VOICES OF VALUE-BASED PURCHASING
Health Care Leaders Reflect on 15 Years of Leadership
The cost of health care is an impediment to covering everyone in the United States, and when we deal with cost issues by scaling back coverage, we are not meeting these issues head-on. The idea of value-based purchasing is critical to moving forward toward the ultimate goal of providing coverage for everyone.

Margaret O’Kane, President, National Committee for Quality Assurance
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Since we were founded 15 years ago, the National Business Coalition on Health and its membership of employer-based health coalitions have been advocates for a health care system built on the principles of value-based purchasing. Simply stated, our goal is receipt of value for every dollar spent in the health care system.
Today, we are closer to our goal than ever, but as readers will find in these pages, we still have a long way to go before value-based purchasing is the rule rather than the exception. Our members and a wide variety of other organizations representing purchasers, payers, providers, and consumers are actively engaged in developing programs that foster the four pillars of value-based purchasing:

1. Standardizing measurement and collecting data on performance,
2. Reporting the results of measurement efforts publicly,
3. Reforming the payment system, and
4. Fostering informed choice for consumers.

In addition, we have seen another important step: the Value Driven Health Care Initiative, which the federal Department of Health and Human Services (DHHS) introduced in 2006.

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Yet, if value-based purchasing is so important to our efforts to improve our nation’s health care system, why did it take 15 years to get to where we are today? It would be easy to say that not everyone agrees with the principles of value-based purchasing.

As the experts who represent some of the most influential organizations in health care articulate in the pages that follow, there are a wide variety of reasons. Some of them are systemic, meaning an entrenched delivery system is hard to change when many individuals, organizations, and interests are tied to the status quo. Some of them are technical, meaning we do not yet have all the tools necessary to operate a health system built on value. Some of them are cultural, meaning, for example, purchasers have lacked the leadership, commitment, and energy to be change agents for a transformed delivery system. For all of these and other reasons, moving to a value-based health care system has been slower than we would like.

But we have made such significant progress in the past 15 years that we now have positive results from value-based purchasing efforts nationwide. It is our aim that publishing this collection of ideas from some of our nation’s best minds on health care will lead us all to a clearer vision about what steps are needed next. And it is our hope that we will have a health care system built on value-based purchasing well before we recognize our 30th anniversary."
One of the most important challenges for our nation today is to keep health care affordable. All of our health goals depend on this foundation. So even as we work to ensure that every American has good access to health care, and even as we support continued scientific progress, we need to keep our eye on the ball of affordability.

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Businesses that provide health care for their employees recognized this reality early on. They also learned that achieving affordability is not a simple matter of cutting costs. The real challenge is achieving value—getting good quality care for every health care dollar we spend. That may sound like a simple concept. But in health care it means creating new approaches to support the delivery of quality care and new ways to measure how well we’re doing. It also depends on a consensus approach involving all stakeholders, with focused engagement at the local level where care is delivered.

As Secretary of Health and Human Services, I have worked to create an action oriented structure, which I call the Four Cornerstones of Value-Driven Health Care:

1. Adoption of health information technology,
2. Assessment of quality of care,
3. Transparency in the price of health care services, and
4. Use of incentives to reward quality, value, and ongoing improvement.

“Achieving value in health care is a process of continual improvement that can work only if it is the shared project of health care providers, purchasers, and consumers alike.”

Those four elements are the keys to creating a value-driven process. Adoption of interoperable health IT is an especially important goal. Health IT is an indispensable tool for both improving and measuring quality care. Since 2005, the work of the American Health Information Community has been aimed at achieving common national standards and widespread adoption of health IT.

Last year, we worked with stakeholders to identify specific actions they can take, such as the elements that can be included in health plan requests for proposal or requests for information. This year, we are adding a focus on building a network of community-based structures called Chartered Value Exchanges. These exchanges will bring purchasers, providers, and consumers together to measure and improve quality of care in their own local areas.

All of these steps constitute a framework for measuring value in health care. But beyond the framework, success will depend on the trust that must be built day-by-day among all stakeholders. Achieving value in health care is a process of continual improvement that can work only if it is the shared project of health care providers, purchasers, and consumers alike. We need to keep our focus on quality as the key to value. And we need to work together in good faith to achieve the goal we share: good value for every health care dollar.”
It’s critical that value-based purchasing continues to evolve to foster improvements throughout the health care system. We are moving toward value-based purchasing with pay for performance programs, but these are narrow first steps. The faster we develop new models of value-based purchasing tailored to a chronically ill population, the better off we’ll be.
Our health care system is designed around acute care because for many years most care was for patients with acute illness. Like our delivery system, our current payment programs are ‘silied’ and focus on individual encounters with the health system. But now, much care involves ongoing management and comprehensive treatment plans for patients with multiple conditions. So we need a new value-based purchasing model with a different set of incentives. Value-based purchasing must evolve to encourage and reward the safe, effective, and efficient management of chronic care episodes that last 12 or 18 months; and, at some point in the not too distant future, to link payment to achievement of patient outcomes.

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Most of the public and private purchasers that are NQF members are actively engaged in putting value-based purchasing systems in place. Other stakeholders in the NQF membership, including consumers, provider organizations, and health care professionals, realize that greater alignment of payment incentives is needed to encourage and enable the health care system to focus on longitudinal or comprehensive management of patients with chronic conditions. We know from the work of Elliott Fisher, MD, MPH, and his colleagues at Dartmouth Medical School, that there is much potential to improve patient outcomes and remove waste through careful management of patients who often see many providers in different settings over the course of a year or more.

