FTI Journal Roundtable
U.S. Healthcare

The FTI Journal recently convened a group of FTI experts from varied yet connected backgrounds and disciplines – from performance improvement and restructuring, to economic consulting and strategic communications – for a discussion about the state of healthcare in the United States and around the world, with a focus on what’s driving increased spending, and how to slow its growth.

The extensive debate playing out in the United States on healthcare policy and reform has revolved around efforts to address rising costs and expenditures, and to expand coverage to a large population of uninsured.

Healthcare costs of approximately $2.4 trillion are substantial (about 17% of GDP in 2008/2009 up from about 15% in 2005 and a mere 5% in 1965) and are anticipated to increase to about 19.5% of GDP by 2017, without comprehensive reform. The growth rate of healthcare expenditures has exceeded that of GDP by more than double over the past four decades. During the same period, there have been dramatic improvements in technology, communications networks, electronic media, treatments for a vast array of illnesses, better understanding of preventive care, improved longevity, and substantial evolution in the organizational structures for delivering care in the U.S. across plans and providers.

Pending legislative proposals involve a wide array of alternatives for addressing costs, quality and extension of care. The national discussion has been focused on cost reduction efforts, including widespread discussion of organizations that have accomplished substantial cost reduction while enhancing quality of service. For example, in his September speech to the U.S. Congress, President Obama mentioned two such organizations – InterMountain Health and Geisinger Health – as examples of healthcare organizations with success in both improved quality and cost reduction (other frequently touted studies include other examples). An open question, which is subject to both policy and empirical examination, is how these ‘localized’ examples can best be replicated in more localities or at the national level. What are their secrets to success and how can they be taken into consideration in forming national policy? The effort to replicate those experiences, and to identify how and why such gains were accomplished, has become a key part of the legislative agenda. The intense focus on cost-reduction solutions is also reflected in the proposals made by healthcare industry representatives – including pharmaceutical
Improvements in overall healthcare will require a common method of measuring change.

CHARLES OVERSTREET

MEG GUERIN-CALVERT: The most frequently cited examples of institutions that have achieved success in cost reduction and improvement of quality of care include some of the nation’s largest and most highly integrated private healthcare organizations. Some of these organizations provide the full spectrum of inpatient and outpatient care and others are more specialized. Kaiser, for example, may be the most fully integrated of the examples mentioned — within this single organization there are physicians, clinics, hospitals and insurance, with fully managed inpatient and outpatient care. It’s also noteworthy that these entities coexist and compete with other organizational forms in the provision of physician services, insurance and hospital care, demonstrating that the healthcare marketplace supports a variety of entities.

There are several common themes from these examples. First, most of these organizations are very large for their locality or region. This suggests that even as a single firm these organizations are able to get relatively complete information on the local population, its healthcare needs and characteristics, as well as on providers.

Second, these highly integrated organizations can use this access to develop and implement solutions to identify higher costs, to reward improved quality and cost reduction, and to induce providers and patients to take preventive care steps so as to reduce more costly inpatient or outpatient care. A common element of cost reduction successes are organizations that have made use of their own data and information on procedures, outcomes and costs, and then developed systematic and comprehensive analyses both internally, and relative to external standards, to identify the sources of variation and to develop solutions. They have developed metrics, and can track and implement them.

Third, the gains from improvements and cost reductions can be internalized by the organization, and thereby create greater incentives to invest in activities such as improved IT and electronic records.

Roundtable Participants

MARTIN COHEN
Senior Managing Director, Corporate Finance/Restructuring-Segment, Leader of FTI Healthcare Practice

CHARLES D. OVERSTREET
Senior Managing Director, Forensic and Litigation Consulting Segment, Leader of FLC Healthcare Services

MARGARET GUERIN-CALVERT
Vice Chairman and Senior Managing Director Compass Lexecon, an FTI Consulting Company

Martin Cohen is a Senior Managing Director in FTI Healthcare and is based in Washington, D.C. Mr. Cohen has 25 years of experience in senior financial, operating, development and restructuring roles. He has extensive experience in the healthcare industry and is the leader of FTI’s dedicated healthcare industry practice.

Charles Overstreet is a Senior Managing Director in the FTI Forensic and Litigation Consulting segment and is based in Nashville. Mr. Overstreet specializes in the development and implementation of improvement strategies for healthcare organizations and brings a strong background in managing organizational transition.

