Clinical Practice—see page 16 for more on that change), which cosponsored the forum.

First, the group identified and agreed on some major flaws of the current system: 1) physicians and other providers are paid more for performing expensive, invasive, high-tech procedures than for providing low-cost, low-tech, preventive care; 2) a huge amount of money is wasted on care at the end of life that does not extend lives and may even shorten them; 3) uncoordinated care is widespread and leads to poor outcomes and higher costs; and 4) patients are poorly informed about their health-care choices.

Then the group debated the pros and cons of several alternative payment models. Although no model received unanimous support, these three—which aren't mutually exclusive—were by far the most popular:

1) Certification of Shared Decision-Making for Major Surgery: Medical centers would be compensated for establishing formal programs that provide patients with unbiased information about their treatment options. Patients who are well informed often choose less-invasive, less-expensive options. (For more on shared decision-making, see page 38.)

2) Chronic Condition Coordination Payment: Patients with chronic conditions would belong to a "medical home" (a hospital, physician, and/or care network) that would receive a single periodic payment to cover all preventive care, management, and minor acute care associated with their condition. The amount would be adjusted for the severity of each patient's situation.

3) Mini Capitations: Payments to hospitals and physicians for major acute episodes would be bundled together, which would require hospitals and physicians to better coordinate their services.

**Models:** Among the payment models that received lower scores from the attendees was the pay-for-performance model that Medicare is currently evaluating. (For more on a Medicare pay-for-performance demonstration project, see page 18.) The group seemed to agree that the pay-for-performance model is better than the current fee-for-service system, but that it has major shortcomings.

In addition, DMS participants in the forum—including Dr. Elliott Fisher, a health-policy physician-researcher, and Dr. James Weinstein, an orthopaedic surgeon and the new director of the Dartmouth Institute for Health Policy and Clinical Practice—put forth several principles to guide the design of any new payment systems. They proposed that incentives be directed toward improving health outcomes, coordinating care, and supporting patient education and decision-making.

**Woes:** The small but diverse group gathered at Dartmouth wasn't able to solve all of health care's woes, but the attendees did agree on some key strategies. So perhaps there's hope for building a national consensus on health-care reform after all.

Jennifer Durgin

## THEN & NOW

**A reminder of the pace of change, and of timeless truths, from the 1902 DMS *Circular of Information*:**

Home births being common then, the obstetrics course comprised "1. A course of 48 lectures illustrated by diagrams and the use of manikins, with occasional quizzes. 2. Recitations with section work upon manikins by the student. Preparation is thus secured for a course in the out-patient department of a lying-in hospital, which the student is advised to take during the vacation at the end of the third year. . . . 3. A few maternity cases are received at [Mary Hitchcock] Hospital, and when possible they serve to illustrate to the students in small sections the teaching and methods of obstetrics."

**1,120**

Number of babies born at Dartmouth-Hitchcock Medical Center in FY2006