



healthcare financial management association [www.hfma.org](http://www.hfma.org)

## COMMENTARY

George C. Halvorson

# healthcare tipping points

Two tipping points, cost and quality, promise to forever change the healthcare landscape as we know it.

### AT A GLANCE

Cost and quality are two significant tipping points that will dramatically change the healthcare environment. Major changes in the way health care is delivered and financed are expected to occur over a relatively short period. Healthcare delivery will need to be reengineered. Key to accomplishing this objective is technology.

American health care in 2005 is poised at the edge of two significant “tipping points”—those times when an entire industry, or even a national culture, can shift in a fundamental way from yesterday’s tried and supposedly true working assumptions and current infrastructure to let a totally new direction come forth. Major changes—in the way health care is delivered and financed—will, I believe, come not gradually, but much more quickly, so that a few years from now we will look back on significant parts of today’s healthcare environment and barely recognize them.

The coming transformations will be at least as fundamental as some of the earlier tipping points in health care. Health care has “tipped” before. Remember the cost-driven shift in the early 1980s from the full indemnity coverage insurance model into comprehensive major medical? One hundred percent, first-dollar coverage suddenly gave way to \$500 or higher deductibles. That entire “tip” happened in about four years. Or remember the equally significant “tip” of buyers in the late 1980s and early 1990s—also driven by rising costs—into managed care? In very few years, virtually the entire marketplace moved from totally unmanaged care and embraced some form of cost management. That cost management ranged from HMOs to IPAs to PPOs. Payment was linked to new provider networks, and discounting—rather than increasing benefit copayments—became the cost savings driver. Both of these “tips” changed the business of health care in fundamental ways and produced periods of subsequent relative price stability—at least until the harvest of low-hanging fruit and one-time savings ran its course for each new direction.

### The Tipping Point for Healthcare Costs

Today, healthcare costs are once again caught in a spiral of unsustainable double-digit increases, and employers are again angry, frustrated, impoverished, and amazingly energized. Soaring health premiums are also now a major factor in the

**George C. Halvorson** was named chairman and CEO of Kaiser Foundation Health Plan, Inc., and Kaiser Foundation Hospitals, headquartered in Oakland, Calif., in March 2002. He has more than 30 years of healthcare management experience. He was formerly president and CEO of HealthPartners, headquartered in Minneapolis.

Halvorson serves on a number of boards, including those of the American Association of Health Plans, the Alliance of Community Health Plans, and the International Federation of Health Plans. He is also a member of the Harvard/Kennedy School Healthcare Delivery Policy

Program and the Commonwealth Fund Task Force on the Uninsured. Halvorson is the author of three books on health care, including *Epidemic of Care*, published in the spring of 2003 by Jossey-Bass. He is now working on two other books, one about organizational behavior and the other about racial prejudice around the world. Halvorson has lectured in a number of academic settings and has served as an adviser to the governments of Great Britain, Jamaica, Uganda, and Russia on issues of health policy and financing.



calculus of America's international economic competitiveness. Little wonder when the simple monthly cost of family coverage in New York or San Diego now exceeds the full cost of employing a computer engineer in New Delhi or Seoul. In reaction, to cut premiums, many employers are scrambling to the cost-shift strategy using much higher copays and deductibles. Some employers are looking to link these new deductibles to some version of consumers' choices about care delivery. Buyers are also demanding some answers about why healthcare costs continue to explode: Why is it, they ask, that consumer products such as DVD players, which a few years ago cost \$700 per unit, can now sell for as little as \$70—with greater functionality—while health care moves in the opposite direction with ever higher costs, fewer benefits, and, sadly, questionable quality?

Buyers want to know why the cost explosion has not been accompanied by clear and measurable quality improvements or even comparative performance information. The people writing premium checks are asking, what's so different about health care that allows it to defy the cost and quality trends that have reshaped so many other American industries?

The typical answer for the care system is to trot out the usual cost-increase suspects: an aging population that demands more care; new, expensive technologies that expand the scope of care; new, expensive drugs, many of which provide marginal, if any,

improvements in efficacy; a healthcare worker shortage; consolidation of hospitals and physicians that's giving new price leverage to providers; a national epidemic of obesity that's driving rising rates of costly chronic diseases such as diabetes and heart disease; litigation; etc.