Margaret ‘Meg’ Guerin-Calvert is a Founding Director of Compass Lexecon (formerly Competition Policy Associates), one of the top competition economics consulting firms in the world. Ms. Guerin-Calvert has an active practice before federal and international antitrust agencies and in litigation, including class certification, healthcare and pharmaceuticals, and network industries.
Fourth, these are largely examples of private organizations, not public or government-funded ones, which have relied on market mechanisms to accomplish their goals. These include a variety of contractual arrangements with many different healthcare market participants.

**CHARLES OVERSTREET:** The most common element in achieving cost reductions is how readily any cost reduction can be measured. Cost reduction success stories are often best illustrated by how the reductions were tallied up. That is to say, whether the reduction or improvement is large or small and how easy it is to track. Many reductions have to do with the overall change in the actual outlay of cash. Supplies, hourly wage, medicines, devices, etc. all have a cost. If we can identify these costs, reduce these costs and then track the reduction, we have a success story.

But cost reduction is often illustrated in more complex scenarios where there may be many variables or components that are being improved (or are perceived to have been improved). The key to success in these more complex scenarios is not in just tracking individual component improvements, but in developing and tracking simple overall statistics of improvement. One classic example is the great strides in improving cost and quality in cardiac surgery. Over the past several years we have seen many improvements in this area of medicine. Why? Yes, medical science has advanced and we have improved medicines, techniques and other factors. But I would argue that one of the major reasons for the improvement in quality and cost in this area is the ease with which one can actually gauge and track improvements.

Some simple statistics that are easily tracked are the real contributing factors of the improvement in this area – Length of Stay (LOS) and Cost per Case. These two statistics are easily calculated and they complement each other. Moreover, most would agree that a reduction in the LOS of a hospital stay is an improvement in clinical quality, and agree that a reduction in Cost per Case is also a success. Both metrics do not allow for much argument or difference of interpretation – ‘they are what they are.’

**EDWARD REILLY:**

*CEO Americas of FTI Consulting*

Edward Reilly is CEO Americas of FTI Consulting. He has more than 20 years of experience in the communications industry, with a background in healthcare, financial services and technology. He has led numerous strategic communications programs for clients in a variety of industries.

**CEILIA HALL:**

*Senior Vice President, FTI’s Strategic Communications Segment*

Celobia Hall is an award-winning journalist and media relations expert who specializes in the European healthcare industry. Most recently, Ms. Hall was with The Daily Telegraph, where she was the medical editor for 11 years. While at the Telegraph, Ms. Hall was twice awarded the BMA medical journalist of the year award for her coverage of the European healthcare industry.

**MARTIN COHEN:**

Historically, hospitals and physicians have addressed cost reduction through enhanced management of labor and non-labor (i.e. medical supplies, cost of implants, cost of contract services, etc) costs. Also, in the early ‘80s (with the introduction of DRG’s) and the late ‘80s and early ‘90s (with the expansion of HMOs) significant improvement was achieved in reducing clinical costs, through better management of the clinical care process. However, much is left to accomplish in this area.

Although hospitals and physicians must (and will) continue to look for ways to reduce labor and non-labor costs, in order to reduce the cost of care in a meaningful way it is essential to continue enhancing clinical care processes through better coordination and management of care delivery. On a day-to-day basis that would call for better coordination of preventive, diagnostic or therapeutic modalities provided by patients’ primary care and specialty physicians. In an acute inpatient setting, this would entail not only coordination of care among the physicians but also the nursing, diagnostic and other professional staff providing care in the hospital.

There are several key elements required to bring about improved coordination and management of the clinical care processes including (1) improved access and transparency of patient medical information (electronic medical records), (2) the development and implementation of best practices with respect to clinical treatment protocols, (3) the need to better track and monitor clinical quality outcome measures and finally (4) the need to align the economic incentives for hospitals and physicians. Each of these is an essential component necessary to improve the effectiveness and efficiency of clinical care processes and all must be addressed.

**CHARLES OVERSTREET:** One of the reasons why reductions/improvements on a broader and deeper scale get bogged down, or do not reach their full potential, is that we get sidetracked in arguing over the metrics of reduction/
improvement, or we cannot develop sound and systematic metrics of measurement. In my example of the cardiac surgery improvements, we can quickly get into a debate over measuring other factors of reduction/improvement when we get into more complex measures such as outcomes, readmission rates, volume of diagnostic procedures, etc. These types of factors are important and need to be measured, but we do not have a recognized commonality of ‘how to keep score.’ Thus I would assert that greater reductions/improvements in overall healthcare will require a common (and agreed-upon) method for measuring the change.

