Reforming the Healthcare System from the Inside

An Interview with Dr. David Sanders

Healthcare reform requires more than a new model of delivery; it takes a new way of thinking about health and the political will to change our system. In this interview, conducted via phone and email over the course of a month, Dr. David Sanders, founder of HealthOregon, discusses the barriers to efficient and effective medicine and his approach to address these problems.

Dr. Sanders is the Co-Chair of HealthOregon, a public service organization with the mission of developing a modern healthcare system in Oregon that ensures affordable and quality health care for all Oregonians. Dr. Sanders is a graduate of the UCLA School of Medicine. He is a graduate of the University of Michigan—Ann Arbor. Dr. Sanders has served as a physician at the Multnomah County Department of Health. In 1995 Dr. Sanders co-founded Salu, Inc, a venture capital funded provider of Internet e-commerce services for physicians and their patients. In 2000, Dr. Sanders co-founded MyHealthBank, a venture capital funded developer of software systems that enables insurers to provide comprehensive self-service and other automated transactions. He served as CEO through 2002 and on the Board of Directors through 2003. In 2002, Dr. Sanders co-founded HealthOregon.

Jay: David, thanks for agreeing to this interview and giving our readers a chance to understand your proposals for reforming healthcare in Oregon. Since this is our election issue, I must first ask you whether you believe that either presidential candidate's plan offers hope for more affordable and accessible healthcare.

David: I wish it were so, but it's not. The centerpiece of Senator Kerry's plan is to reinsure large health claims incurred by small businesses. That is, he proposes to subsidize health insurance purchased by small businesses. The fundamental flaw with the Kerry plan is not that it commits to a new, large government expenditure, but that it knowingly commits to an expenditure growing three times faster than government revenue and offers no way to control the expenditure. It will be bankrupt before it begins.

Jay: You are referring to the fact that healthcare costs—the costs of doctors, hospitals, drugs, MRIs and the rest—are increasing more than 10 percent per year, more than three times faster than general inflation.

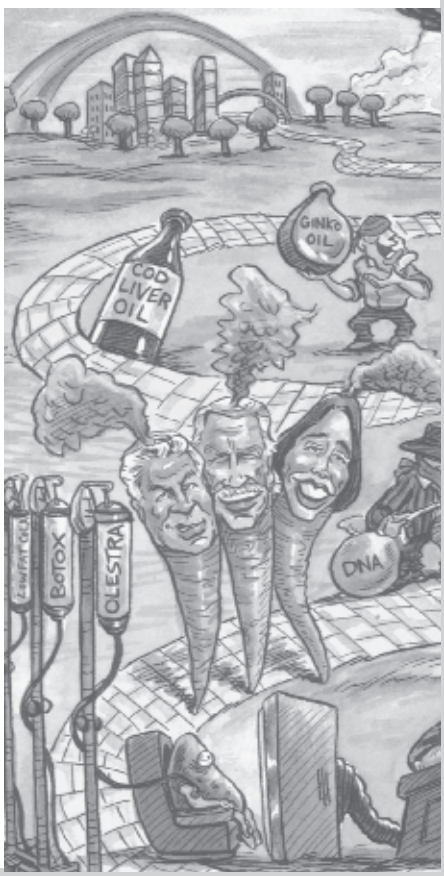
David: That's right.

Jay: Wouldn't Kerry supporters argue that it would reduce the costly practice of cost-shifting, where doctors and hospitals shift the costs of uninsured patients to employers that pay for their employees' health insurance?