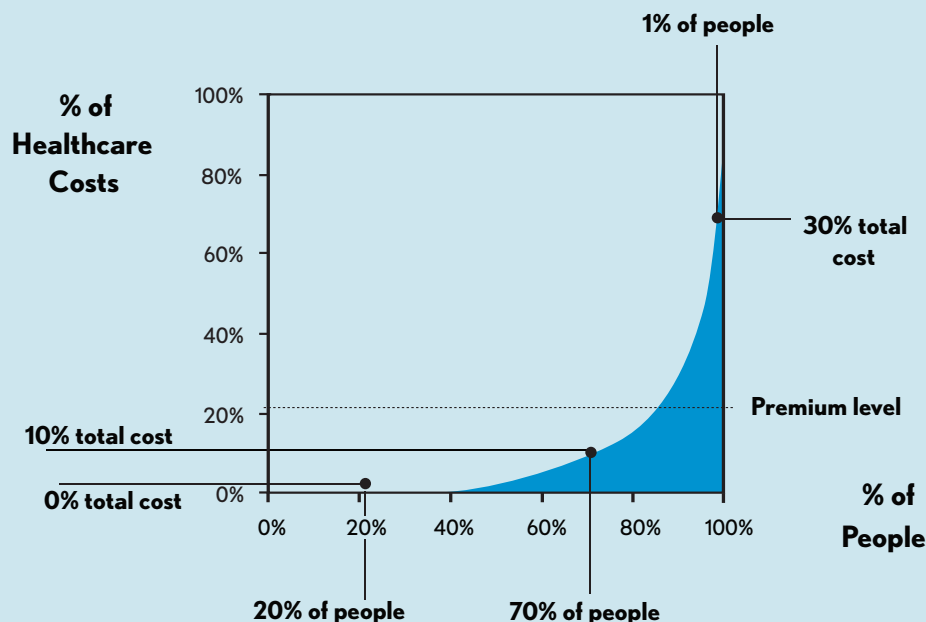
This is a very good list of usual suspects. Every one of them is genuinely guilty. Each is a cost driver. Each drives up a piece of the cost. Unfortunately, there is no silver bullet that can fix major percentages of healthcare costs by fixing only one of these issues. So the total impact of the cumulative costs is moving employers to a new tipping point—one that has yet to be fully defined.

### The Quality Tipping Point

There is yet another huge momentum and agenda developing in health care—perhaps the biggest of all. After years of assuming that all healthcare providers are basically equal relative to quality and efficiency, employers are finally becoming aware of the vast chasm that exists in healthcare quality. Over the past five years or so, the buyers who spend most of the healthcare dollars in this country (including the federal government) have been newly enlightened and even partially empowered by a torrent of fresh and compelling information about an American care environment that studies show to be inconsistent, nonsystematic, idiosyncratic, and far too often dangerous for patients. The Institute of Medicine's patient safety (2000) and quality chasm (2001) reports led the way, noting, "Health care today harms too frequently and routinely fails to deliver its potential benefits." Groups such as Leapfrog and the National Coalition for Quality Assessment are helping to convince both the big purchasers and ordinary consumers that all healthcare quality is not equal, that huge leaps in quality are possible, and that even small gains in quality can produce major, long-term cost savings.

The landmark Rand study (2003), for instance, which examined the care received by 20,000 Americans in a dozen communities, concluded that close to half the patients studied received care that was inadequate and did not follow widely agreed-upon best-care practices. A particularly glaring example showed that two-thirds of diabetics received inappropriate care.

## COST DISTRIBUTION OF CARE



A small percentage of insured Americans accounts for most of the healthcare dollars.

That amazing and disheartening inconsistency in care delivery represents a huge excess cost, and the people who pay that cost—the big buyers of health care—are finally sitting up and taking notice because the new research is so compelling and credible.

So, as an industry, we find ourselves at the edge of two interrelated momentums—and two potential tipping points—cost and quality. The 64 billion dollar question is whether we can relatively quickly devise melded strategies to address the demand for short-term cost containment while supporting the longer-term requirements for those quality improvements that are our best hope for achieving a sustainable, high-performing, and efficient care delivery system.

### Reengineering the System

To answer that question, buyers are beginning to realize that health care needs to do what every other kind of business would do, which is to look systematically at where the dollars are being spent—the total cost of all the processes and tools for getting a health-care product to market—and to figure out where the cost and quality issues and opportunities lie. Where are the broken or wobbly parts of the core production system that are driving costs and impeding quality improvements, and how can we fix them?

If we look at the problem systematically, the first fact we can all recognize is where the costs really are. As the exhibit demonstrates, less than 1 percent of Americans actually require care at the level of their average premium. There is a vast inconsistency in healthcare spending. In fact, 20 percent spend virtually zero percent of total costs, and 70 percent spend only about 10 percent of total costs. Clearly, solving the problem of the healthcare cost crisis does not reside among that 70 percent of all insured Americans.