MARTIN COHEN: Although there have been attempts to address the essential elements I described earlier, they have not been addressed in a comprehensive way and accordingly have met with varying degrees of success. For example, the establishment and growth of HMOs have provided a significant reduction in the cost of care. However, these reductions in cost have been primarily driven from the economic incentives provided to providers and reduced access to services. Absenting the transparency of medical information, development of clinical pathways and better tracking and monitoring of meaningful clinical quality measures, this method of reducing costs has a limited upside and is certainly not grounded in clinical effectiveness.

On the other hand, substantial work has been done in the development of electronic medical records, development and tracking of quality measures and establishment of enhanced clinical protocols/pathways. But until providers, both physicians and hospitals, are reimbursed for services in a manner that provides aligned economic incentives, and until quality becomes a component of how providers are paid, history has proven that behaviors are not likely to change and significant cost reduction impact will not likely be achieved.

In order to achieve the real efficiencies available through enhanced coordination and management of care, the Federal Government, through modifications to the Medicare system of reimbursing physicians and hospitals, will have to lead the way.

MEG GUERIN-CALVERT: The examples of individual organizations are the most dramatic and perhaps most informative, but may obscure other sources of gains in the management and reduction of costs. During the 1990s and early 2000s, there was substantial consolidation of hospitals, the vast majority of which raised no antitrust concerns and which resulted in substantial and well-documented efficiencies. In addition, efforts on the health insurance and provider sides have focused on mechanisms to create incentives for improved preventive care, pay for performance, and metrics.

CELIA HALL: The United Kingdom’s National Health Service (NHS), which oversees the delivery of healthcare to all UK citizens, has pursued some noteworthy reforms that deserve more attention as the United States looks for opportunities to control costs and preserve quality.

One initiative has been to break up the organization into smaller, more flexible and more autonomous units such as NHS foundation trusts covering both hospital and primary care. These are self-governing organizations that run hospitals and provide healthcare to the general public but are able to raise their own capital and save and invest any savings they generate. They work to nationally agreed standards, in order to provide consistent standards of care across the country. Hospitals can only obtain and maintain foundation trust status if they are able to prove and show good financial control and governance.

The foundation trusts are similar to medium-sized businesses, and there is a belief that it will be easier for these locally focused organizations to contain costs and cut waste. According to the independent regulator of NHS foundation trusts, the trusts spent £22.7 billion in 2008/09 and generated a retained surplus of £209 million. While this is a tiny amount compared to total spending, each of the 122 trusts in England is under an obligation to make efficiency savings every year or face loss of their foundation trust status.

EDWARD REILLY: We can also look to employers as innovators in developing ways to reduce healthcare costs while improving quality of life for their employees and families. For example, Coca-Cola has taken very innovative steps to control costs, by focusing on behavioral changes, and incentivizing people to live a healthy lifestyle. By next year, it is going to cover 100% of the cost of preventive screening for its employees. The program is projected to save an average of $300 in healthcare costs per employee per year, and reduce the company’s healthcare costs by 8%, annually.

Another example is the tremendous transformation we have observed at Walmart. It is counseling employees on how to take advantage of government healthcare options. And it is very active in promoting wellness programs, taking a more progressive approach, while putting more responsibility on employees. Some may be surprised by the fact that one of the elements we’re seeing in our ongoing public opinion research is that employees perceive employers to be a primary steward of their interests.

So employers have an even more
critical role to play in communicating with employees what can be done to better manage costs to the business, and what individuals can do to change their behavior in ways that will help to reduce healthcare costs. The human resources departments in particular are playing valuable roles when employees interact with an insurance company — educator, explainer and advocate.

Our research shows that people are willing to make sacrifices to keep their employer-provided health insurance. Indeed, a recent FTI survey found that 70% of all respondents are willing to take a pay cut to keep the healthcare insurance currently provided by their employer. The same survey found that while 29% of those surveyed blame employers for rising health insurance premiums, five other groups were identified more frequently as the source of such increases (health insurance companies, hospitals/medical facilities, lawyers, government, and consumers/employees).

