Testimony before Committee on Oversight and Government Reform Subcommittee on Energy Policy, Healthcare and Entitlements

Statement of Martin A. Makary, MD, MPH, FACS
Director, Surgical Quality and Safety, Johns Hopkins Hospital
Director, Pancreas Islet Transplantation Center, Johns Hopkins Hospital
Associate Professor of Health Policy, Johns Hopkins Bloomberg School of Public Health

April 25, 2013

Mr. Chairman, Ranking Member Speier, members of the subcommittee and staff ~ good morning. Thank you for inviting me today. My name is Marty Makary and I am a surgeon at Johns Hopkins and an associate professor of health policy at the Johns Hopkins Bloomberg School of Public Health. I am the primary author of the original scientific publications on the operating room checklist and recently wrote the book *Unaccountable* outlining the national effort to make healthcare safer and more efficient by increasing transparency.

While some innovations in healthcare are making the system better, the broader problems remain endemic and more costly than ever—specifically the wide variations in medical quality. The Institute of medicine states that up to $750 billion, or 30% of the entire healthcare expenditure, may be going to overtreatment, unnecessary tests and other forms of waste in healthcare.

Not only are Americans are paying hundreds more for their health insurance this year, but now they are getting hit with escalating co-pays of $100-$500 per encounter. American businesses cite medical costs as the leading reason they have trouble competing with businesses overseas. And when I talk with business leaders, they consistently tell me they are frustrated paying more and more for healthcare without any metrics of good or bad performance.

Every proposed solution to this unsustainable trajectory calls for measuring hospital performance by tracking patient outcomes. But where are these outcomes?

The answer is that much of it lives in federally-funded registries, with little or no access to the public that that pays for them with their tax dollars.

In my field of surgery, a national Pancreas Islet Transplant registry funded by the NIH tracks patient outcomes. When I do an operation, the patient's information is voluntarily reported to the registry, which has data on which centers are performing well and which are performing poorly. But this data is not available to the public. Similar barriers exist with Medicare data.

After a lot of work, my research team accessed one government-funded databases but with the hospital names removed. We looked to see whether hospitals are performing common surgical operations using the minimally-invasive (laparoscopic) method in

situations where it has been well-established to result in lower infections, less pain and better functional outcomes compared to open surgery. Here's what we found. Despite lots of evidence, including an extensive Cochrane review to support the lower complications with laparoscopy, it's use at U.S. hospitals varies widely. In the case of appendectomy, on the left side of the figure, we see that many U.S. hospitals perform the operations using an open operation, and on the right, hospitals performed most using laparoscopy. The same wide variation was true for some of the most common operations in medicine-- hysterectomy, colon surgery, and others.

When I recently asked a patient of mine, why did you choose Johns Hopkins for your care, she told me "Because of the parking." Patients make choices in a dysfunctional free market where competition exists, but it exists at the wrong level. It exists at the level of billboards and valet parking, leaving patients uniformed about outcomes which are currently being collected. Imagine if you as a patient were looking for a hospital to have your appendix removed and you could see a hospital's outcomes including their surgical complication rate, and what percent of their operations they perform using the laparoscopic operation. It would likely create competition around patient-centered outcomes, and drive the entire marketplace towards good outcomes.

My team has complied a registry of national registries in healthcare. There are over 150 national clinical registries which track patient outcomes. One-quarter are taxpayer funded, yet only 3 make their outcomes available to the public. Making public access a condition of taxpayer funding is one simple reform which would allow the free market to work to cut waste in healthcare.

Transparency also needs to be applied to well-defined medial errors-errors currently tracked by hospitals. If this information were public it would create more accountability, and incentivize improvements. If medical mistakes and preventable infections together were a disease, it would rank as the number #3 most common cause of death in the U.S. We spend a lot of time and money on #1 (cardiovascular disease) and a lot of time and money on #2 (my area of cancer). It's time to address the problem through standardized public reporting.

Most doctors, including myself can testify that we've seen patients harmed and disabled from overtreatment driven by profit motives in medicine. Reasonable size additional salary bonuses based are one thing, but purely volume based quarter-million-dollar bonuses, and harassing emails and text messages from hospital managers about meeting monthly volume targets bring out the worst of American medicine--a driver of the overtreatment epidemic and a contributor to the 46% national physician burnout rate described in a the 2012 Mayo Clinic study.