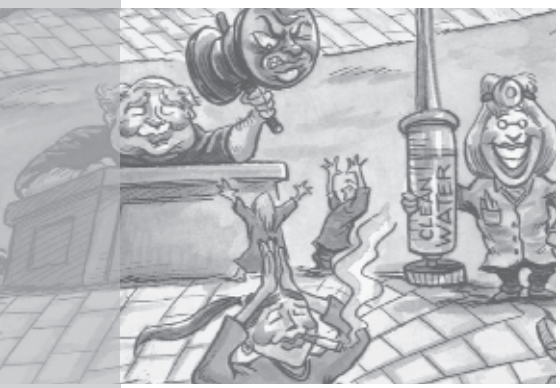
David: They would argue that. That's the problem. They missed the diagnosis. Cost-shifting is a peripheral issue. No amount of new money can keep up with healthcare hyperinflation. If the US economy had the inflation rate of the US healthcare economy, we'd be Brazil in the 1990s. Reducing cost-shifting would generate a one-time savings for health insurance purchasers. But hyperinflation would continue and undermine any one-time savings from reduced cost-shifting.

Jay: And President Bush's plan?

David: The centerpiece of President Bush's plan is the Health Savings Account (HSA), which he argues will make healthcare more affordable by making American health consumers more cost conscious. Like Senator Kerry's plan, President Bush's plan is largely peripheral. One could envision a comprehensive reform strategy that included Health Savings Accounts,



but President Bush has narrowly focused on them. Here's the rub. Ten percent of the population accounts for 90 percent of healthcare's costs. Most of this 10 percent have a small number of common, complex, and costly chronic conditions, such as diabetes, heart disease, asthma, cancers, and severe joint conditions. Their healthcare bills exceed $25,000 per patient annually. Since most Americans are struggling to fund their health insurance let alone their retirement, how will they also set aside tens of thousands of dollars to fund out-of-pocket healthcare costs? At the end of the day, when people are sick they need insurance so insurers will continue to pay nearly all healthcare bills. So empowering consumers is constructive, but it just scratches the surface.



Jay: Is it possible that President Bush and Senator Kerry have accurately taken the public's pulse and recognize that 85 percent of Americans are insured and are simply hoping to hold on to their healthcare insurance rather than risking and enduring comprehensive reform? For example, Oregon voters resoundingly rejected a single payer ballot measure in 2002.

David: I believe you are correct—in the short term.

Look, the media keeps reciting the stories of the collapse of the Oregon Health Plan and the growing number of uninsured. The public yawns. The public will decide for itself when healthcare is a problem. They will decide it is an issue when they can no longer afford it. In other words, change will await healthcare becoming a personal issue, a pocketbook issue, for the middle class. By 2010, mid-

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dle class voters will be forced to make explicit decisions about whether to fund education or healthcare. Consider the impact on access to care. The media keeps reminding us that 500,000 Oregonians are uninsured and another 500,000 go without insurance for part of the year. But what percentage of these Oregonians vote, contribute to campaigns, write letters to editors, and send e-mails to their state representatives? By 2010, the next 1 million Oregonians will personally experience being uninsured for the first time. This middle third of Oregonians won't stand by quietly. When the middle class comes face-to-face with diminishing take-home wages, access to care and valued public services, they will cry "Uncle!"

Jay: So, are you suggesting that we wait till the public cries "Uncle" to address healthcare reform?

David: No, not at all. I am suggesting that we develop a roadmap of specific steps that build toward our goal.

Jay: What goal are you referring to?

David: I am looking at 2014. Here's what I see. All Oregonians have lifetime health insurance. Costs are under control. The quality of healthcare in Oregon is the highest in the world. And, Oregon's economy is the nation's strongest. Established companies are moving to Oregon to take advantage of our superior healthcare value.

Dimensions of Issues

Rajiv Sharma Comments on David Sander's Proposal

Sanders's diagnosis of problems with the Kerry and Bush healthcare plans is pretty much on the money. He does an excellent job of identifying problems with the delivery of healthcare including variability in quality and costs, the importance of transparency, importance of incentives to both consumers and providers to prevent and manage disease, importance of sensitivity to public attitudes, the need for reorganization of healthcare delivery to take advantage of information technology, and the essential commitment to a shared system required for universal coverage. He also makes the crucial and useful point that money for universal coverage or for additional care must always come from our own pockets.

