Alternatives for American Healthcare

In its January 8th, 2015 issue Time Magazine published a thought-provoking article by Steven Brill, "America's Bitter Pill: Money, Politics, Backroom Deals, and The Fight to Fix Our Broken Healthcare System." As it turned out, the Time article was the first chapter of Brill's similarly titled book "America's Bitter Pill," published in 2013 by Random House.

Brill's book evoked much discussion which is why we choose it for this starting point for considering how healthcare might be brought under cost control with improved health outcomes for Americans. While Brill provides a starting point for this discussion, however, he does not explain why healthcare is so different from, say, food delivery. Both involve a necessity for well-being. Both require a high standard of quality. Both are susceptible to life-threatening errors. And, yet, for the most part, America's food industry is seen as well-functioning while healthcare involves out-of-control costs with less than optimal outcomes.

This analysis relates to Brill's book taken as a whole. Brill makes the point that the cost of healthcare in the United States is astronomically out of control and that the Affordable Care Act is insufficient to address the problem though it has brought more people into the system.

Steven Brill is a journalist and he uses words well. He also gained extraordinary access to some of the key decision makers, primarily in hospitals, who are impacting America's healthcare cost challenge.

Brill focuses particularly on hospitals and he is very critical of the artificially inflated chargemasters and the use of local market power by hospitals to demand

premium pricing from healthplans and, ultimately, from employers. He is also critical of the American system which gives greater tax advantages for providing healthcare to employers than those available to individuals.

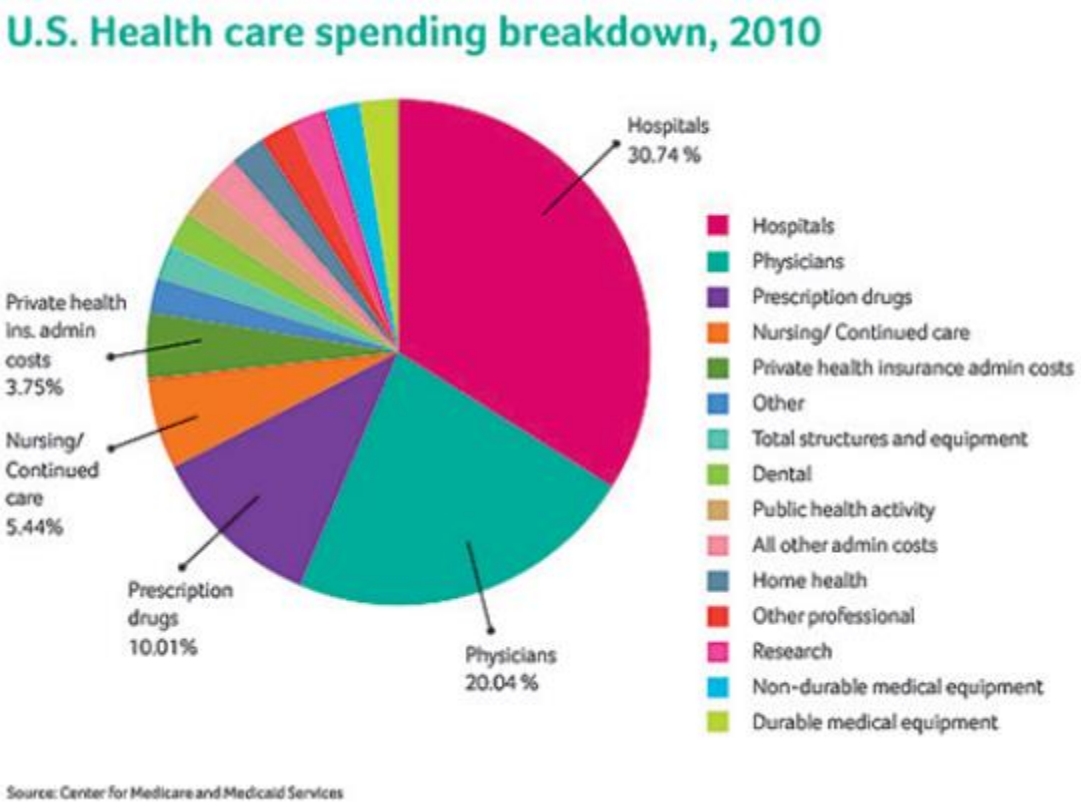
His argument is that an internationally competitive healthcare system would have to empower individuals to make informed healthcare decisions for themselves. He also recognizes that individuals cannot make such informed decisions at the point of service, because cost becomes secondary when one feels that personal survival is at stake. Moreover, hospitals and other providers feel free to pile on fees for services at the discretion of the provider without patient knowledge of why or what is reasonable.

His solution, however, is to allow a modified kind of closely regulated monopoly in various localities. The idea is that all-wise government regulators will oversee the private providers of care who will then have incentives to provide better care at an optimal cost. He proposes to accept and embrace the market dominance, say, of a New York Presbyterian hospital system or of the Partners Healthcare System, which was founded by Boston's Brigham and Women's hospital and Massachusetts General.