The state of Maryland recently submitted a proposal to Medicare to allow the state to pay hospitals in a radically different way. The HSCRC Waiver application outlines how the state's hospitals could be paid based on quality and outcomes per beneficiary, rather than by volume. If approved, it would change the profit incentives from a focus on more to better. We need to start rewarding quality, not just quantity.

Rewarding hospitals for participation in national registries and their public reporting option, participation in external peer review, and creating public access to Medicare and AHRQ data are important reforms that will re-align incentives to focus on what's right for the patient.

Transparency can inform patients seeking care, make competition over quality, and cut the waste in medicine that harms our people and burdens our national debt.

Thank you.

Martin Makary MD, MPH, FACS

Home:
3650 S. Glebe Rd., #471
Arlington VA 22202
Mobile (443) 205-0158
MartyMakary@gmail.com

Johns Hopkins University:
600 N. Wolfe St, Halsted 614
Baltimore, MD 21231
Tel (410) 502-6845
mmakary1@jhmi.edu

CURRENT APPOINTMENTS

Director of Surgical Quality and Safety, Johns Hopkins Hospital
Associate Professor of Health Policy, Johns Hopkins Bloomberg School of Public Health

EDUCATION

Johns Hopkins University	2004	Fellowship	Cancer Surgery
Georgetown University	2003	Residency	General Surgery
Harvard University	1998	M.P.H.	Health Policy
Thomas Jefferson University	1998	M.D.	Medicine
Bucknell University	1993	B.A.	Biology

LEADERSHIP

2008 – 2010 **UNITED NATIONS, WORLD HEALTH ORGANIZATION (WHO)**
World Patient Safety Alliance
Member, Core Group Executive Committee, Safe Surgery Saves Lives Project
Developed a surgery checklist and chaired taskforce to develop standardized ways to measure surgical quality globally

2007 – present **AMERICAN COLLEGE OF SURGEONS**
National Surgical Quality Improvement Project (NSQIP)
Member, Executive Steering Committee ACS-NSQIP
Co-leader of a national collaborative of 100 hospitals to reduce infections

2007 – 2010 **DIRECTOR, CENTER FOR SURGICAL OUTCOMES RESEARCH**
Johns Hopkins University
Managed a research infrastructure which served hundreds of physicians

RESEARCH

2004 – present **AUTHORED 150 MEDICAL JOURNAL ARTICLES**
New England Journal of Medicine, JAMA, Health Affairs, Lancet
and other peer-reviewed journals
Majority describe original health services research in safety and quality

2008 – 2011 **AGENCY FOR HEALTHCARE RESEARCH & QUALITY** (**AHRQ)**
Grants for obesity, cost, and surgical outcomes research
Focus of these grants was on reduction of health complications and cost

MEDIA EXPERIENCE

Contributor	*Newsweek, Wall Street Journal* (2012)
Medical Commentator	*CNN*; *Fox News* (2008-present)
Surrogate Speaker on Health Policy	Barack Obama Presidential Campaign (2008)

Committee on Oversight and Government Reform
Witness Disclosure Requirement – "Truth in Testimony"
Required by House Rule XI, Clause 2(g)(5)

Name:

1. Please list any federal grants or contracts (including subgrants or subcontracts) you have received since October 1, 2010. Include the source and amount of each grant or contract.

U.S. AGENCY FOR HEALTHCARE RESEARCH AND QUALITY (AHRQ)
9/15/11 - CURRENT, $17,970/YR, ROLE: CO-INVESTIGATOR
ACTION II CENTER TASK ORDER # DUN 00191077
10/1/11 - 12/31/11 $ 50,000 ROLE: CO-INVESTIGATOR
DECIDE CENTER TASK ORDER #9

2. Please list any entity you are testifying on behalf of and briefly describe your relationship with these entities.

NONE

3. Please list any federal grants or contracts (including subgrants or subcontracts) received since October 1, 2010, by the entity(ies) you listed above. Include the source and amount of each grant or contract.

ABOVE

I certify that the above information is true and correct.
Signature: Martin Makary Date: 4/23/2013