There is some hyperbole in his statements—such as the comparison of the US healthcare system with Brazilian hyperinflation. His proposal for fee-for-condition payments is worth exploring and fine-tuning in pilot programs. If they do live up to their promise, we should roll them out more widely or incorporate features that work into current systems. The US healthcare system remains a work in progress, and we need additional information to proceed in the best direction. Of course the devil is in the details. In Sanders's program how are specific conditions defined, risk-adjusted, and paid for? Even within groups of patients with the same conditions, the majority of costs are incurred by a small percentage of people.

Therefore, there is a major possibility that payment for conditions will cause providers to seek out subgroups within

conditions who have relatively low costs. Fee-for-condition payments actually already exist for an important subgroup in the US healthcare system. Since 1984, Medicare has paid hospitals on the basis of patients' diagnosis-related groups (conditions in Sanders's terminology), rather than on the basis of procedures and tests carried out. The introduction of this system did slow down hospital spending in the 1980's, but growth has since resumed. *(See DRG in the glossary —Ed)*

David Sanders Responds

Proffessor Sharma correctly points to Medicare DRGs as an instructive reference point for the fee-for-condition concept. I believe that Sharma would also concur that the Medicare DRG has been regarded on the whole as successful and has been and is being adopted by most nations. Sharma is also correct in suggesting that DRGs have shortcomings. Medicare and policy activists have been trying to fix these shortcomings but faced political challenges. Shortcomings and solutions have been well described in the literature. Basically, our proposal builds off the DRG but aims to fix the shortcomings based on the 20 years of experience we've had with them. For example, DRGs exclude physicians, they are site specific, and they too often presuppose a specific treatment rather than allowing the provider to make a treatment decision. Also, importantly, any of the three pillars in isolation cannot be effective. DRGs prices have been set by the government (and lobbyists), but there has been little usable transparency and no rational consumer incentive policy. My main point is that Sharma is correct and really kicks off an important discussion that we need to have to help our community flesh out the issue.

Oregon has become an entrepreneurial haven: innovators, freed of the health insurance job lock, are building new companies at a rate surpassing the Silicon Valley.

Jay: Is this realistic?

David: I believe it is. But our roadmap must be keenly sensitive to public attitudes and differentiate between changes the public will accept now and those it will accept over time as healthcare becomes less affordable.

My premise is that it is fruitless to fund expanded access to care if the cost of that care is hyper-inflating.

Jay: Give me an example of a change the public will accept now.

David: A rare consensus has been reached in our community. Even those leaders who publicly oppose it have privately accepted it. It goes like this: We are all better off if health consumers have some skin in the game so that they become more cost and quality conscious. This was heresy a few years ago. Employees equated the cost of healthcare with their nominal co-pay. This bubble has burst for many and will soon burst for all.

Jay: I thought you criticized President Bush's plan for overly relying on consumer financial incentives.

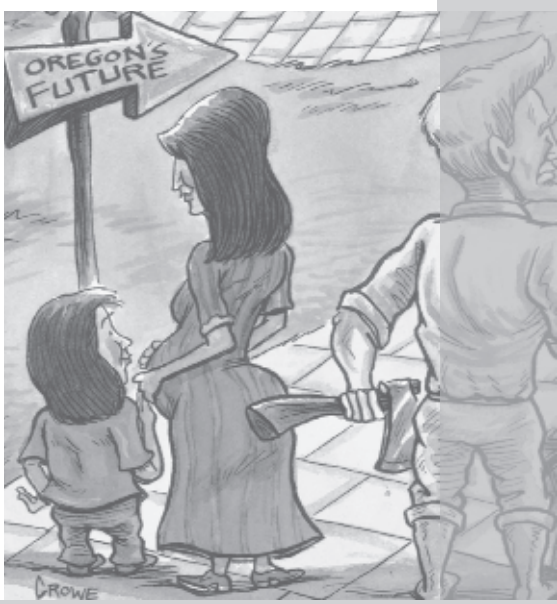
David: That's right. Establishing the right role for the consumer is merely the first step toward reform and this is well underway.