CHARLES OVERSTREET: In continuing my theme on the need for common measurement, I think that measurement and tracking are essential for aligning incentives for all those participating in the healthcare marketplace. Reduction in the costs to consumers must be balanced with the real or perceived loss of revenue from the perspective of the provider.

The promise of truly managed care allowed for some of this balance. Payments for care were to be placed in a pool and used as needed by a patient population. Through responsible management of that care and a focus on ‘health maintenance,’ the total outlays from the pool were to be reduced. When the year was over, whatever was left in the pool was shared between payer, provider and beneficiary, and thus, all of those involved had aligned incentives. This is the simplest way to initiate and sustain real reductions and improvements.

MEG GUERIN-CALVERT: Even where there is sound measurement and metrics, there still needs to be sufficiently broad data (both cross-sectional and time-series) to be able to conduct a sound empirical assessment of the variation in costs and quality, while controlling for the wealth of factors that can affect both. As Charles notes, there are often many factors that explain a given result, meaning that empirical analyses must be sufficiently sophisticated to deal with the complexity.

A hallmark of the FTI professionals working in the healthcare area is knowledge of healthcare data, extensive experience with empirical analyses at the most disaggregated and detailed level, and a thorough understanding of the approaches and mechanisms used to improve costs and quality — whether for firms in financial distress, those seeking process improvement, others via merger, or in the development of new ventures.

CELIA HALL: There are similar challenges in the United Kingdom, which is battling the problems of an insatiable demand for healthcare, little incentive to use the service responsibly and an ageing demographic. In the UK, two generations have got used to the idea of free healthcare and the NHS is very much seen as a sacred cow. There is little incentive for politicians to tackle the cost issues head-on so any changes will be a case of evolution rather than revolution.

Similarly, small hospitals in medium-sized towns are very inefficient. It is impractical for these hospitals to provide every single service or expertise that can be provided by larger regional hospitals. But there are huge political constraints, particularly for local representatives, in addressing this.

Another issue in the UK is that in trying to reduce costs, implementing comprehensive reforms can prove to
be quite costly. There have been well-publicized delays and cost overruns on a central IT operation for the National Health System. The IT was designed to link 30,000 GPs and 300 hospitals to a central system and contain information on 30 million patients. It was projected to save more than £1 billion a year. But it is now four years behind schedule and it may also end up costing four or five times the original £6.2 billion budget.

EDWARD REILLY: As a result of the healthcare reform debate, irrespective of the final resolution, there will be greater scrutiny on healthcare providers and the cost and effectiveness of what is being delivered. Although not directly included in health reform, the Government has set aside billions of dollars for comparative effectiveness trials to look at the relative benefits of various treatments for the same indication or diagnosis. For example, a trial would look to compare rehab therapy to surgery for a specific orthopedic procedure, review the outcomes and assess the relative benefits. The tools are available today to design and implement patient registries, studies and technologies for evaluating real world outcomes for safety, effectiveness, quality and value.

MEG GUERIN-CALVERT: As my colleagues in this roundtable have indicated, achieving clear gains in costs and quality depends on developing and assessing sound empirical evidence, which must then be connected to effect changes in performance, whether by physicians, hospitals, insurers, employers or patients or some combination of them. That involves organizational structures, including some internal to firms, and others that require coordination across otherwise independent players. I can envision that such extensive empirical analyses could be conducted by individual health systems, by insurers, by physician groups, as well as by combinations of such entities. While there are opportunities for substantial cost savings at the individual provider or insurer level, there are likely to be even greater potential gains from finding the means to develop sufficient data to conduct sound studies by multiple entities in an area and to implement the results across firms and markets. That is a challenge because it requires development of contractual arrangements to accomplish data-gathering, development of the empirical analyses, and then implementing solutions for cost reduction and alignment of incentives.

The experience of successful healthcare organizations shows that in a market-oriented healthcare system, the market can function to achieve substantial cost savings, where it can replicate by contractual arrangements what integrated firms have been able to develop internally. However, increased coordination can lead to a reduction in competition. And so antitrust authorities will need to provide greater guidance about the standards by which any new types of arrangements between and among participants will be evaluated, because existing guidelines suggest that many of these arrangements fall outside of recognized safety zones. For example, would antitrust issues arise if hospitals and physicians, hospitals and plans, or smaller independent plans within a region, pool data and information on claims or procedures, collectively fund empirical research on the sources of cost increases, and then implement initiatives to change behaviors so as to reduce costs?