To support the continued evolution of value-based purchasing, we must develop more sophisticated standardized performance measures. NQF is working to enhance its portfolio of endorsed measures to include more measures of patient outcomes, such as health functioning, measures of care coordination and patient engagement in decision-making, and measures of cost and resource use. As you might imagine, this work is easier said than done. Longitudinal measurement systems with a focus on outcomes confront data challenges and raise concerns regarding attribution. But these issues can and are being addressed.

Over the next few years, I expect we will move toward a system of value-based purchasing that is quite different from the one we have now. The programs of the future will link payments to outcomes as well as safe, effective, and efficient processes. A lot of very promising and innovative developmental work is already underway."
Employers have introduced tiered benefit plan designs encouraging the value-based selection of providers, and other programs offer incentives to physicians who demonstrate superior performance in heart/stroke or diabetes care. NBCH’s eValue8 tool and methodology assess value-based health plan performance. Health plans have implemented pay-for-performance programs, which may include both efficiency measures and a combination of gain-sharing and risk-sharing incentives in the future."
Projects such as federal Health and Human Services Secretary Michael Leavitt’s Four Cornerstones initiative for health quality and the federal Centers for Medicare & Medicaid Services’ expansion of performance measures and payment reform for both physicians and hospitals indicate a recent acceleration of value-based measurement and purchasing strategies. Finally, the Institute of Medicine’s reports on quality and the momentum around standardized performance measurement reflected by the National Quality Forum and other organizations augur well for the future of value-based purchasing.

“Value-based purchasing is in its infancy. Patience, mutual responsibility, and constant application of new knowledge are required to help it develop and ultimately advance health care and the health of consumers.”

I hope purchasing on the basis of clinical quality and efficiency by consumers, health plans, and purchasers will become more widespread over the next 15 years, but every stakeholder has a responsibility to support this trend. Providers need to improve their individual and collective accountability for performance and service. Purchasers need to promote efforts toward value-based purchasing by introducing value-based benefit designs and support health plans, particularly when provider or regulatory backlash occurs. Regulators should encourage credible and relevant attempts by plans at transparency, innovative benefit designs, and incentives. Consumers, of course, will need to be educated and supported regarding their understanding of, and payment for, value-based services.

For value-based purchasing to succeed, there are a number of hurdles to overcome, such as provider unfamiliarity with performance measurement and public accountability; technical obstacles inherent in the evolving science of performance measurement; challenges in designing appropriate and meaningful incentive programs for consumers and providers; and regulatory understanding of market-based innovations. Value-based purchasing is in its infancy. Patience, mutual responsibility, and constant application of new knowledge are required to help it develop and ultimately advance health care and the health of consumers.”
No single entity on its own can affect the quality and nature of patient care—which is the ultimate goal of value-based purchasing. But if all parties act together, all will benefit. We believe the best way to realize the benefits of value-based purchasing in the near term is to think and set standards nationally and act locally. Most of the concepts associated with value-based purchasing—data collection, public reporting, and consumer engagement—are front and center in our past, current, and future efforts.
We began laying the groundwork for our regional quality strategy with our first effort in this arena, a program called Aligning Forces for Quality: The Regional Market Project, which is focused on performance reporting, quality improvement by health care providers, and consumer engagement.

This starts with the doctors, nurses, and other providers who deliver care and have committed to improving the quality of the care they deliver to patients with chronic conditions. We are working to define goals and standards so they can publicly disclose data on quality, performance, patient safety, and price. That will allow consumers and referring physicians to make better decisions about where in their regions they can find high-value care. We also are giving voice to patients and consumer advocates. We are asking them to contribute to the quality improvement effort by taking a greater role in their own health care, from the way they select their providers to the way they manage their chronic conditions. And we are asking community leaders and those who pay for health care—government, employers, insurers—to reward performance and direct attention and resources to quality improvement.

"Value-based purchasing is in its infancy. Patience, mutual responsibility, and constant application of new knowledge are required to help it develop and ultimately advance health care and the health of consumers."

Understandably, the debate about value-based purchasing is heated, and it is far from over. Doctors and other providers are raising the most serious reservations because their competence and reputations—indeed, their careers—are under scrutiny. They worry that inaccurate and unfairly reported data will unjustly punish providers that treat patient populations that are sicker than average to begin with, such as the uninsured and the poor. They also worry that standardized performance requirements may override a physician’s clinical judgment, and that physicians who do not participate will be financially penalized.

Going forward, physicians must have a strong voice in how performance is measured, reported, and rewarded. Value-based purchasing should also reward physicians who help their patients manage chronic illness and who effectively coordinate their care. There is no question that it takes a village to improve health care quality. Civic, business, and health care leaders must all be committed. Doctors, nurses, and other providers must strive to improve the quality of care they deliver—and they must have the resources and capability to improve. Purchasers must be willing to reward high-quality care. And patients and consumers must be prepared to use information about quality and performance, not only to choose providers but also to actively manage their own care. ☞
Under the traditional employer-funded health care system, patients have not considered the financial consequences of their health care decisions, nor have they requested information about quality. But in recent years, employers and consumers have increasingly sought information about health care quality and cost in order to make value-based health care decisions.
Providing this information is an important role for health plans. In the past, health plans made value-based decisions for their enrollees. When health plans did so, physicians perceived these efforts as intrusive and members viewed them as restrictive. Today, health plans are providing information to employers and consumers so that they can make value-based decisions for themselves. For example, Aetna’s Web site provides quality and cost data specific to physicians and institutions. The site also provides content about clinical conditions, helping patients understand their conditions, reminding them to seek preventive-care services, and assisting them in deciding which treatment options to choose. We also have created a personal health record that our members can take to their physicians so that complete information about the patient’s health is available immediately. In these and other ways, health plans are supporting value-based health care by helping members become better patients and helping doctors practice better medicine.