Jay: What's the next step?

David: The next step is also underway, but it lags behind the evolution of the health consumer. There is an emerging consensus in our community that goes like this: We are all better off if those who pay for and receive healthcare know the prices and performance of the providers of healthcare—transparency. I say emerging because some important providers of healthcare have not embraced it. The consensus is being driven by the realization that consumer empowerment without transparency is a sham, but also by the community's growing appreciation for the extent of medical errors and variations in provider cost and quality. Though it will face withering opposition, the intellectual justification and moral authority for transparency make it inevitable.

Jay: So you are painting a picture of empowered consumers with information about the price and performance of their physicians. But, again, you criticized President Bush's plan because ultimately, the vast majority of healthcare bills will be paid for by the insurer rather than by the consumer.

David: My premise is that it is fruitless to fund expanded access to care if the cost of that care is hyper-inflating. We should debate how to fund universal access once costs are stable. Cost and quality of care is the product of healthcare professionals, hospitals,



pharmaceutical companies and other providers. Our community is now rightfully focusing its attention on the delivery of care itself. Further, I have suggested that we are developing a consensus around two pillars of a modern healthcare delivery system: consumer empowerment and transparency. But for our community to succeed we must adopt a third pillar: to pay providers for preventing, diagnosing and treating conditions, rather than for performing individual tasks. We call this **fee-for-condition** provider payment. Today, we are far from consensus on this pillar, but it will come.

Jay: You want realignment of the incentives that govern provider and consumer behavior. But how critical is this third pillar; what you call fee-for-condition? Won't greater transparency go a long way toward decreasing medical errors, which should reduce costs? To use a well-known example, the auto industry goes to great lengths to minimize errors to reduce the costs of rework.

David: Auto companies minimize errors because they cannot pass the costs of rework to car buyers. In addition, by investing to improve all aspects of efficiency, not just avoiding rework, they minimize their costs and maximize their profits. *Doctors and hospitals face the opposite incentive.* In healthcare, all tasks provided by doctors and hospitals are billable, whether due to disease or human error, prudent or imprudent decisions, well organized or poorly organized systems of care. If we paid car companies like we pay doctors and hospitals we would pay them for running their factories regardless of the result. Cars would roll off the line without wheels and doors.

Jay: Don't some of the proposals to reduce medical errors include paying doctors to install electronic medical records and for following evidence-based practices? Wouldn't this change the incentives adequately?

In healthcare, all tasks provided by doctors and hospitals are billable, whether due to disease or human error, prudent or imprudent decisions, well organized or poorly organized systems of care.

David: No, paying doctors bonuses for specific activities will not adequately change the incentives. As the quality guru, Dr. Donald Berwick, was quoted as saying last week in the *New York Times*, "We could get the same or better results with half the money, but the flows of money do not allow you to find the waste and reinvest it." In fact, these bonuses will simply reward sheep-like behavior and superimpose new costs on a broken system, rather than stimulate physicians and hospitals to zealously, creatively root out inefficiencies and pursue innovations that maximize results. Only when we pay providers for caring for conditions will they be fully accountable for the cost and quality, and generate the results Dr. Berwick suggests are possible. *(New York Times August 11, 2004 "Health Plan That Cuts Costs Raises Doctors' Ire," Gina Kolata —Ed)*

Jay: So, you are suggesting that empowered consumers, transparency, and fee-for-condition are the policy pillars of a modern healthcare delivery system.

David: Yes.