In short, Brill thinks that a locally dominating hospital combined with regulatory limitations somewhat like a public utility, e.g. regulated returns on capital, would be the solution. Like single payer on a nationwide basis, Brill thus concludes that local monopolies can operate with greater efficiency. To curb their dominance, though, such local monopolies would have to periodically spin off competitors to keep them on their toes. In short, Brill's approach is a hybrid of single payer

ideas, pursuit of business efficiency, and the urgency bred by competition. Frankly, it seems impractical.

American healthcare today exists in special interest silos which work awkwardly together but which are not integrated and not well understood by the American public. Each silo-ed sector contributes cost to the rainbow of costs that is the American healthcare cost challenge.



[see http://www.aetna.com/health-reform-connection/aetnas-vision/facts-about-costs.html]

Clearly, hospital and physician costs dominate in this spectrum of cost contributors. There are some treatments that are simply intrinsically very expensive, and we, Americans, want to have access to those treatments when they are needed. But not every hospital has to have the full spectrum of medical equipment, devices, and specialists needed to provide every aspect of patient

care. A system in which a local emergency center stabilizes time-critical patients so that they can be transferred to centers of excellence for treatment could be more cost efficient and provide improved outcomes relative to our current system of widely distributed medical intervention services. This local network might consist of a new concept of hospital, an integrated care delivery hospital.

We believe that the solutions would have to be entrepreneurial. To meet that need we need to integrate healthcare enterprise into a one stop shop. People could then contract for their healthcare with the local provider organization – an integrated care delivery hospital – that best fits their needs for cost, reputation, quality, and convenience. Regulation would then be principled rather than today's complex of rules defining the micro-minutiae of all that can present itself. The resulting healthcare delivery organizations would be accountable for their outcomes and responsible for their mistakes. Such organizations, though, would be free to deliver healthcare as ingeniously as they are able consistent with quality outcomes for their patients.

Any reform of the healthcare system will be disruptive. With hospitals contributing 30.74% of today's inflated healthcare cost, it's evident that there are too many over extended hospitals grubbing for sufficient revenues to cover their costs. Pushing back is the Federal government's Centers for Medicare and Medicaid (CMS), which seeks to constrain reimbursement rates, with the result that an intricate dance results between the coding of procedures, tests, etc. and the billing that the government finds acceptable. This is an inherently costly and financially unstable system.

Likewise, physician costs will need to be constrained since physicians contribute slightly over 20% to the whole. This may require a rethinking of physician education and qualification and a rebalancing of physician services between general practitioners, qualified to treat the entire human organism, and specialists, who are learned in the most forward-leaning procedures to address conditions that not-long-ago resulted in death or disability.

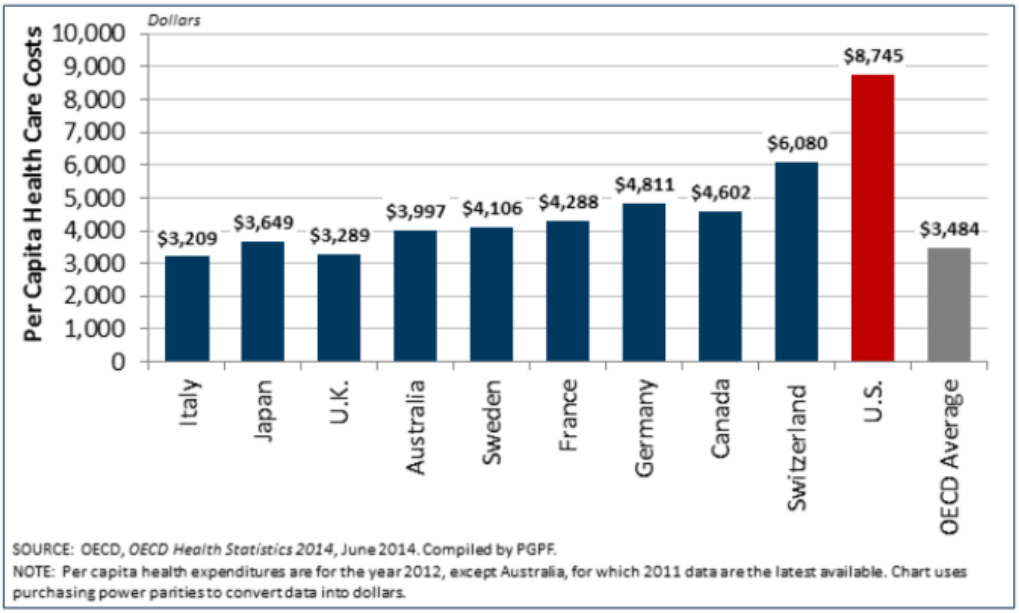
A change of this magnitude is risky so it would make sense to allow a number of entrepreneurial pilots in selected geographic regions. An umbrella nationwide emergency response catastrophe plan can handle the needs of frequent travelers, but most healthcare is locally delivered so it simply would make sense to allow local markets to experiment with entrepreneurial approaches. CMS has already tried to implement something like this with the waivers that it has granted to Accountable Care Organizations (ACOs) to try improve quality of care while providing incentives to contain the cost of care. But, for the most part, ACOs have fallen short of their promise and part of the reason is that they are dependent on a single customer, CMS, who provides the bulk of their revenue. Insurance companies generally have to adapt to CMS reimbursement and coding practices because of the relative dominance of CMS.