"In the past, health plans made value-based decisions for their enrollees. Today, health plans are providing information to employers and consumers so they can make value-based decisions for themselves."

Impediments to value-based purchasing include good quality data and research confirming which strategies will improve quality and cost. Health plans will continue to address these obstacles and consider alternative benefit designs that promote value-based health care.

Many observers assume that employers, consumers, and health plans are the major proponents of value-based purchasing, but providers have embraced the trend as well. Forward-thinking physicians and provider organizations see the focus on value as an opportunity to differentiate themselves in their markets. For instance, in response to a growing desire for publicly available cost and quality data, Aetna provided data support and changed reimbursement methodologies when the Virginia Mason Medical Center in Seattle developed more efficient and effective ways to deliver care for selected conditions. The relationship led to quality improvements and lower costs.
Value-based purchasing can play an important role for NCQA’s constituents, meaning the American public. The cost of health care is an impediment to covering everyone in the United States, and when we deal with cost issues by scaling back coverage, we aren’t meeting these issues head-on. The idea of value-based purchasing is critical to moving forward toward the ultimate goal of providing coverage for everyone.
One of the main obstacles to the widespread use of value-based purchasing is the relative lack of data at the provider level. There is no doubt that having real transparency at the provider level would move this whole agenda forward. It’s difficult to get that data; chart review is prohibitively expensive and intrusive, and claims data only go so far. When we get into a world where there is widespread use of electronic medical records, we’ll be in a whole new place.

Meanwhile, NCQA is pushing hard to review and accredit provider organizations, in line with the large accountability movement in this country. NBCH has been really helpful in this effort.

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Being able to assess value is critically important to understanding quality, because comparing outcomes isn’t always enough. If you compare the outcomes of certain surgeries, the question should also be asked: Should the surgery have been done in the first place? If you do procedures on people who don’t need them, they tend to have good outcomes. We need to be more careful about what we do in the first place.

That’s why I’m pleased by a number of recent developments, including Medicare’s new policy not to pay for preventable medical errors, demonstration projects designed to reward performance, and business coalitions driving the quality agenda. In a number of states—Minnesota, California, Wisconsin, Massachusetts—collaborative quality measurement and reporting efforts among providers and health plans are yielding great results. These developments are sending clear signals to the delivery system about what’s important.

One of the most important developments is that consumers are gaining an understanding that quality varies. That’s a good thing, although there is still far to go in this area. I’m not sure that consumers are at the point yet where they understand that cost and quality can not be traded off, one for the other. Consumer engagement is important, but others need to pull their weight as well. ✹
Americans are justifiably proud of the advances in providing effective, high quality care over the last quarter century. But America’s hospitals are keenly aware of the growing frustration with the health care system with regard to the lack of affordable options for everyone, inconsistent care quality, and poor care coordination. Hospitals are striving to adopt strategies to ensure the efficient and effective delivery of care."
Purchasers can encourage improvements in care by amending their contracting and payment strategies to reward higher quality, more efficient care. Conceptually, the idea of aligning payments with desired goals is exactly right. Practically, however, such systems might have unintended consequences. For example, if many different payers use many different quality measures, the administrative burden of measurement will add costs to the system and potentially generate conflicting assessments of quality and efficiency. One solution is to adopt common quality measures. Over the past five years, hospitals, working collaboratively with purchasers, government agencies, consumers, and other providers, have created an effective and reliable set of publicly reported measures through the Hospital Quality Alliance.

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Through this and other efforts, hospitals play a critical role in advancing value-based purchasing. Hospitals are eager to work with other stakeholders in designing value-based purchasing plans that encourage good clinical care, respect patient preferences, and streamline care delivery. They are engaged in collecting and publicly sharing reliable information, and are actively seeking better ways to support patient and consumer choice. Hospitals want payment systems to recognize patient severity differences across hospitals; to reward both excellence and improvement; and to align hospital, physician, and patient incentives.

Hospitals are cornerstones of their communities. They are among the largest employers and often include community leaders on their boards. Improving America’s health calls for leadership, participation, and shared responsibility from everyone, including individuals, employers, insurers, health care suppliers, caregivers, and government. Bringing all stakeholders together can make more data available, provide a diverse set of insights about opportunities, and facilitate discussions about how to eliminate barriers and actively promote high quality efficient care.
There is now near-universal recognition that the quality of health care in the United States is unacceptably low and that costs have become so prohibitive that we now have many people without insurance coverage. These realities suggest that it is time to stop saying, ‘We want something better,’ and actually seek care in ways that encourage higher value.
Obviously, that’s the theme of value-based purchasing. But until recently, VBP was an issue that only the vanguard such as certain companies and certain organizations such as NBCH were talking about.

People are realizing that we can’t keep paying for care the way we do and expect to get anything other than the high cost and low quality care that we get. A theory in economics explains the folly of rewarding A and expecting B. That is the way we have been paying for health care for many years. We pay for one thing and hope to get high quality care without actually measuring quality and without requiring it as a contingency of doing business. So now, value-based purchasing is as critical as it has ever been, and I hope that value-based purchasing will be spreading over the next 15 years.