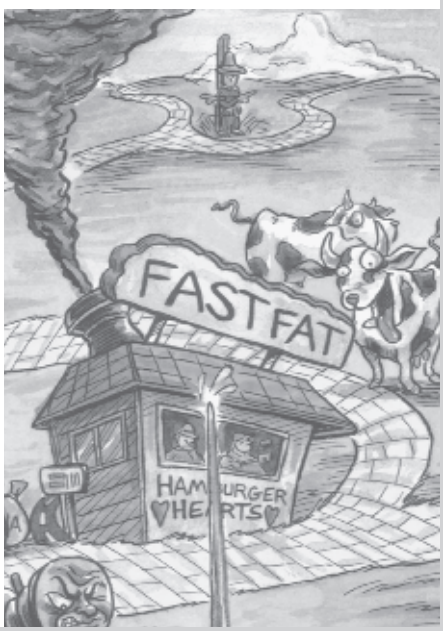
Jay: Help me understand how providers will respond to these incentives.

David: They will respond as they always have in the past to evolving incentives. They will organize themselves to best serve their patients and to maximize their financial returns. Current incentives reward providers for delivering more care and more expensive care, not necessarily for the best care or for the most efficient care. By focusing payment and measurement on what patients care about most, providers will organize to do those things that will lead to demonstrably better results at far lower costs.

Providers will place a greater emphasis on medical evidence to guide clinical decision-making, particularly regarding technology utilization. Expensive new technologies will be scrutinized for their impact on costs and quality. Providers will no longer be able to simply bill for technologies. They will bill for conditions. If a technology improves quality or reduces costs it will be adopted.

Providers will organize into care teams so that the most effective and efficient resource is allocated to the right role. The idea is that healthcare will no longer be delivered by individuals rewarded financially for producing more visits, procedures, and surgeries.

Providers also will have the incentive to invest in information technologies to share information among themselves and with patients. Today, information technology is used primarily to manage



Mercer Human Resources Survey

Skyrocketing healthcare costs and premiums are clearly hurting our economy. Many businesses are struggling to provide healthcare, but the cost is prohibitive. One remedy is to pass more costs on to workers in the form of higher premiums, co-pays and deductibles. [mh1]

In a Mercer Human Resources survey, 42% of Oregon employers surveyed said they would increase the percentage of premium/plan cost contributed by employees and 38% said they would implement cost-sharing provisions such as deductibles, co-pays/co-insurances and out-of-pocket maximums (*Mercer Human Resources, National Survey of Employer-Sponsored Health Plans 2003*). Employee healthcare coverage is becoming a bigger and more contentious fight in union contract negotiations across the county. The recent California grocery workers strike largely centered on healthcare. In Oregon, healthcare has been the center of contract negotiations for workers at Powell's Books, Smuckers' Jam, among Portland teachers, Jackson County public employees, and many others.

Maribeth Healey, Oregonians for Health Security

(Maribeth Healey is working on an article which will discuss how states are the best incubators for solving problems of the uninsured —Ed)

scheduling and billing. There will also be a renewed focus on prevention through proactive intervention and continuous communication.

For common, costly, complex conditions, providers will organize and market themselves to maximize volume and experience necessary for economies of scale with specialized services.

Jay: What would this mean for, say, someone with diabetes?

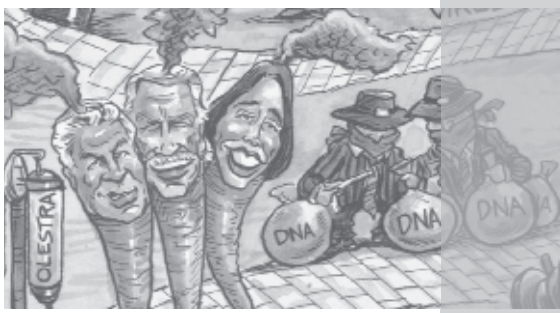
David: The patient or her family would be able to review physicians and provider organizations which care for diabetes based upon their historical results at controlling diabetes. If she has coinsurance (pays a portion of the bill) she would also want to know how much each provider will charge per month for caring for her diabetes. Makes sense, doesn't it? But, it's impossible today. Even more importantly, once she has selected her provider, she will notice a big difference. Her provider will do best financially when her diabetes is well controlled and when she is an active participant in her own care. This will positively ripple through every aspect of her care. She will be delighted!

