

Increasing the Value of Healthcare in Southeastern Wisconsin: Why Innovation is the Critical Factor



A Value Analysis and Systems Technology Whitepaper

Ever-increasing costs will result in a healthcare marketplace driven by the value-based purchase decisions of consumers. If today's healthcare delivery organizations are going to survive into the middle of the century, innovation must be at the center of all operational processes—from the back office to patient care to marketing—and not limited to driving breakthroughs in expensive medical technologies. The innovative healthcare organization will improve quality while decreasing costs, creating the highest degree of value. By adopting a proactive innovation program, healthcare organizations can benefit in the near term and thrive in the long term.

Healthcare providers operate in a marketplace, and like any other enterprise, they rely on revenue in order to continue operations from year to year. But the artificial marketplace, in which providers tell the consumer what they should purchase, and third-party payers get the bill, is going to change.

Healthcare costs are increasing rapidly enough to warrant using the term “crisis.” This crisis shows no signs of slowing. The federal government estimates a cost increase of over 30 percent by 2006, which many think is a conservative figure—despite the efforts of intelligent and committed men, women, and organizations. The pressures created by yearly double-digit rises in healthcare costs will drive change within the healthcare system as a whole, but more importantly, within individual healthcare organizations, be they large health systems or stand-alone facilities. The change will manifest itself as the imposition of quality, safety, and other performance benchmarks, all of which will lead to market share determined by the level of value provided to the con-

sumer. The value-driven healthcare organization will come about from one or a combination of the following: the aggregation of large-scale healthcare coverage purchasers into de facto consumer advocacy pressure groups (the beginnings of which we see now in such organizations as the Leapfrog Group or the Midwest Business Group on Health); the state and federal government in the form of expanded regulations; or from the marketplace decisions of individual healthcare consumers. Regardless of which group or set of circumstances eventually causes the change, healthcare organizations that intend to thrive in the future will attend themselves to implementing processes designed to increase value across the continuum of care, from the back-office to the boardroom, and out into the community.

Costs are approaching the tipping point

Double-digit growth in healthcare costs threatens the entire economy. Employers, especially in the Southeastern Wisconsin

market, pay a heavy price to offer healthcare to their workforce. This price will only increase—comprising a massive crisis in the making. To attract and retain high-quality workers, employers must offer competitive benefits, but they must also make profits. As increasing costs threaten profitability, employers will have to shift some of the cost burden to their workers, which may result in employee dissatisfaction, increased turnover, or even the large-scale loss of jobs within the local economy as employers look elsewhere for less demanding workers.

How might such a change in healthcare benefits come about? One possible source is the defined contribution plan, under which employers set aside a certain number of pre-tax earnings for use in funding healthcare choices. Once consumers become responsible for how their limited healthcare dollars are spent, market forces will influence provider revenue as never before. When this happens, there will be a shakeout, and organizations that have prepared themselves to innovate will be the ones that thrive in the even more competitive consumer-driven healthcare market. Already, jumps in employee premium payments and out-of-pocket costs are on the rise nationally, and this trend shows no signs of abating.

That consumer choice drives the value shift is the ideal scenario. Far worse is the possibility that the government may step in and impose its own interpretation of value standards on the provider community. Regardless of whatever good intentions might motivate such a move, the outcome would be a disaster. We have already seen government cuts drain billions of dollars out of the healthcare system. The government is the largest purchaser of healthcare today—over 70 percent of all healthcare dollars are spent through federally supported programs—today's cutbacks in payment levels will lead to tomorrow's mandated price caps

and rationing.

Innovation's role in value creation

Attacking cost of services (price) alone—known as optimization—will not suffice to ensure the long-term survivability of our local and national healthcare systems. Why? Cost has an irreducible minimum. That minimum is the downside of any optimization program, regardless of industry: There is a bottom-limit to what can be achieved through controlling cost. The promise of managed care was to drive unnecessary cost from the system, and in regions where managed care is still the dominant payer approach, many in the industry would concede that managed care has stripped all the cost from service delivery that it reasonably can using current methods. Still, costs rise, outstripping inflation by multiples. What is needed is an entirely new approach, one that increases quality in every process within the healthcare organization. The best way to improve quality is by increasing the innovation ability of the people engaged in the various processes. Innovation has no bottom limitation.

A structured approach to innovation is the one sure way to solve the several, complex, contradictory problems that face the healthcare delivery organization. Why? Because innovation focuses on improving the people who make up the system. We often consider innovation in healthcare to refer to technology breakthroughs in new, more effective medical devices, but restricting innovation to the science of healthcare is a mistake. Regardless of technology's advances, healthcare workers are the industry's most important resource. Relative to technology, people are very expensive. Between 60 and 70 percent of healthcare's expense dollars are spent on human resources. Investing in the human resource by increasing innovation skills will have a greater effect on healthcare than perhaps any other industry.

Why is innovation so important to healthcare? Innovation is, among other things, the processes of resolving contradictory requirements without compromising either requirement. Consider this: A central contradiction of the value-driven healthcare market will be the need for providers to reduce cost *while increasing the quality of service provided*.

