



Healthcare Reform

It's not who pays

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

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The hot topic for this summer is healthcare reform. It has consumed our Congress as well as most of our national publications and TV/radio talk shows. In spite of all this attention, we still do not have a solution. In my view, we have focused too much on one possible approach—the national healthcare option—and have not focused on the basic problem that we need to address. So this month, please consider a perspective that perhaps has not been advanced as much as it should if we are ever to address the core issue.

From my perspective, the current discussion is far too preoccupied with the question of who pays. And, for many, it is apparent that national health insurance, in some form, must be implemented to assure that all Americans have access to high quality, affordable healthcare. While probably no one quarrels with the goal, it is questionable whether the proposed remedy addresses the real problem. Let me explain.

The awkward dinner party

Picture a group of friends who meet periodically at a posh restaurant for dinner. The food and the wine are excellent and good humor prevails until after the brandy when the waiter discreetly places the check in the middle of the table. It is immediately apparent that the prices have gone up two to three times faster than the incomes of the diners since they last dined together. Uncomfortable jockeying to avoid picking up the check begins.

One diner, an automaker from Detroit, complains that health benefits for his workers now cost over a thousand dollars per car and are significantly higher than his Japanese and European competitors, and the gap continues to widen. The time when he could pass these increases on through higher prices has ended. Prices are no longer set in Detroit. They are set in Tokyo and Frankfurt. He is now forced to close plants; Mr. Detroit wonders if it isn't time for the small business owner sitting next to him to pick up his fair share.

After quelling the outburst of coughing which this suggestion provoked, the small business owner makes his case for avoiding the check. Always hanging on by his fingernails, he is beset by increased regulation, a higher minimum wage, tougher foreign competition and limited access to capital. He reminds one and all that he alone accounts for new jobs in America. He is sorry, but if you saddle him with the



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bill, you will have to kiss new jobs goodbye. He looks across the table at the woman from Washington.

Ms. Washington stares at the check, slowly shaking her head. Then she explains how the government is caught squarely in the middle of the deficit and the desire to avoid new taxes to maintain any semblance of economic recovery and growth. She's also concerned about international competitiveness as well as recognizing that Medicare and Medicaid programs are running out of money.

The resulting silence is broken only when someone suggests that maybe next time they should eat at a cheaper restaurant.

Nobody notices the people outside looking through the window who apparently have nothing to eat at all.

The debate

Unfortunately, the debate over healthcare reform is too often limited to the question of who picks up the check. With healthcare consuming nearly 20 percent of our gross domestic product and continuing to increase, we must start by admitting that nobody can pick up that check. Increasingly, our choices are constrained by the world economy. If we keep arguing about how to divvy up the check, it's likely we will all end up washing dishes.

What to do? The answer seems clear: we must eat at a cheaper restaurant. Figuring out how to do this, still be adequately nourished, and be able to invite hungry people standing outside to join us is the task at hand.

A perplexing case study

Some people have suggested that management deficiencies in hospitals contribute to excessive costs. I'd like to suggest a different perspective:

Imagine a manufacturing plant—a large job shop employing perhaps 2,000 people. On any given day, 300–400 jobs are active in the plant. Any given job takes five or six days to complete. As we study the plant more closely, we discover a curious thing. Every morning, about 100 or so manufacturing planners walk into the plant, write shop orders defining the work to be done that day on their particular jobs by the 2,000 plant workers—cutting, drilling, milling, grinding, inspecting, assembling, painting and the like—and then walk out.

We stop several of these shop planners in the parking lot as they are leaving, and discover a strange thing. Indeed, few of the planners are actually employed by the plant; most are paid directly or indirectly by the plant's customers. Although they have implicitly defined almost all of the plant's costs by the shop orders they have written, they bear no responsibility for them nor are they economically affected by them. Upon closer questioning, we discover that, moreover, most are ignorant of the costs incurred by the plant as a result of their shop orders. Asked to guess, their estimates are almost always grossly in error.



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If we were to present this story as a case study to first-year students at Harvard Business School, not one would fail to point out the problem. Our plant has broken a cardinal rule of management: *never separate authority from accountability*. The students would probably go on to add that they've never seen such an unrealistic case study. But they'd be wrong and all of you know why—*this is exactly the situation today with hospitals and doctors*.

The solution seems clear. We must reassert the necessity to place authority and accountability in common hands. Whose hands? It must be the physicians; there is no other rational choice, because each decision made in a hospital has both clinical and economic implications. Hospitals and doctors are directly responsible for 31 percent of healthcare costs and indirectly affect much of the remaining costs (e.g. prescriptions for drugs and follow-on services).

The responsibility is ours

I firmly believe there are specific and immediate actions on which hospitals and doctors can collaborate to drive the cost of healthcare down. These include:

- Making physicians more aware of the hospital costs of commonly ordered drugs and services; monitoring the resources they consume in relation to the quality of their outcomes
- Creating standard disease management protocols for the chronic diseases (e.g. diabetes and asthma) that consume a very high percentage of healthcare expenses—these protocols should provide quality and effective care while reducing the wide variation in treatment expense (e.g. unnecessary laboratory tests and lower cost drugs)
- For patients in the last days of their lives, creating standard protocols that emphasize home care and minimize significantly more expensive (up to ten times more!) hospital care that has no positive effect on quality of life
- Understanding why many healthcare costs, such as laboratory costs, are growing at a significantly faster rate than inflation and taking corrective steps
- Understanding the large variation in LOS among hospitals for similar illnesses and procedures and taking corrective steps—for example, Time magazine recently reported a \$40,410 difference in the cost of care for the last two weeks of a Medicare patient's life between Mayo Clinic (\$53,422) and UCLA (\$93,842)
- Eliminating unnecessary cesarean births
- Eliminating unnecessary coronary bypass surgeries for patients who gain no increase in lifespan beyond what they would have achieved through medical management of their condition
- Eliminating unnecessary pacemaker implants
- Eliminating unnecessary upper gastrointestinal procedures that do not result in any change in treatment



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- Curtailing the 'arms race' in construction and new services, especially for services where volume is decreasing such as CABGs

I could go on, but it seems to me that doctors and hospitals have it within their combined scope of authority and responsibility to address the rising costs and to do so quickly. Clearly, they must work together—either voluntarily or by government mandate. As CIO, you have the wherewithal to provide the tools to facilitate this partnership (e.g. online protocols and evidence-based medicine reports).

As a tangential comment, I do not believe that all of the recent government-provided funding for healthcare IT will achieve its anticipated result until it is directed toward this critical initiative.

The issue is not who pays for healthcare, but rather how do we drive down the costs of the (currently very inefficient and expensive) healthcare delivery system while improving our quality (and not quantity) of care. If we set our minds to it, I believe we can do it and without government intervention and control.

Tally Ho!

Ward