

# Innovative Collaboration to Create Value

## The Antidote for the Perils of Healthcare Reform, or What Healthcare Can Learn from the Automobile Industry

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In his November 11, 2008 *New York Times* Op-Ed Column, Thomas Freedman blames Detroit's current economic crisis on:

"... the combination of a very un-innovative business culture, visionless management, and overly generous labor contracts ... instead of focusing on making money by innovating around fuel efficiency, productivity, and design, G.M. threw way too much energy into lobbying and maneuvering to protect its gas guzzlers."

Hospitals and physicians need to learn from the mistakes of the automobile industry or face a similar fate.

### We Know the Face of Healthcare Reform and It Ain't Pretty

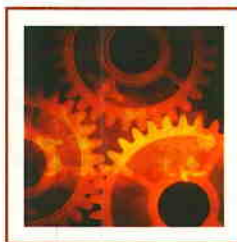


The primary focus of the politicians' healthcare reform plan is mandated universal coverage. Experience in Massachusetts shows that mandated universal coverage may improve access to care, but other systemic problems may get worse. The newly insured beneficiaries in Massachusetts are reported to be using emergency department services at almost twice the rate of the nation. One possible reason for this is the shortage of primary care physicians in the state. Clearly, universal coverage does not address the critical shortage of providers.

Universal coverage does not address the deteriorating financial condition of physicians and hospitals. Since the implementation of universal coverage in 2006, the operating margin for Massachusetts hospitals has trended down.

And finally, universal coverage appears to have accelerated the exponential growth in healthcare expenditures. In his March 24, 2008, *Boston Globe* Op-Ed article, Christopher Anderson states:

"With its massive cost overruns and missed deadlines, the healthcare reform law is quickly becoming the Big Dig of the next generation, an ambitious and beneficial but deeply flawed public initiative with back-breaking costs to the taxpayers. Unlike the Big Dig, Massachusetts taxpayers, not Congress, will pay most of the healthcare tab."



The old adage clearly applies to the Massachusetts Healthcare Reform Plan: *if you think healthcare is expensive now, wait until it's free*. Implementing a universal coverage plan nationwide could cost the nation an additional \$12.4 billion per year.

While the politicians are working on universal coverage, the bureaucrats are wrestling with the issue of cost and quality. CMS has stated unequivocally that the fee-for-service payment system must be changed. They are currently experimenting with alternative payment methodologies including:

1. Population-based payments (also known as capitation)
2. Bundling the physician/hospital payment around an episode of care
3. Competitive bidding to become the sole preferred provider of Medicare services in a region (the A.C.E. Demonstration Project)

Rather than view a payment to a physician as a *transaction*, both hospitals and physicians should adopt the paradigm that the hospital's "give" is an *investment* in return for which the hospital is "asking" the physicians to collaborate, innovate, and help create value in new ways.



Until fee-for-service is replaced by a new payment methodology, CMS is implementing its planned reduction in Medicare margin contribution for physicians and hospitals.

This margin erosion, which began around 2001, has caused disequilibrium in the traditional hospital-physician relationship. Physicians are threatening that unless their local hospital stabilizes their incomes, they will affiliate with competitors, or even leave the market. Many hospitals have responded by negotiating a broad range of financial transactional relationships with their physicians including:

- Directorships
- Call pay
- Employment
- OWA (other weird arrangements)

The nature and tone of these hospital–physician negotiations are markedly similar to the labor–management negotiations in Detroit. Experience has shown that transactional relationships promote the art of blackmail and do not contribute to collaboration and innovation.

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### Gives and Asks



The traditional, independent, community-based physician business model is being threatened by the pricing policies of Medicare and commercial payers. Most hospitals and health systems are “giving” physicians the resources they need to stabilize their incomes. These physician investments have accelerated the economic pressures at hospitals because, in many cases, these payments to physicians represent incremental cost with no incremental revenue. Like Detroit, this will eventually create financial hardship for the entire industry (including the physicians). Rather than view a payment to a physician as a *transaction*, both hospitals and physicians should adopt the paradigm that the hospital’s “give” is an *investment* in return for which the hospital is “asking” the physicians to collaborate, innovate, and help create value in new ways.

It has been demonstrated that, together, physicians and hospitals can enhance the financial viability of their hospital, thus making more resources available to stabilize physician incomes. This stabilizes the local health system and, ultimately, benefits the patients and the community. Collaborations that have added value include:

- Using best-practice protocols and team medicine—which improves quality and reduces cost.
- Standardizing supply use and limiting vendors—which reduces hospital costs.

- Focusing on reducing length of stay avoids the need to build expensive beds and add staff—which improves the profitability of Medicare patients.
- Clinically integrating around an electronic health record enables the provider network—which, by extension, enables providers to demand fair rates and terms from the managed care payers and prepares the physicians and hospitals for bundled payment and competitive bidding.

### The Traditional Hospital–Physician Relationship Must Change



Many physicians and hospitals resist changes to the independent medical staff model. However it is clear that the traditional consensus-based hospital–physician relationship can be an impediment to innovation. As Bill Cosby said, “*I don’t know the key to success, but the key to failure is trying to please everybody.*” Consensus-based solutions tend to preserve the status quo and rarely result in true innovation or optimal results.

Hospitals must rely on physician leaders who share their strategic vision and recognize the need for change to guide the health system toward innovation. In order to enfranchise physician leaders, hospitals must delegate more responsibility and accountability to these physician leaders in the management of the hospital and its service lines.

Like any cultural change, the transition to this new hospital–physician relationship will be bumpy and require open and safe dialogue, shared values, joint decision making, transparency, and trust. As Ben Franklin stated so eloquently, “*We must hang together or most assuredly we will hang separately.*”

It is up to us.

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