Reverse Engineering and the Golden Goose

Posted on April 22, 2008 by George Van Antwerp

I listened to part of the initial presentation by Hans Rosling from Sweden which was very interesting, but I was mostly getting coordinated for the day.

Here is the video of a similar talk he gave at TED.

I am very excited to sit down and listen to George Halvorson's presentation called "A Practical Model to Achieve Health Reform". [George is the Chairman and CEO of Kaiser and recently wrote the book Healthcare Reform Now! A Prescription for Change. Some of my notes on this are here although I am still finishing up the book.]

Here are some of his quotes and some of my notes. [You know you are a key person when you are able to quote yourself.]

- Talking about Kaiser, "When we look for someone to blame, we have to look in the mirror." He talked about how they play all the positions all of the time (payor, provider, lab, pharmacy).
- Said that they had about 2M e-visits last year and have 92,0000 member contacts per day on the Internet. They are trying to figure out how to leverage the new toolkit in a way that makes sense.
- He dedicated his presentation to Dr. Jerome H. Grossman who recently passed away.

"American health care could be transformed fairly quickly if a number of high leverage buyers chose to strategically use their market leverage."

- Reform can't be voluntary…it needs to be a product…defined, purchased, and paid for by buyers.
- He talked about the old market:
  - Hundreds of "slices"
  - Commodity products
  - Financial conduits rather than care delivery focused
- He talked about the new market:
  - Sumo wrestling
  - Total replacements
  - Shrinking total market
  - Growth focus to drive stock value
- This new market reality gives power to the employers in terms of pushing change. This is an interesting perspective really pushing the employers to drive for change.
- It is a great, simple point that he makes around HC in America is becoming unaffordable…BUT financing reform is not enough. Most of what we hear about is financing change. He points out

that the multiple payor system only explains 20% of the cost difference between the US and Canada.

- What we need:
  - Universal coverage
  - Individual mandates
  - Guaranteed issue
  - Subsidized coverage for low income

"Care delivery in the US is uncoordinated, unfocused, inconsistent, unmeasured, extremely inefficient, perversely incented, and excessively expensive."

- He talked about how healthcare is the fastest growing and most profitable segment of US economy ($1.2Trillion). [Key point on profitability.]

"HC takes everyone's money with an amazingly low level of accountability for the product it sells." [Key point on why HC will never reform itself.]

- Smart people don't kill the geese that lay the golden eggs. We have lots of smart people and golden geese in the US HC system.
- More efficient and effective caregivers simply deprive themselves of income.
- Truths:
  - Current increases in cost are unsustainable.
  - Current rates of increase for Medicare and Medicare with eat entire budget by 2050.
  - 1% of people drive 35% of costs
    - If everyone in CA had coverage - $300 per month
    - If only 1% - $12,000 per month in cost
  - 75% of cost is from chronic care
    - Eliminating breast cancer would be create but only impact 2% of costs
  - Benefit design is clumsy and even inept
- Some realities that drive out costs assuming we start with roughly the same base as other countries: [Although he points out that we do start at a higher base than Canada around office visits…$23 in Canada…$73 in US…$150 in NY.]
  - Inflation
  - Worker shortages – lab techs, nurses, pharmacists
  - New technology, treatments, drugs, etc. which all drive costs
  - Number of MRIs, transplants, etc. all higher…more high tech care (tertiary care)
  - No value screen for technologies or drugs…test is will someone buy it [Seems like an obvious problem]
  - Inefficient, uncoordinated, unlinked care
  - Multiple MDs with no coordination
    - 10,000 fees for unites of care
    - No reward for outcomes
  - Aging population

"We can't stop aging, inflation, new technology and provider financial motivations."

- What we can do:
  - Focus on chronic conditions (CHR, Asthma, Diabetes, +2 others)
  - Work backwards (continuous improvement)…where do we want to get and then how do we get there

"Random reengineering doesn't work…need a goal in mind."

- Tools:
  - Benefit design
  - Public messaging
  - Care tracking – PHR/EMR
  - Mandatory care registries and care linkages (tools will evolve once we have a goals)
- Nurses spend 25% of their time on direct patient care [a pretty low amount]