Maine Hospital Association

MAINE'S LEADING
VOICE FOR HEALTHCARE

My name is Jeffrey Austin and I am offering these comments on behalf of the Maine Hospital Association.

My comment today is essentially a question:

Will the Office of Affordable Healthcare have a public dialogue on the data sources it is going to use in the course of its work?

There is no doubt that healthcare spending is a concern to Maine people, businesses and government.

It is a concern for the providers of care as well.

Yet, quantifying the "cost" of healthcare is easier said than done. In our opinion, there is no single measure that best encapsulates cost. There are many different measures, each with their own strengths and limitations.

We think it would be wise for the OAHC, at the outset of your work, to take a little time to discuss the different data sources, clearly identify their strengths and weaknesses, and select the ones you are going to be using as part of your work – and explain why.

Again, we don't think there is a data point or data source that is perfect. Nor do we think there is a data source that will prove there is no affordability challenge.

However, if this office is going to be exploring interventions we believe you should be identifying the measuring sticks by which you, and others, can see if that intervention has succeeded or failed.

At the first meeting of the OAHC Advisory Council, staff presented a power point presentation. In it, no less than 8 different sources were cited with different measures of affordability.

They included:

- CMS
- The Commonwealth Fund
- Rand
- Forbes
- MHDO

- Altarum
- Kaiser Family Foundation/BLS Data
- Health Care Cost Institute

Understanding what the data is telling you is important.

A thermometer can tell you if a patient is running a fever, but it can't tell you why.

The data should generate further discussion and analysis. I hope the OAHC doesn't skip that step.

For example, many data metrics reflect "per capita" spending; this is a common and important measure. But, in some ways, it simply measures the relative age of the patients and the relative costs (housing, taxes, etc.) of the state.

In other ways, some of these measures capture "good" spending; like the spending associated with people having health insurance coverage (people with coverage consume more healthcare than people without coverage). To what extent is per capita spending higher in Maine than in Texas because Maine expanded Medicaid and Texas did not? Or, the breadth of services actually covered is more extensive in some states vs. other states (e.g., infertility treatment).

This matters. It is unfair to expect per capita spending similar to Texas if we want public policy that is similar to Massachusetts.

What is the data actually telling you?

Sometimes the measure captures "bad" spending that is associated with forces external to the traditional "healthcare" system. For example, if nursing homes can't accept patients from hospitals in Maine that would be accepted by in a similar situation in another state, do higher hospital costs reflect challenges with the hospital system or the long term care system?

Other causes are rooted in policy and are neither "good" nor "bad." For example, Maine has one of the highest minimum wage laws in the country. It has some of the most generous labor laws (paid leave etc.) in the country. How do the different data sources account for these policy differences? If they don't, are you presenting the public with an honest comparison or a misleading one.

Is reversing these policy choices on the table as cost containment interventions?

The data rooted in international comparisons is some of the trickiest to understand. For example, how much of the labor costs in the U.S. healthcare system is rooted in higher education costs. When hospitals in the U.S. hire workers, the need of those workers to service their education loans is a factor in their pay. In the U.S., salaries finance the higher education system which is the most expensive in the world.

The National Academy of State Health Policy is based at Georgetown. The cost of one year of education at Georgetown is $82,000. To become a doctor requires 8 years of higher education.

If Europe's outcome is what we want, then maybe the price intervention the United States needs relative to Europe is in higher education pricing?

There are other differences between us and Europe. The State of Maine is currently debating whether to impose nurse staffing ratios in hospitals. Here is a table of ratios in the U.S. vs. Europe?

Table 3

Nurse staffing in 12 European countries and the US. Data are mean (standard deviation) unless stated otherwise

	Nurse staffing ratio		
Country	**Patients to professional registered nurses**	**Patients to total staff***	**No of hospitals**
Belgium	10.7 (2.2)	7.9 (1.7)	67
England	8.6 (1.5)	4.8 (0.6)	46
Finland	8.3 (2.2)	5.3 (0.8)	32
Germany	13.0 (2.3)	10.5 (1.6)	49
Greece	10.2 (2.8)	6.2 (2.1)	24
Ireland	6.9 (1.0)	5.0 (0.8)	30
Netherlands	7.0 (0.8)	5.0 (0.7)	28
Norway	5.4 (1.0)	3.3 (0.5)	35
Poland	10.5 (1.9)	7.1 (1.4)	30
Spain	12.6 (1.9)	6.8 (1.0)	33
Sweden	7.7 (1.1)	4.2 (0.6)	79
Switzerland	7.9 (1.5)	5.0 (1.0)	35
US	5.3 (1.4)	3.6 (2.0)	617

Open in a separate window

*Total staff include professional registered nurses plus lesser trained care personnel.

The U.S. currently has RN staffing level that is nearly double that in Europe. The Legislature is debating whether to take Maine even lower. This would clearly make our cost comparison to Europe worse. Does the OAHC have concerns with this potential cost driver?

Understanding the different measures will potentially help focus conversations around policy interventions. We all want successful interventions. But interventions that ignore the root causes of the problem are doomed to fail.

Our biggest concern with not having a conversation around data is that sometimes the price of healthcare is not the disease but is instead the symptom. Truly understanding the causes of healthcare spending is essential to making solid and defensible recommendations.

Let's not skip this step of understanding what the data is telling us, and is not telling us.

Thank you.