Jay: Can you point to any example of where this is already happening?

David: I can tell you that we are working with insurance companies, physicians and other healthcare professionals, hospital systems, and employers across the state to pilot and develop fee-for-condition. We are finding that there is a high degree of interest in validating the approach. Over the next 24 months we will develop more tangible experience for the public to evaluate.

Jay: So how does all this help the uninsured, low-income families with Medicaid (Oregon Health Plan), and seniors with Medicare?

David: My main point has been that the foundation for a modern healthcare system consists of a set of incentives that reward patients for demanding ever greater quality at affordable prices, and reward providers for continuously improving quality and reducing costs. The opposite incentive exists today. So, without this foundation, expanding access will unfortunately prove unsustainable.



Jay: OK. Once the incentives are properly aligned, then what? Can we get to a day when all Oregonians have lifetime access to essential healthcare?

David: I believe so. What we know is that numerous nations have achieved near universal access to healthcare, at a lower per person cost, and with comparable or superior health status to the United States. Some of us may cite aspects of care here in Oregon that we prefer to what's available in these nations, but in terms of access, costs and health, it's difficult to dispute our shortcomings. But here's the telling part. These nations have widely divergent healthcare systems: government run with private delivery systems (e.g. single payer in Canada, Taiwan and France), government run insurance with government run providers (England's National Health Service), blended private and government insurance systems with private and public providers (Switzerland and Japan). My point is that though we have tended to equate universal care with single payer systems, there are many models and

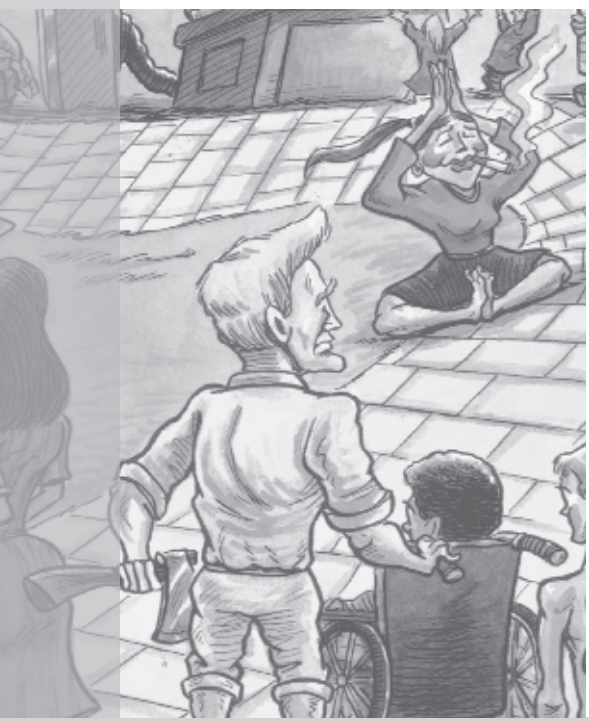
we should develop one that is culturally acceptable to us. The barrier is to commit to universal care.

Jay: Pretty big barrier.

David: As we said at the beginning of our discussion, it can only happen when the public cries "Uncle!"

Jay: Is there anything else we can learn from nations with universal healthcare?

David: Yes. There cannot be one system for the underclass funded by the middle class and another system for the middle class funded by the middle class. When times get tough, the middle class cannot afford or believes it cannot afford to pay for healthcare for others and will reject requests to pay more. In fact, we've proven that in Oregon, too. Despite over a decade of effort, we failed to build an effective separate system for the sick and unemployed and those struggling with poverty—known as the Oregon Health Plan. The failure of the Oregon Health Plan demonstrates that maintaining a parallel healthcare system for the poor is unsustainable.