The collaborative approach is fundamentally important because the story over the next 15 years is that collective efforts by coalitions will have to spread the word about value-based purchasing.

We recently surveyed employers and found that many of them are not directly engaged in value-based purchasing activities. To me, that says that organizations such as NBCH and its members are critical because individual employers correctly view themselves as too small to have the expertise to do value-based purchasing effectively and too small to influence the market.

Therefore, the collaborative approach is fundamentally important because the story over the next 15 years is that collective efforts by coalitions will have to spread the word about value-based purchasing. Nowhere is that more obvious than when we think about the importance of profiling providers and the public reporting of quality information, which can be done most effectively through coalitions. The principles of value-based purchasing have been around for a number of years, but it is only recently that this issue has been coming together largely through coalition efforts, some of which involve coalitions of coalitions, such as NBCH and others.
For unclear reasons, health care purchasing decisions are almost exclusively driven by cost, while other services are determined by value. Since there is no guarantee that the least expensive option will achieve the desired clinical outcome, we need to ask explicitly about the return on investment purchasers get in health care.
Only recently have private and public payers, both large and small, started to ask, “What kind of health care are we getting for every dollar spent?” The more they ask that question, the more they find that the incentives are misaligned for patients, clinicians, and health systems alike. We need to create a system in which each stakeholder is encouraged to increase the use of interventions that produce high levels of health and discourage the use of those that don’t.

“It is clear that the one-size-fits-all benefit design that currently exists in nearly every self-insured employer’s plan and in most health plans is inefficient.”

Organizations should not look solely at health care costs or quality independently, but rather they should address the cost-quality divide. The same tools they have applied to purchasing automobiles, computers, factories, and carpeting should be applied to purchasing health care. The lowest cost car or computer is rarely the market leader; the same should hold true in health care. We have the capacity to rigorously measure the health outcomes achieved per investment made in terms of both medical costs and productivity, just as we calculate the value of these other commodities.

If we continue to focus exclusively on costs, we will forget the motivation and the objective for health, health insurance, and health interventions in the first place, which is enhanced quality and length of life for our beneficiaries. It is clear that the one-size-fits-all benefit design that currently exists in nearly every self-insured employer’s plan and in most health plans is inefficient. A typical beneficiary will pay the same amount for every doctor visit, every emergency room visit, every diagnostic test, and every drug depending on its tier. We need to align incentives to get individuals to do those things that lead to the most health and away from those things that don’t provide improvements in health at all.
Some say that every system is perfectly designed to get the results it gets, and right now our health care system is not designed to produce reliably high quality care. Value-based purchasing is potential rocket fuel to get us there.
Currently, there are challenges in each of the four areas of value-based purchasing—data collection, public reporting, payment reform, and consumer engagement. Done wisely, with an eye toward what type of information we need to improve care delivery, data collection benefits everyone. But it is quite a challenge to collect data in a way that is useful and not just a burden. For data to truly add value for physicians, it must be fed back almost in real time so that physicians can make good decisions at the point of care.

The strong association between public reporting and improvements in care is significant and important, but public reporting alone isn’t enough to close the quality chasm. This is why payment reform is also essential.

The essence of value-based purchasing is to pay for results instead of units of care. Our current payment system rewards all providers equally, regardless of whether they are doing a heroic job of providing care or not.

The essence of value-based purchasing is to pay for results instead of units of care. Our current payment system rewards all providers equally, regardless of whether they are doing a heroic job of providing care or not. Because physicians are concerned about the metrics involved in paying for performance, we can’t do value-based purchasing successfully without serious engagement and collaboration of physicians. Fortunately, physician groups are increasingly getting involved in this effort.

Consumer engagement is critically important as well and they are getting involved in at least three ways. First, some critical mass of consumers—and no one really knows how many people this will be—needs to pay attention to quality ratings and the cost of care and use this information to make decisions. They’ll create a tipping point. Second, to provide good care, doctors need good information from patients. And third, what’s killing us financially and literally is chronic illness, and you can’t manage chronic illness successfully without an engaged patient.

Multi-stakeholder quality alliances have been effective in moving the quality/value agenda forward, and need to continue promoting collaboration and innovation, and insist on transparency, including how measures are developed and how the data are used.
With the continued growth of consumer-driven health insurance products and increases in consumer cost-sharing, greater transparency for quality and cost of care is critical. Health plans must work with members and physicians to promote evidence-based care, particularly around the use of new biological agents, new technologies such as advanced imaging, and proven health care services for preventive and chronic illness care. »
WellPoint references scientific data to determine drug safety and effectiveness and expand knowledge of what clinical services work best in real-world settings. Health plans also have an obligation to engage members in health improvement activities, including better nutrition, exercise, and other meaningful lifestyle changes that promote health.

Many programs related to value-based purchasing are already underway. One concept that is firmly established is pay-for-performance (P4P). WellPoint’s P4P programs target areas in which there are significant quality gaps and where improvements are likely to have the greatest impact on health.

"Insurance companies should focus on collaborating with and building trust among their members and physicians and health professionals."

Personal health records also are a growing trend. WellPoint’s personal health record, available to the company’s nearly 35 million members, includes information that can be of value to physicians and patients. Our goal for this tool is to encourage members to take a greater interest in and control of their illness or health status.