However, if we look at the other end of the cost continuum, opportunities abound. A mere 1 percent of the insured are consuming 30 percent of total costs, and the top 5 percent account for as much as two-thirds of all costs. Herein lies the problem—as well as the massive potential for what we might call a “5 percent solution.” That solution lies in identifying the specific chronic and acute conditions that move people into that high-cost 5 percent bracket, and then systematically and consistently bringing to bear strategic, targeted, consistent, high-leverage interventions to keep those people from migrating to the high-cost end of the curve. When people are in crisis, we need to provide best care. But we also need to stop large numbers of people from progressing into that crisis.

We already know what those very expensive conditions are: the leading chronic diseases and certain acute conditions like cancer that account for the lion's share of healthcare spending. We also have increasingly robust evidence regarding the most effective and efficient interventions for most of those conditions, and in those select systems in which evidence-based interventions are consistently practiced, they have proven their value. The problem is that systematic interventions are not practiced consistently across most of American health care, because America is badly handicapped by its prevailing nonsystem of care.

## A few years from now we will look back on significant parts of today's healthcare environment and barely recognize them.

### A Wobbly System, Wobbly Outcomes

If we look at the American healthcare "system," such as it is, from an industrial focus—an engineering or reengineering perspective—we would have to conclude that the healthcare production machine is full of wobbly, dysfunctional parts. And any process engineer can tell you that no matter how skilled or dedicated the people who run any production machine are, a wobbly system will always produce wobbly products and inconsistent outcomes. Wobbly healthcare systems simply cannot, in their finest hour, produce Six Sigma health outcomes. It's sad but true that a mere 75 to 90 percent best-practice compliance rate in health care earns an industry gold medal. That same 75 percent performance would mean bankruptcy in all other industries.

What are those healthcare wobbly parts? The most obvious culprits include the following.

*The paper medical record.* It's sad, ironic, and a bit frustrating that an information-dependent, high-

tech profession is relying for the most essential, actionable, context-setting clinical data on scraps of paper that are too often inaccessible and illegible and are always completely inert.

*Best-practice diffusion and implementation.* The inability of physicians to keep pace with the accelerating flow of medical knowledge through the traditional journal-based information diffusion system means, as the IOM sadly pointed out, that it takes five to 17 years before a new best-care practice becomes the standard for even 50 percent of specialists in a given area.

*Patient support and follow-up.* Most physicians lack any systematic means of supporting or tracking the care they provide during an office visit. They don't even have access to such vital information as whether their patients' prescriptions have been filled, taken, or refilled.

*Feedback data for tracking and improving care.* Few physicians have sufficient data to identify what works and what doesn't or to track and report outcomes in a way that can support accountability and produce new knowledge.

### Computerized Physician Support

Reengineering the wobbly parts of this dysfunctional system cannot be accomplished without a vitally important new tool: computerized physician support, including a comprehensive, automated medical record. Computerized support tools are, in fact, the key to solving every one of the problems above:

- > Instant and ubiquitous access to critical patient information
- > Automatic and instant access to best-care practices and current science through embedded protocols and tutorials
- > Tracking data and automatic reminders for follow-up care
- > Automatic tracking of care and measuring of results so that we know what works and can build quality and efficiency improvements on that knowledge

None of this seems like a lot to ask in health care at a time when most, if not all, other industries and professions already take such capabilities for granted. It's time to give those very same useful tools to providers of care. Given the early evidence of

significant quality and efficiency improvements from those systems that have implemented clinical IT, there simply is no longer any excuse for delay. Five years from now, I am convinced, we will look back on today's information-barren healthcare landscape as a kind of Dark Ages. People will ask: How did we ever practice medicine without this tool?

deductibles of \$500 to \$1,000 today. Some individuals and small employers are buying deductibles as high as \$3,000 or more. Large employers are holding back a bit, but Mercer estimates that 73 percent of them will offer \$1,000 deductibles as a health savings account option by 2006, and that upwards of 40 percent of insured Americans will have a \$1,000

**If we look at the American healthcare “system,” such as it is, from an industrial focus—an engineering or reengineering perspective—we would have to conclude that the healthcare production machine is full of wobbly, dysfunctional parts.**

The reengineering of health care with the aid of computerized systems of physician support is already a reality among a relatively small number of large integrated delivery systems, including our own organization, where we are investing \$3 billion to implement what we call Kaiser Permanente HealthConnect over the next three years. Henry Ford, Geisinger, Mayo Clinic, Cleveland Clinic, and other integrated delivery systems have reached the same conclusions and have implemented similar electronic records in the past few years. However, for most of the disaggregated nonsystem of independent practice American health care, the challenge of financing and implementing sophisticated computer systems is still over the horizon: The path will be longer, and the gains may be less dramatic in the short term.