If the goal is to improve quality, while reducing cost, the best approach would be an engineering approach. To set the pricing for a product, an engineer starts with a competitive analysis to determine the price point that must be met. Then, the engineer works to see if it is possible to offer the product for a better price or with better features so that a profit can be earned for the price that the market will tolerate.

The same approach can work for healthcare if hospitals (as the logical institutional providers of service) are freed of artificialities like the chargemaster and excessively constraining regulations so they can reengineer the healthcare provided to a community. Community members could then contract with the hospital that they deem provides the best value, i.e. the best balance of quality with cost, for their healthcare. In return for a monthly payment, the hospital would agree to provide all healthcare to that individual or family.

If the hospital values its reputation, it would not let the compliance freedom resulting from regulatory waivers prevent it from providing excellent care to its members. Just as selling tainted food can be fatal for a food store, so inadequate care would be fatal for the reputation of an integrated care hospital. Weak hospitals would soon fall by the wayside, and the hospitals with the better reputations would be the surviving healthcare providers. Unlike the current system in which physicians use the hospital as a platform for their practice, the integrated care hospitals would be responsible for supervising the work of the physicians and other practitioners operating under the hospital's auspices.

Consider for a moment how providing care might be engineered to a price. At the top of the next page is a comparison of per capita healthcare costs among a comparable set of nations. The United States stands out for the sheer cost of healthcare per person relative to other nations, none of which are viewed as backward or deficient in medical effectiveness. In fact, some other countries, such as Germany and Switzerland, are viewed as on a par with the United States in terms of quality measures for medical procedures. Many people travel to these countries to receive care that is not available in their home countries.



[see http://pgpf.org/Chart-Archive/0006_health-care-oecd]

Clearly, American healthcare is exceptional for its high cost. Is that a necessary aspect of American culture or is an alternative approach possible? Let's say that a county, or a hospital catch basin area, or some other defined geographic subdivision, were to price healthcare at the same level as that of Germany plus a 10% margin, i.e. at ($4,811 * 1.1 =) $5,300, or about $450 a month. That would mean a savings of over 38% over the current cost of U. S. healthcare.

If that were set as the constraint, and if a business-minded engineer were charged with delivering the best possible care within the pricing constraint, the engineer might view it as a resource allocation problem. Such an engineer would likely start by examining the German healthcare system, which is eerily similar to that in the U.S. Things like the financing of physician education, the placement of hospitals and clinics, etc. could be studied to see if we could reach the same cost level with outcomes comparable to what we now have. Although it can be

difficult to make quality and acuity comparisons between groups of patients, Germany appears to deliver a quality of care comparable to that in the United States.

An article published by the U.S. National Institutes of Health explains the German experience as follows:

> "The cost containment measures have resulted in a dramatic decrease in the relative salaries of primary care physicians, which have fallen from 5.1 times the average for wage and salary workers in 1975 to 2.7 times that average in 1990. By U.S. standards, physician's salaries are relatively low. In 1993, the average German physician earned $75,700 with general practitioners receiving $64,300 on average and orthopedic surgeons receiving $107,600. More than 100,000 students attend one of the 29 medical schools run by the state. After completing the six-year curriculum, physicians must first practice in a hospital setting for five years before they are allowed to enter private ambulatory practice. Hospitals also have less high technology diagnostic, therapeutic, and surgical equipment than is available in the typical urban hospital in the United States. Germany has 22.6 percent fewer MRI units per million compared to the United States. The one area where Germany has more technology is CT scanners, where they have 17.1 per million population compared to 13.7 per million in the United States. [see http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3633404/].

Contemplating for a moment our current system in which employers are responsible for the healthcare of their employees and the employees families (as illogical as that may seem when stated starkly like this), imagine how many employers would be attracted to the first geographic area to constrain healthcare costs as described above. If local Economic Development Officers were able to tell employers consider where to locate that healthcare costs for their employees' healthcare plans would be 38% less than the cost of such plans elsewhere, the compelling competitive pressure to locate in the low cost area would be overwhelming.

That brings us back to Steven Brill's core observation that we have a "broken healthcare system." He's right about that. Costs have spiraled out of all proportion to other nations with which we compete in the global marketplace

and, yet, we can't claim a proportionally better quality of population healthcare than, say, Switzerland, which is also a popular country in which the world's wealthy seek specialized treatment when needed. We can do better.

America has always excelled by freeing entrepreneurial initiative to innovate and to search for better solutions to human challenges. By freeing entrepreneurs to come into healthcare delivery we can lift the United States from laggard to leader. Today's hospitals are led predominantly by administrators rather than entrepreneurs. But that can change with the right incentives and now is a positive time to try to attract entrepreneurial initiative and to free it from convention and micro-managing regulations.

-- J. B. Cumming
January 24, 2015