WellPoint also is expanding Anthem CareComparison, an online tool launched in Ohio in 2006 that provides consumers with the total costs associated with all aspects of nearly 40 specific medical procedures performed at area hospitals. The cost information is facility-specific, so members can compare the differences in costs among hospitals. In addition, members can get information on the specific medical and surgical procedures and quality outcomes as well as how frequently these procedures are performed at each facility. This information opens a meaningful dialog between patients and physicians and allows more informed decision-making.

Still another example is the Quality Insights Hospital Incentive Program (Q-HIP) that WellPoint developed in collaboration with hospitals in Virginia, the American College of Cardiology, and the Society of Thoracic Surgeons. Q-HIP collects data from hospitals and provides feedback on health outcomes, patient safety, and patient satisfaction metrics. We have seen impressive results in a number of performance measures, such as accelerated use of life-saving therapies for heart attacks and safer cardiac interventions and surgery and demonstrated improvements in quality and value. The Q-HIP example illustrates how successful collaboration can drive meaningful results.

Insurance companies should focus on collaborating with and building trust among its members and physicians and health professionals. Greater trust will lead to enhanced understanding that health plan programs can lead to the delivery of higher quality and cost efficient care.
As a nonprofit organization whose mission is to drive health care improvement through information and information technology (IT), there is broad understanding and appreciation that these activities will improve health and health care. In fact, health IT serves as a strong foundational underpinning for all four components of value-based purchasing. There is also broad understanding that health IT can play a supporting role in each activity.
Multi-stakeholder groups must work to develop common principles and strategies for mobilizing data electronically to support care delivery and improve population health. To get where we need to go in terms of measuring and driving quality improvement, we need to capture both claims and clinical data. Clinical data provide a key component of measurement. And once you start building a foundational platform of clinical data, it supports care delivery, quality measurement, and consumer engagement.

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Business coalitions, payers, and purchasers need information about how physicians are doing, and physicians need that same information at the point of care, which helps them make good decisions right away, as opposed to getting a report card a year later.

The progress made in health care quality improvement in recent years has been significant, and the next five years will be critical to the effort. Movements such as value-based purchasing, health IT, and the patient-centered medical home initiative are encouraging. I’m hopeful that in the next five years these will come together with consumer activation wrapped around them.

Trust will be an important ingredient of value-based purchasing. It requires the building of social capital and good will. Much like health information exchange, it requires a radius of trust across those who deliver, manage, pay for, and receive care. Lack of trust is the biggest obstacle; we have the technology and the measurement tools.
Value-based purchasing is critical if we are to sustain an affordable health care system. But VBP is possible only when there is reliable evidence on effectiveness and performance, and data collection and public reporting are critical elements. We must move the payment system away from pay-for-procedures and toward pay for integrated patient management, adherence to quality and safety practices, and improved outcomes. In other words, pay-for-performance.
The Blue Cross and Blue Shield companies, in partnership with the Blue Cross and Blue Shield Association, have developed a national network of Blue Distinction Centers for bariatric surgery, cardiac care, and transplant services that meet national standards for structure, processes, and outcomes of care.

In addition, the association’s Technology Evaluation Center is a leader in evidence-based health care technology assessment. Its mission is to provide health care decision makers with timely, objective, and scientifically rigorous assessments that synthesize the available medical evidence on the diagnosis, treatment, management, and prevention of disease.

“We must move the payment system away from pay-for-procedures and toward pay for integrated patient management, adherence to quality and safety practices, and improved outcomes. In other words, pay-for-performance.”

Also, the association is developing a private institute to offer consumers and health care providers information on the effectiveness of new and existing medical procedures, drugs, devices, and biologics. A national database of de-personalized claims information from 80 million Blue Cross and Blue Shield members provides a rich resource for decision making and evaluating evidence-based care.

If value-based purchasing is going to have a significant effect on health care, other stakeholder groups must be involved. Health care quality can be improved only by a broad partnership of insurers, physicians, hospitals, employers, and the government—in other words, through a public-private approach. Our success will be realized when all of us commit to evidence-based medicine, a robust free market, advances in health information technology, and properly aligned incentives.
The most tangible component of value-based purchasing is consumer engagement. We believe that patients need to be informed and actively engaged in order to participate in their care and decision making. But educating, informing, and activating patients is a challenge.
Collecting and using data on health care quality is an important starting point for patients and payers to judge value of care. Patients need reliable data to help them select a practice or physician, and the onus is on the practice to provide that data. Collecting and reporting data, however, require practices to create significant infrastructure that is not currently affordable for most small practices. This situation must change.

Moreover, collecting data is just the beginning. To make informed decisions, consumers need information and knowledge, which goes beyond just data. They need to be educated and actively engaged with their patient-centered medical home. This takes a lot of time, and in our current payment system, that kind of time is just not available. It’s critical that physician practices be reimbursed for the time involved in educating patients and coordinating their care.

It’s very common now for consumers, health plans, physicians, other members of the health care team, and hospitals to talk about how to improve quality together, and make purchasing of health care a better value.

Another component of value-based purchasing, payment reform, must shift the fee-for-service system away from its emphasis on volume. We need a payment system that creates incentives to do the right things, not just more things. Strong advocates for the concept of a medical home, ACP-member physicians believe that financial incentives should reward care coordination and pay providers to support better self-management among patients, including through reimbursement for remote care.