So what, in the meantime, do we do to address the tipping point on healthcare costs?

### **Tipping into CDHPs**

Employers are not waiting for answers. The vast majority of corporate purchasers are already employing an array of strategies to shift a significant portion of their costs directly to employees through products featuring rising copays, premium sharing, and, especially, the deductibles that are at the heart of the brilliantly labeled “consumer-directed” healthcare products.

In California, as elsewhere, we've already gone in the individual and small group markets from a norm of full coverage just a few years ago to typical

deductible by 2007 (*Mercer Survey on Health Savings Accounts*, 2004).

Are CDHPs and health savings accounts a credible answer to healthcare costs and premiums? Certainly on the premium side, the early evidence and plain common sense argue that they do enable significant premium reductions. Why? About 80 percent of Americans typically use less than \$1,000 of care in a given year. For this population, those who are insured under such plans will have virtually no insurance claims. They will operate in a purely cash economy for whatever care they receive.

However, it's a different story for the 5 percent of insured Americans who account for more than two-thirds of total healthcare dollars—the diabetics, asthmatics, heart patients, patients with kidney failure or cancer, and other chronic disease patients with comorbidities. For these much sicker patients, the \$1,000 deductible is painful but almost irrelevant, because most sick people will quickly blow through the \$1,000 deductible in primary care settings before they ever reach the truly high-cost settings.

Even if they didn't, a \$1,000 deductible is not likely to have much practical influence on an individual's healthcare spending decisions or behavior when the patient is deciding between a hospital that costs \$5,000 a day versus one that costs \$10,000. In fact, because the patient will go through the deductible in either hospital within a couple of hours, one could argue that the reverse incentive could happen. Why

## COMMENTARY

wouldn't the patient be essentially motivated to choose the most expensive hospital on the assumption that it provides superior care?

How the important chronic care population, which accounts for 40 percent of all healthcare dollars, exercises its newly empowered choice in the various primary care settings will of course also be significant, since this is where it is possible to drive those high-leverage interventions that, if done well and early, can prevent patients from moving into the high-cost 5 percent bracket. The danger here, of course, is that patients with little disposable cash will too often choose not to spend their deductibles on the recommended medications and screenings and other preventive care regimens designed to keep them out of that 5 percent. New studies of the impact of just doubling the copay show significant reductions among this population in the use of prescription drugs and significant increases in emergency department visits and hospitalizations.

Thus, on the cost question, we might expect to see significant increases in intensive and acute care needs and costs if a significant number of chronic care patients choose frugality in the primary care retail market and then fall into mandatory excess when they have a heart attack and move into the insured catastrophic care setting. The net impact could actually be an acceleration in the rate of overall hospital and acute care costs at the same time we see new price competition in primary care and pharmaceuticals.

### The Electronic Link Between the Cost and Quality Tipping Points

If the above assumptions are correct, the question becomes whether the quality strategy of reengineering care with the aid of computerized physician support still makes sense in the cost-sharing world of CDHPs. Can those early, high-leverage interventions

for carefully targeted populations—interventions that require a high level of patient participation and buy-in—remain effective in a world of high deductibles?

Despite the apparent conflicts between these strategies, I believe the case for reengineering care is stronger than ever. The reason is medical—we must get a bigger clinical bang from those up-front preventive care costs if we are to offset the economic power of the deductible to avoid increasing the back-end costs. If we fail to do that well, the whole nonsystem could sink of its own weight.

We must reengineer care, and to do that we must have the automated medical record and all the decision support that it enables.

We must reengineer care, and to do that we must have the automated medical record and all the decision support that it enables. It is the key to identifying the target populations, and the clinical data it provides are the key to systematically and consistently doing the high-leverage interventions. And, importantly, we also need to create more flexible pricing and benefit packages for those chronic care patients so that they are not tempted to skimp on essential preventive care.

If we are looking for the link between the quality agenda and the cost agenda, the computerized medical record is the electronic tool that will give physicians the information they need to make the kinds of interventions that will both contain costs and improve the quality of care simultaneously.

We definitely live in interesting times. ●