



Healthcare Reform:

Getting to the Real Issue

By: Ward Keever, CTG HealthCare Solutions Executive Director of Executive Services

At the spring CHIME Forum meeting in New Orleans, I was profoundly impressed by a presentation given by Mr. Jamie Orlikoff of Orlikoff & Associates Inc, the national advisor on governance and leadership to the American Hospital Association and Health Forum. As that presentation pointed out, healthcare now accounts for 16% of our GDP and is projected to reach 19% by 2013. To put these figures into sharper perspective, keep in mind that healthcare represents only 1% of China's GDP and 2% of India's. It's hard to compete on a world scale with such a huge handicap. Orlikoff's second slide showed a histogram of U.S. population by age group, with baby boomers comprising about 76 million and the succeeding 'Generation X' only about 49 million. As boomers begin to retire, the burden on Generation X to continue funding Medicare at the current level of services for such a huge retired population will become overwhelming.

Consider the following healthcare facts:

- The same drug from the same manufacturer costs more in the U.S. than in other countries. Why?
- An air pump used to inflate a tire costs about \$30. Paint it a different color and use it for a healthcare need, and the cost to Medicare is over \$100. Why?
- Lawsuits result in such fantastically high penalties, and insurance companies are allowed to charge so much in premiums, that OB/GYN doctors are abandoning their practices because they just can't afford the insurance.
- People file for bankruptcy at a rate of one every 30 seconds due to medical bills.
- The average employer-based family premium has risen 87%—to \$11,500 annually—from 2000 to 2006. How much further will it go over the next seven years?

The percentage of employed individuals with health insurance has dropped from 70% in 1987 to under 60% today, with the number of uninsured now approaching 47 million. Furthermore, employed people in the 50-64 age range are less confident about their healthcare insurance being continued by their employers. Someone in this age group who loses his or her employer-paid insurance most likely is not eligible for public assistance (e.g., Medicaid) and must purchase private insurance, just at a time when

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age has a significantly negative impact on insurance premiums (which in 38 states can be pegged to age).

Surcharges don't end with age. In most states, insurers can charge higher premiums or deny insurance entirely for preexisting conditions. Private insurance companies like Blue Cross are expressing growing concerns about cost shifting and are beginning to demand the same terms Medicare receives from hospitals and doctors. And as Jamie Orlikoff suggests, the situation is about to become even more dire.

In the teeth of this pending disaster, politicians are encouraging a broader coverage of care. Senator Hillary Clinton has proposed coverage for poor children while Representative Patrick Kennedy wants to improve healthcare by expanding the use of IT, including computerized patient health records. The governors of Vermont, Massachusetts, and California have enacted or proposed universal healthcare coverage that would include illegal immigrants. And most recently, AHA has also called for universal coverage.

These initiatives won't fix the problem; they will compound it. If healthcare is extended to everyone, *Forbes* magazine predicts we'll need 35,000 more physicians, 40,000 nurses at hospitals and doctor offices, 15,000 additional pharmacists, 125,000 more health aides and technicians, 4,000 additional dentists—and 1,800 fewer ER doctors, since the current uninsured use ER disproportionately. The net impact on healthcare costs would be over \$20 billion dollars per year.

The recommendations of the politicians and AHA may be politically popular and generate a near-term boom for hospitals and doctors, but they don't address the basic problem: where will the money come from over the next several years to maintain the level of healthcare we've all come to expect? Most recently, the Administration has proposed a reduction in planned increases of \$4 billion over the next five years—not a cut, as it's being called by the press, but a reduction in previously planned increases—prompting healthcare lobbyists to scramble frantically to influence Congress against the proposed decrease. The problem with this modest change is that hospitals will try to keep doing business as usual, and consequently incur a smaller bottom line to the detriment of the *real* solution: to make substantive changes in healthcare organization, processes, and delivery. Innovations like these involve hard work and hard decisions, but they're essential elements of the much larger set of initiatives required to avoid pending disaster.

A recent government healthcare IT e-mail newsletter reported that "CalRHIO has just awarded a contract to Perot and Medicity for \$300 million in private financing for start up expenses." The article goes on to say that "user fees will support the exchange. No details about the fees have been made public [but] savings as a result of having better information to care for patients will be many times greater than the cost of the exchange services". In the same e-mail letter, another article stated that "The Santa Barbara [California] Care Data Exchange, the longest-running effort to launch a major U.S. regional health information organization, recently folded because of privacy concerns and doubts about on-going costs." The article went on to say "the organization involved in the exchange didn't see any on-going value to its involvement."



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I wonder what Cal RHIO knows that the Santa Barbara group missed after several years of trying. But beyond the concerns about RHIOs I've previously expressed (See the November 2005 *Insights*: "Regional Healthcare Initiatives: Barriers to Success"), I simply fail to see how RHIOs address the basic problems we face in fixing the root cause of the coming healthcare disaster.

A key issue, as I see it, is that the financial incentives are wrong. The current system requires us to pay to *get* well, rather than financially motivating us to *stay* well. For example, I'm six feet tall and weigh 210 pounds, which means I'm at least 25 pounds overweight. My cholesterol and blood pressure require daily medicine. I know how to fix this! Exercise, eat less, lower salt intake, stay away from ice cream, and so on. If my healthcare premiums were meaningfully higher—say \$200 per month—because of that excess weight, I'd probably do those things, since my continuing lack of attention to my own health would result in a personal financial burden. As it is, I take my medicine and if I have a problem, leave it up to the doctor and hospital to fix it.

A few years ago, a major academic medical center undertook implementation of several dozen ambulatory disease management protocols. The ambulatory patients loved the protocols, which succeeded in keeping people with conditions like asthma and diabetes out of the hospital emergency room. Then financial problems arose at the institution, and as their first act, the consultants brought in to fix the bottom line eliminated those very protocols. Why? They were costing the institution several million dollars each year by reducing its opportunity to provide emergency care and get reimbursed. Does that sound to you like the right way to resolve the healthcare crisis?

Clearly, there is a growing and significant interest in healthcare reform that seems to be manifesting itself as a push for universal coverage. But be careful what you ask for! The country simply cannot afford the additional costs and increased percentage of its GDP that concept represents. And Generation Xers can't be expected to tolerate the increased taxes that would be required to support the healthcare needs of retiring baby boomers.

We need *real* change, not more money, especially if we are to compete successfully on the global playing field. We need to restructure financial incentives, control drug prices, limit the size of lawsuits, reduce insurance premiums, and control phony prices for common equipment used in healthcare—to name just a few of the measures we must implement.

As a healthcare executive, you represent a critical success factor in addressing the urgent need for healthcare reform. Rather than majoring in the minors as so many politicians and healthcare executives are doing, I urge you to fight with perseverance to repair a broken system instead of merely looking for opportunities to apply technology. This is a cultural problem that is fundamental to our future, and the country needs your help in solving it.