Organizations such as NBCH are impressive because of their active advocacy for improving health care quality. As a result of the efforts of NBCH and other organizations, there is much greater collaboration among stakeholders than ever before. It’s very common now for consumers, health plans, physicians, other members of the health care team, and hospitals to talk about how to improve quality together, and make purchasing of health care a better value. I give the community at large good marks for being willing to come to the table to solve these problems.
Value-based purchasing holds tremendous promise to improve the quality of care, while helping to control costs and expand access to care. While health care costs and the number of uninsured are rising, a third of our health care spending is wasted on payments for medical mistakes and poor quality care.
Our payment system perversely rewards treatments and services that drive up costs and undermine quality, causing millions of patients to get care they may not need, and in some cases, care that makes them sicker. It is time to re-align the incentives in the payment system to ensure that we encourage and reward delivery of the right care, at the right time, for the right reason, and at the right price. We believe that the four components of value-based purchasing are critical steps toward that goal.

"It is time to re-align the incentives in the payment system to ensure that we encourage and reward delivery of the right care, at the right time, for the right reason, and at the right price."

Consumers can play an important role in fostering value-based purchasing if they are given the proper tools. If consumers are appropriately armed with good, reliable information about the cost and quality of care, they will make good decisions and choose plans and providers that offer the highest quality in the most cost effective manner. Few consumers are familiar with the concept of value-based purchasing, and many believe that recent trends in benefit design are simply ways to shift more costs to them. Consumers need to know that there are significant variations in the quality and costs of care; they must have easy access to credible information to compare costs and quality; their benefit design should incentivize good decision making based on both quality and cost; and benefit design should encourage appropriate utilization of primary and preventive care.

To reach these goals, all stakeholders must be committed to achieving better quality and lower costs. In each community, a strong consumer voice is required to ensure that patients’ needs are given the highest priority."
Value-based purchasing has the potential to foster quality improvement throughout the health care system. Value-based purchasing changes the environment in which QIOs operate and all improvement initiatives are pursued. We believe that financial or similar incentives alone are not always sufficient to drive sustainable improvement results. You also need to know what to change and how to change.
QIOs are a national field force working to maximize the effect of quality-related incentives such as public reporting and pay-for-performance programs. Many providers, especially smaller ones, need help to implement improvements. QIOs provide that help. We also bring providers together to learn from each other. And all that accelerates improvement and results for the whole community.

The U.S. health care delivery and payment systems are moving toward value-based purchasing in two important ways. First, standardized measures have become much more common, and there is widespread support for efforts such as the AQA and the National Quality Forum to ensure that we all are measuring the same things in the same way. That wasn’t true even 10 years ago. Second, many payers have begun to put resources behind value-based purchasing. In my opinion, pay for reporting and pay for performance are primitive forms of value-based purchasing, but they show real progress and commitment nonetheless.

“\nNo single stakeholder group will be able to make the necessary changes happen. Purchasers, providers, policymakers, and patients all need to work together to create lasting positive change.\n”

Many of these payment reform efforts have happened in the last five years. So in that way, we are just at the beginning. Now we need at least two developments for value-based purchasing to take hold. First, we need more experimentation with the fundamental design of the payment system. The approaches in use now don’t do enough to provide an incentive to invest in fundamental redesign, meaning the real rewards in the system are still heavily weighted toward the status quo. Second, we must increase the investment in measurement and health information technology to support measurement. Initially, purchasers may need to pay for or demand much more clinical measurement to build the necessary infrastructure to support consumer engagement and payment system redesign.

No single stakeholder group will be able to make the necessary changes happen. Purchasers, providers, policymakers, and patients all need to work together to create lasting positive change. The AHRQ—Coordinated Chartered Value Exchange program model is the best vehicle right now for this kind of collaboration in value-based purchasing. QIOs are working actively in many states to coordinate or partner with the CVE applicants. In fact, QIOs have much to offer to the value-based purchasing movement. We have strong connections and good working relationships with providers across the country. We have expertise in process redesign, change management, collaboration, convening, and statistical analysis. We need to reach out better to purchasers and consumer groups to build effective partnerships, and many QIOs have already begun to do so.
Value-based purchasing, and particularly the benefit design aspects of VBP, offer an effective way to change consumer behavior. The Center for Health Value Innovation has identified more than 100 companies that use benefit designs with built-in financial incentives to drive consumer behavior. Value-based purchasing and value-based benefits use data to identify the most important services in health improvement.

David Hom
Chairman, The Center for Health Value Innovation
St. Louis, Missouri
When you consider the investment value of fostering access to preventive-care services, providing medications for patients with chronic conditions, and making sure they get their labs and diagnostic tests done along with having access to physicians’ offices, then value-based benefit design is critical to improving patient health. The incentives drive the purchasing decisions, making the cost of care transparent to patients and engaging them in using the health care system effectively.

Consider an example involving medication compliance for patients who have diabetes, hypertension, or cardiovascular disease such as high cholesterol. These patients may visit the pharmacy 12 or more times a year, and each of those visits to the pharmacy offers a chance to change a person’s behavior. There’s an opportunity to reinforce taking the medication they need and getting their lab work done and their glucose monitored. That requires engaging them in their own health care. Employers, other purchasers, and health plans are using data to invest in engagement—through value-based benefit design—building health competency and adherence.

“When you consider the investment value of fostering access to preventive-care services, providing medications for patients with chronic conditions, and making sure they get their labs and diagnostic tests done along with having access to physicians’ offices, then value-based benefit design is critical to improving patient health.”