Quality's role in value creation cannot be overstated. If you build quality into a product, you reduce recalls. Just as pressure from value-driven manufacturers led to dramatic improvements in the quality of American-made automobiles, pressure from value-driven purchasers can improve American healthcare. That close to 100,000 people die annually because of medical errors is a clear call to improve quality. The cost of errors in terms of inappropriate treatment and managing new problems runs into the tens of billions of dollars each year.

That structured innovation programs can drive the changes required in healthcare organizations should come as no surprise: Unstructured innovation has driven change in healthcare for a century. Innovation is a powerful force, but can innovation be managed and focused toward a particular goal, in this case, higher quality outcomes at reduced cost? The answer is yes. The methods, tools, and processes now exist to structure innovation and focus it toward defining and overcoming the obstacles that prevent or block value creation.

The typical approach to innovation—waiting for inspiration from one or two key players in a particular department—will not generate the systemic change that we will need. The kinds of innovations that will keep healthcare organizations alive and healthy into the next century are not about one person or department. Innovation must be institutionalized within the provider community, and Southeastern

Wisconsin should lead the nation in accomplishing this. We have a great deal to lose if we do not.

Why Southeastern Wisconsin needs healthcare innovation

Healthcare is going to remain a top business issue for the next several years, especially in Southeastern Wisconsin. Federal Bureau of Labor statistics reveal that Milwaukee's Medicare medical costs rose 6.2 percent in 2002, the 2nd highest growth rate in the country, well above the national 4.7 percent average for urban areas. In general, Southeastern Wisconsin's healthcare costs are between 20 - 25 percent higher than the national average. Moreover, healthcare costs at a state level, primarily for Medicaid, Badger Care, and Senior Care have now become the most expensive component of the state budget, consuming more than 10 percent of the tax collected.

The greater Milwaukee area was once a managed care community; today, however, nearly 75 percent of the population in Southeastern Wisconsin is enrolled in either a broad network health maintenance organization (HMO), a preferred provider organization (PPO), or point-of-service plans.¹

That restrictive managed care products could not survive in Southeastern Wisconsin should be a warning to the scale of the potential crisis facing us. As a leading manufacturing center, Milwaukee employers have traditionally offered generous benefits to attract and retain skilled workers. In addition, organized labor secured extensive healthcare coverage during contract negotiations. At the same time, the market demanded that every

¹ Unless otherwise indicated, market-specific figures and statistics are drawn from *The 2002 Greater Milwaukee Annual Report on Healthcare*, which is available at www.hctrends.com. VAAST recommends reading this report in its entirety.

plan network include virtually all providers in the area. It is little wonder our costs are so much higher than the national figures. If employer revenues are threatened on the national level, Milwaukee may be among the communities most at risk of serious economic consequences from the status quo.

Today, about a half million people are enrolled in commercial HMO products, with one health plan, United Health Care of Wisconsin, accounting for almost half of all HMO enrollment. Reflecting a national trend away from gatekeeper insurance products, only 40 percent of the enrollees participate in traditional HMOs, while 60 percent participate in open access point-of-service products. Consumers of healthcare in Southeastern Wisconsin want choice. The question is, how long will we be able to afford to give it to them?

Utilization is the key

In examining the cost of healthcare, one must be careful not to focus only on unit price, i.e., the fees charged by providers. There is another aspect to healthcare cost, which is utilization. To look at true healthcare cost, one must use a simple formula:

$$\text{Utilization} \times \text{Unit Price} = \text{Healthcare Cost.}$$

The primary reason for rising healthcare costs is alleged to be increasing utilization, which comprises about 2/3 of the total rise. Having said this, the unit prices of healthcare services have been rising as well, accounting for 1/3 of the increase. Thus understood, a continued focus on the price side of the equation (optimization) will yield fewer benefits today. When utilization escalates, quality becomes an increasingly important factor in containing cost.

Cost related to quality is clearly an issue

in our region. The Midwest Business Group on Health study entitled, "Reducing the Cost of Poor Quality Health Care through Responsible Purchasing Leadership," has estimated that 30 percent of healthcare expenses, or about \$1,700 per covered employee per year, are wasted on poor quality care. As utilization increases, so does cost.

The factors that contribute to utilization rates will only grow over the next decade, as massive numbers of Baby Boomers enter their senior years. They will be the healthiest, most-demanding, longest-lived generation of Americans to date, and not surprisingly, they will interact with the healthcare system increasingly as they seek to maintain their health and lifestyle expectations into their 70s and beyond.

Simultaneously, they will represent the best-educated group of healthcare consumers in history. Access to health-related information via the Internet, through specialized media outlets, and from increasingly pervasive direct-to-consumer marketing, creates a desire for the newest treatments and therapies, regardless of their benefits relative to other treatment options. One leading-edge indication of this trend can be seen in drug benefit cost increases. The costs of prescription drugs have risen astronomically, from approximately \$282 per member in 1997 to nearly \$700 per member in 2003.

