Comments in a Roundtable Discussion: The Rising Cost of Health Care

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It's really a pleasure to be here and talk about what is really a big topic, I mean a big topic. I don't know that we're going to be able to do this justice tonight. For my part, I'm going to talk about this law from a provider standpoint. As Jim indicated, at UnityPoint Health we have 15 owned hospitals and another 15 that we have very tight affiliation with across eight regions covering virtually all of Iowa into central Illinois – almost 900 employed physicians. Quite frankly, UnityPoint Health has been preparing for healthcare reform, transforming how we deliver care really, over the last six years. Why? Your question maybe would be why would we do that?

From our viewpoint, and I personally have held the view for a long time, I've been in health care, running hospitals, for almost 40 years - many more years than sometimes I'd like to remember - health care as we know it today, and as we have known it for 40 years, does not work very well. It doesn't work very well, because it's very fragmented; it's very siloed. There are a lot of profit takers. There's very little focus on value. There's much more focus on how do I produce revenue and how do I produce volume? When you think about our country, Medicare covers today 45 million Americans, all those over the age of 65. So federal benefit, entitlement, your pay, your taxes, my taxes pay for that. With the aging of America, over the next 18 years we will add 75 million more Medicare beneficiaries that you and I are going to pay taxes to help provide healthcare for. Up until last year, the rate of increase for medical inflation was running about 7%, when general inflation has been running probably less than 2%, 2½%. That is a recipe for disaster. You cannot sustain a fee-for-volume reimbursement basis and cover that many more people with federal tax dollars. You and I will not be able to pay enough tax to be able to do that.

Like many other systems, think tanks, institutes, politicians, we began a long time ago thinking about what we could do, what we should do, differently. And we were very supportive of healthcare reform. Now did we get everything in this law that we were after? Absolutely not! Do I think it is a perfect law? Absolutely not! Do I think it is a great start? Absolutely! We had to start somewhere, and we have to begin to think about how we pay for value in terms of the healthcare that we're paying for, that we're getting.

Let me tell you about a stunning number for me. Let's look at the United States per-person per-year spent for medical care as compared to five other developed countries, including Spain, Sweden, Germany, Japan, the United States, on a by-age basis. In the United States we compare very favorably to those other developed countries from age zero to about age 55. At age 55, our line in the United States starts going up, diverging dramatically from those other countries to the point where when someone reaches 85 years of age in the United States, we spend four times more per person per year for healthcare than those other developed countries. So not only is the crisis a challenge for our Federal Treasury, for our pocket book; it is a challenge and a pending disaster for our ability to compete with other countries.

Finally, I think about healthcare as a public good. Part of the problem with the way our delivery system and our industry has developed has been that we are basically a cottage industry with many, many niche players. All are focused on how I can produce more volume, more units of service, so I can bill, collect, get paid for this. If you're going to solve the healthcare cost issue so that you can provide more health care for more Americans, you have to fundamentally think about how you pay for care differently – what you will incent hospitals and physicians to do, how you will measure their success. We as providers need to think about delivering care very differently and that's what I want to talk about for just a few minutes.
Healthcare law to me is really three parts. First is expanding care to the uninsured, Medicaid expansion or a variation of that that we'll end up doing in Iowa to the uninsured, estimated to be 50 million Americans. Second part is insurance reform. No longer do you get penalized for pre-existing conditions. Lifetime caps are removed. I can cover my children until they're age 26. There's a third part of the law that allows for delivery reform, payment reform, and that's really what we have been focused on. Our other speakers here this afternoon will also talk about this.

What we had been working on is really thinking about where do we spend money, where is the inefficiency, where is the waste? And if you think about a siloed system – hospital over here, physician clinic over here, homecare over here, not talking to one another, not focused with the patient at the center – it is very easy to have a lot of units of service with the left hand not knowing what the right hand is doing, not really focused on what the patient needs. The focus is really much more on what I as a provider need to do in order to bill and collect for the care that I am running.

So we, with our new name UnityPoint Health, have launched a new brand that says we are going to be your care coordinator. We are going to work together to have our physicians, hospitals, and home care all integrated around the patient at the center and focused on what the patient needs. We should get paid on the value that we produce; best clinical outcome, the best patient experience, and at a reasonable affordable cost. Thus patient experience to me is ready access, the delivery system helps the patient navigate, coordinate across these silos. And of course, best clinical outcome is best clinical outcome. Our vision statement at UnityPoint Health is "Best outcome, every patient, every time." It speaks to providing that high quality, but doing it reliably. Cost is another consideration, and we ought to be paid on our ability to manage care, to coordinate care at the lowest cost possible. It has been estimated that waste consumes conservatively 20% of our $2.5 trillion that we spend every year on health care. $2.5 trillion, 20%. That's a half a trillion dollars a year in waste. Some economists argue that that waste factor is more like 30 or 40%.

I believe that value is best clinical outcome, best patient experience. The delivery system providing the care should also get paid when we extract the waste, when we take cost out of the system. So we are working on creating medical homes, surrounding our primary care physicians with resources, mid-level providers that Don talked about, with care coordinating capability, integration of a call center so the patient has 24 hour access and can make next day appointments with their physician, get their prescriptions renewed, integrating home care into the primary care office so home care is available for increased interaction with the patient.

50% of what we spend in the United States is for the management of chronic disease. Chronic disease; 50% of that $2.5 trillion. Managing chronic disease is not rocket science. It is really about compliance with diet, exercise, and medication therapy. If you have a siloed system delivering care, an episodically-based system delivering care, it's unlikely when the patient falls out of compliance that the delivery system is going to know that that has happened.

Part of our care-coordinating focus is to increase the number of interactions that the primary care physician will have with the patient and increase the likelihood that the patient will contact their physician when they are having an emergency, instead of an automatic “I'm going to go to the emergency room because its after 11 o’clock at night and my doctor certainly isn’t in his office or her office.” We have to change the mindset and the focus, increase the reliance on the primary care physician, and increase the opportunity or probability that the physician will have more interaction with their patients, particularly their chronic disease patients. If we do that we will, in my view, lower cost. We will increase the clinical outcome and improve the clinical outcome, which is about average now across the United States, and we’ll make it a much better patient experience. I’ll bet everyone in this room has a story to tell of frustration with the left hand not knowing what the right hand is doing in this delivery system that we have today.

You are getting exactly the incentives and not what you are paying for. If you pay for units of service, you are going to get units of service. We have got to start paying for value. Best outcome for every patient every time. Best value is best outcome, best patient experience. We will reduce the cost if we do those first two things. I'm confident of that. I think I will say one last thing and then I will sit down and let the other speakers talk. For too long in this country we have said that competition should be between insurance companies. I think that competition should be between networks of care. And we’re building a network worth of care. Mercy here in Des Moines and the University are building a network of care. We look forward to competing with them on who can create that best value. That’s the competition. That’s ultimately what will reduce the cost.