In our center, our stakeholders are from all segments of the health purchasing spectrum, including health plans, large and small employers, business coalitions, unions, physician groups, and state governments. These are the major stakeholders who pay for and deliver health care for employees and dependents. They believe in the fundamental assumption that improving consumer adherence will improve outcomes. In other words, they believe, as the saying goes, that an ounce of prevention is worth a pound of cure.

Our stakeholders use incentives to get their patients or plan beneficiaries to spend the money necessary to take care of themselves to avoid the episodic costs and intensive use of health care services such as in hospitals and emergency rooms. These organizations that have implemented value-based designs for their associates have tested it and found that it works. Now they want to work collaboratively to educate the market further on a peer-to-peer basis. The center provides a “studio” for learning, sharing, and coaching new companies in value-based designs.

Within our organization, we are using case studies and other educational materials to teach the marketplace how to build the business case for value-based designs. Our results show that this approach works. Peer-supported education helps foster improvements in outcomes by teaching purchasers and payers to use value-based designs for improved outcomes.
For physicians, the first step toward working in a system using value-based purchasing is to define ways to measure performance. Defining ways to measure performance is a function that would be impossible for nonphysicians. Therefore, all physicians, regardless of specialty, need to decide how to define high quality care and that means defining how to measure it. That’s the most important role for physicians right now.
It’s clear that the health care system is moving in the direction of value-based purchasing. Medicare has proposed making as much as 5% of payments a function of performance. When Medicare promotes pay for performance, physicians start to accept the concept by getting together in their specialty societies and deciding how to address the issue effectively. In addition, studies show there are more than 100 pay for performance programs across the country. Not everyone is doing it, but enough people are doing it so that it has gotten the attention of providers.

So many physicians and other providers support society’s efforts to measure and reward performance, but not all physicians, not all hospitals, and not all nursing homes buy into it.

But physicians also are responding to the overall sentiment in society that quality and safety in health care are big deals. Physicians are tired of hearing about their mistakes and that we as a profession are not doing enough about it. So many physicians and other providers support society’s efforts to measure and reward performance, but not all physicians, not all hospitals, and not all nursing homes buy into it. There are still many providers who, in the face of tremendous evidence of performance variation and imperfect quality, nonetheless would rather all this discussion just go away so they could go about their business.

At the same time, there is still a substantial number of payers who are not participating in pay for performance and the other elements of value-based purchasing. So those doctors and those institutions inclined to ignore this issue can find confirming evidence that maybe most people don’t care much about this issue. The lack of absolute cohesion on the part of the payers and providers is probably the biggest obstacle to further growth of value-based purchasing at this time.
Public reporting is the foundation of quality improvement in health care and thus the foundation for value-based purchasing as well. In addition, payment reform is essential to get most providers to take seriously the need to improve, and consumer engagement reinforces these strategies by shifting volume toward higher quality and more efficient providers.
Consumers are the ultimate purchasers of health care, and as they become more informed about cost and quality variations, they will become more activated in support of a value-based purchasing agenda. Consumers as patients, however, are likely to put choice, quality, and clinical performance ahead of cost considerations. After all, what good is a 10% discount if the odds of acceptable outcomes for you or a family member are 10% less favorable?

Another obstacle for consumers is that those who are insured through employers may not have a direct stake in a value-based purchasing strategy unless they can see a benefit to themselves. Consumers may prefer choice over accepting their employer’s definition of value.

“Private insurers need to coordinate with Medicare so that as we move toward value-based purchasing the public and private sectors proceed side by side.”

Consumers are often ambivalent about the employer-based system. While many insured workers and their families appreciate that employer-based insurance may offer them a better deal on premiums, without the threat of underwriting, attitudes often change when they are confronted with limitations in choice or coverage. Parents with a seriously ill child, or those facing mental health issues, for example, may feel that they would be better off being able to select their own insurance plan appropriate to their needs.

If done carefully so that public support is maintained, a move toward value-based purchasing in the years ahead is possible. Private insurers need to coordinate with Medicare so that as we move toward value-based purchasing the public and private sectors proceed side by side. If the sectors do not progress on parallel tracks, contradictory messages from Medicare and private insurers are likely to create confusion among consumers and patients.
The health care system has already moved toward value-based purchasing. Why not? It can make more people take medicine, result in less illness—and save lives and money. The need for more information is an obstacle, but I am confident that we will have better, more integrated health records. Researchers will provide more evidence on the value and efficacy of treatment options. That means when employers—and others—negotiate contracts they’ll know not just the immediate cost of what they’re buying, but the long term and presumably higher value.

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That should command greater reimbursement than low value services. So should market forces and high quality providers—though we’ve already seen the beginning of reimbursement for quality through pay-for-performance.

In fact, employers are already fostering value-based purchasing through innovative benefit design. Employers see the effect illness has on workforce productivity. That’s true when workers are too sick to come to work and when they come in but don’t feel well enough to write a memo or unload a truck. Since employers buy most of the private health insurance in the United States, they’re already adopting disease management and health and wellness programs.

“Researchers will provide more evidence on the value and efficacy of treatment options. That means when employers—and others—negotiate contracts they’ll know not just the immediate cost of what they’re buying, but the long term and presumably higher value.”

Some have created value-based insurance benefits for enrollees with chronic conditions. They’ve lowered or even eliminated co-payments for preventive services and medicines. We’ve done this at Pfizer. But I’ve heard about good experiences at Pitney Bowes; the City of Asheville, N.C.; Marriott Corporation; and the University of Michigan.