It is only natural in a consumerist economy that healthcare consumers want the latest and greatest. Further, as patient satisfaction is an increasingly important factor in ranking quality (and by extension, determining market share), there is subtle pressure on healthcare providers to promote the sense of entitlement consumers have developed. This sense of entitlement extends to a desire for emerging medical technologies, which are invariably more expensive than conventional treatments. Consider another problem resulting from

higher than necessary rates of utilization: cost shifting. Doctors practice medicine because they want to treat patients, which means affording them every possible advantage to ensure good clinical outcomes. But when more treatments or services are ordered than are needed for the patient they are examining, doctors shift the cost burden to the patients in their waiting rooms or in the offices next door.

Beyond the inherent motivation of doctors to provide quality care, physicians' contribution to over-utilization is motivated by their legitimate fears of runaway malpractice exposure. Today, approximately 6 percent of malpractice payouts, which include both settlements and jury awards, now exceed 1 million dollars, double the percentage report of just 5 years ago. To insulate themselves from litigation concerns, physicians are driving up healthcare costs by:

- Prescribing unnecessary antibiotics
- Suggesting unnecessary biopsies
- Making unnecessary referrals
- Ordering unnecessary tests

The interconnectedness of utilization-based cost drivers becomes clearer when one considers how the expenses related to unnecessary procedures are compounded by critical shortages in key staff.

The severe nursing shortage has strained hospital budgets and forced mandatory overtime for already overworked nurses. It is also delaying surgeries and greatly increasing the potential for medical errors, all of which add to unnecessary cost. Nationally, the nursing vacancy rate is estimated to be 11 percent and growing. This nursing crisis will not go away soon. Our nation will have less than 1/2 of the 1.4 million nurses it will need in 2010. The reasons for the shortage are well publi-

cized and include the graying of America and the concomitantly increased complexity and acuity of casework, combined with a decline of people entering the profession. The staffing crisis requires little elaboration, except to say that it is made more critical by increasing shortages in lab and medical technicians, certified nurses' aides, and other allied health roles.

Individually, each of these threats poses a significant challenge to the delivery of healthcare services, and together, they create a potential for disaster.

The problems relating to cost in healthcare are systemic, and as such, cut across perceived boundaries. The system includes many subsystems: providers, employers, consumers, payers, state and federal government, and medical technology companies—including pharmaceutical manufacturers. Pressures on each subsystem element—large and small—aggregate at the system level, which is one reason why past approaches have failed: They have concentrated on one or two subsystems. A truly integrated approach to innovation is called for to save the healthcare system, but individual healthcare organizations can start benefiting from innovation today.

If the solutions were simple, we would have them already

There are short and long term solutions to many of the problems facing healthcare as a system, all of which require innovation. Real healthcare cost savings, resulting from improved quality and efficacy of all operational processes, can be achieved today by providers, employers, and third-party payers.

This will require healthcare to reinvent itself as a value-driven industry, by improving the innovation skills required to

resolve the many complex contradictions that exist today.

VAAST focuses innovation

VAAST can help healthcare organizations become more innovative, and in doing so, benefit the employers who pay for medical coverage, by applying its methods and tools to these and other areas in which healthcare needs innovation:

- Ensuring the right person gives the right care at the right time to the right patient
- Reducing medical errors
- Performing cost-benefit analyses for all operational processes
- Improving resource management, thus driving out waste
- Improving clinical quality by, among other things, reducing variations in treatment
- Improving the Information Technology environment, so that doctors have access to appropriate administrative, financial, and clinical data
- Increasing the satisfaction and effectiveness of every employee by making them feel responsible for the success or failure of their department or organization
- Improving the healthcare consumer's understanding of what constitutes appropriate care

This is not intended as an exhaustive list, nor are there “off the shelf” solutions to the problems addressed here.

Maximizing value as a competitive advantage is more complicated than implement-

ing standards, even ones for quality. Various methods exist today to improve quality; one under scrutiny is computerized physician order entry (CPOE), for example. If CPOE becomes an industry standard, and everyone adopts the technique, it ceases to be a competitive advantage.

In the future healthcare market, competitive advantage may be the factor that separates thriving, successful health systems from those that are simply waiting to die. True value comes from the innovative organization, and that is what VAAST helps create.

The people employed in healthcare-related organizations—and increasingly, members of the public—understand that a set of complex, interrelated challenges face the healthcare delivery system. Unfortunately, they wrongly assume they can do little or nothing to solve them.

The ideas, talent, education, and training necessary to move healthcare organizations into the highest levels of obtainable value exist within the healthcare system today. VAAST's structured, systematic Facilitated Innovation™ process² can take this untapped potential and turn it into present and future reality.

Facilitated Innovation is the right tool at the right time to save healthcare from an uncertain future.

Interested in learning more about Facilitated Innovation and VAAST's other service offerings? We invite you to contact VAAST via telephone at (262) 246-7369, or visit us online at www.valueanalysis.com

² For more information on Facilitated Innovation and its application in the healthcare industry, visit www.valueanalysis.com and read one of our Facilitated Innovation case studies.