Research now underway will help. It’s no different than owning a house. If you don’t know that insulation pays for itself over time, you just see the cost—and might say no. When decision makers see only the cost of a treatment they react the same way. Most patients, physicians, and employers, though, want high quality care for themselves, their patients, and their employees. The move to value-based purchasing will accelerate once they have full information about the tradeoffs among treatment options, the quality of health care providers, or the effect of cost containment measures imposed by insurers.

They will see then that higher co-payments on drugs, for example, may help contain costs today—but discourage patients from taking medicines properly. They’ll see how that can lead to higher medical spending and lower productivity at work, both in the future and right now.

And where do we need information most? Certainly when it comes to procedures and other areas which are less well researched. But we also need better information technology. That will help us move to electronic patient records. That in turn will give doctors easy access to evidence when they’re making a diagnosis or writing a prescription.
Value-Based Purchasing: An Idea Whose Has Time Has Come

Once again this year, health care reform is among the most pressing issues for voters in the 2008 election cycle. Attention on this issue means each of the candidates for public office will have an opportunity to address the need to improve health care quality, control costs, and increase access to care, particularly for the more than 47 million Americans who are uninsured.

Clearly, the pressing urgency of this issue demonstrates that we are at a watershed moment in our history. Amid this call for reform, the National Business Coalition on Health, the federal government, and a growing number of national health care organizations would add their voices to those who seek to transform the health care system so that incentives are realigned to reward physicians for providing quality care, so that consumers are more engaged in all aspects of care delivery, and buyers are focused on value-based purchasing.

NBCH, the federal Department of Health and Human Services, and others are advancing value-based purchasing. HHS has launched its Value-Driven Health Care Initiative, saying that giving consumers information on the quality and cost of health care provides them with the information and the incentives they need to choose health care providers based on value. “Every American should have access to a full range of information about the quality and cost of their health care options,” says HHS Secretary Michael O. Leavitt.

“In cooperation with America’s largest employers and the medical profession, this initiative is laying the foundation for pooling and analyzing information about procedures, hospitals, and physician services,” HHS says. “When this data foundation is in place, regional health information alliances will turn the raw data into useful information for consumers.”

The Robert Wood Johnson Foundation, in Princeton, N.J., has launched the Aligning Forces for Quality: The Regional Market Project to accelerate improvements in care at the community level by cultivating and aligning market forces with quality improvement efforts. The project is designed to help communities improve the quality of health care for patients with chronic conditions such as diabetes, asthma, depression, and heart disease. The foundation has given grants to a number of NBCH-affiliated coalitions to close the gap between the quality of health care that Americans now receive and what the health care system is capable of delivering.

The foundation also is funding work by the Engelberg Center for Health Care Reform at the Brookings Institution, America’s Health Insurance Plans Foundation, and others to support the Brookings’ Quality Alliance Steering Committee. The funding will help the committee measure performance in a way that provides a broad look at measures of the appropriate use of resources and quality of care for patients with certain conditions. The funding also will allow the committee to provide a comprehensive picture of individual physician’s care patterns.

These and other developments show that our nation is moving steadily toward a consumer-centric health care delivery model that will transform the way care is delivered in cities and towns nationwide so that all purchasers, including governments, employers, and individuals, are getting the most value for the dollars invested in health.
About NBCH

The National Business Coalition on Health (NBCH) has a membership of 60 employer-led coalitions that represent more than 7,000 employers, and 34 million employees and their dependents. These business coalitions serve mostly mid-sized and large employers in both the private and public sectors nationwide. The member coalitions of NBCH are committed to community health reform, including improving the value of health care provided through employer-sponsored health plans and to the entire community.

NBCH provides expertise, resources, and a voice to its member coalitions and represents each community coalition at the national level. As a coalition of coalitions, NBCH spreads the tenets and practical applications of community health reform to areas where employers have yet to organize their purchasing power. As part of its efforts to make the coalition movement the vehicle for meaningful change in the U.S. health care system, NBCH has pursued national purchasing initiatives to offer turnkey health care products and services to community coalitions and their member employers.

To ensure that its members are on the leading edge of market-based reform, NBCH member coalitions and employers have joined together to purchase health care collectively, to challenge high costs and the inefficient delivery of health care, and to share information on the quality of care. At the heart of NBCH’s initiatives are community health reform efforts in which coalitions and their employer members foster reform through value-based purchasing, which means getting the highest quality care at the most reasonable cost. In markets across the country, NBCH coalitions are working closely with employers to foster value-based purchasing.

Purchasing value means rewarding quality and cost-effectiveness in the delivery of health care services—not just seeking the lowest price. Coalitions and their member employers are working with providers to improve health care delivery systems from Maine to California by holding providers accountable for their performance through the development of information systems to collect data, monitor health care outcomes, and measure value.
Member Coalitions

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Joanne Steffen
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Jerry Burgess
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Jerry Custer
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The cost of health care is an impediment to covering everyone in the United States, and when we deal with cost issues by scaling back coverage, we are not meeting these issues head-on. The idea of value-based purchasing is critical to moving forward toward the ultimate goal of providing coverage for everyone.

Margaret O’Kane, president, National Committee for Quality Assurance

The National Business Coalition on Health acknowledges the support of Pfizer, Inc., for this publication.
VOICES OF VALUE-BASED PURCHASING

Health Care Leaders Reflect on 15 Years of Leadership