Jay: Are you suggesting that we must all have the same insurance? I'm not sure that will fly in Oregon.

David: No. But it does mean we must all make a contribution to a shared system that ensures our access to essential healthcare. It need not restrict our choices but it must limit how far we can fall in tough times.

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Jay: But where would the money come from for a system that ensures access to healthcare for all Oregonians.

David: Money will come from where it always comes from, from the only place it can come from—individual Oregonians. At the end of the day, individuals would need to agree to purchase health insurance (as in the case of auto insurance), pay an earmarked tax for health insurance, or agree to have their employer deduct money wages to fund their health insurance.

Jay: So you are pointing to the fact that people act as if their health insurance is free but they really are paying in lieu of higher wages?

David: Yes, ultimately employees pay. Consider where the money would come from if we compelled employers to purchase insurance or contribute funds to pay for it. There are only three options: from reduced profits, from price increases, or from employee money wages. Let's assume that most employers cannot afford to reduce their profits. Some may be able to gradually transmit insurance costs into

Healthcare Economics 101: Demystifying Healthcare Costs

In response to our interview with Dr. Sanders several commentators observed that we already know how to control costs from Kaiser or any number of universal healthcare systems. This is basically true. Healthcare costs are determined by four variables. Any healthcare system that aims to control healthcare costs must address one or more of these four variables.

Determinants of Healthcare Costs

1) **Covered Benefits** (what's paid for)
2) **Utilization** (the amount of care people seek)
3) **Prices** (the prices of doctors, hospitals, drugs, etc)
4) **Administration** (such as the cost of processing claims)

Here's how some well known systems control costs.

- **Canada's Medicare (single payer).** Controls provider fees: Sets annual global budgets for hospitals and applies consolidated bargaining power to negotiate physician fees and drug prices. (This is why Americans want to import drugs from Canada.) Administrative costs are also reduced due to simplified administrative requirement of single payer.
- **England's National Health Service (government operated delivery system).** Controls provider fees by employing healthcare professionals and operating state-owned hospitals.
- **Oregon Health Plan (Medicaid, a government insurer).** Proposed to reduce covered benefits through evidence-based rationing and to channel patients into managed care. In reality, covered benefits remained extensive with little impact on cost. Managed care companies pulled out due to low

reimbursement or shut their doors. The Oregon Health Plan ended up controlling costs by setting provider fees at least 40 percent lower than market rates.

- **Kaiser (pre-paid group practice —an insurer operating its own clinics and hospitals).** Controls provider costs by paying salaries rather than per visit and procedure. Reduces utilization costs by emphasizing prevention and coordination with information systems and other methods.
- **BlueCross BlueShield (traditional private insurer).** Private insurers primarily control costs by limiting the services they cover, by sharing the costs with patients, which reduces utilization, and negotiating for price discounts.

- **US Healthcare (managed care company, now owned by Aetna)**. Managed care companies aimed to control costs primarily by reducing utilization of specialists through gatekeepers and requiring prior authorization of expensive services. Managed care companies have abandoned these practices and adopted the practices of traditional private insurers.

While this hopefully demystifies a bit the nature of healthcare's costs, it also points to the conundrum. Admittedly, it is hard to imagine US physicians becoming government employees or US hospitals submitting to government set annual budgets. However the current cost control methods of US health insurers do not seem sustainable. A more rational set of incentives for providers and consumers may be more culturally palatable than a single payer system managed by government. A set of rational incentives would seem to reward adoption of known best practices such as those observed at Kaiser, including emphasis on prevention, coordination, and greater use of information systems.

prices. But most employers would, as they do now, primarily pay for health insurance by reducing employee money wages.

Jay: Now, many people will suggest that the level of reform you propose will await federal reform.

David: The federal government will continue to nibble on the edges of reform as typified by recent legislation: the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the so-called Medicare Modernization Act of 2003. Arguably, these steps tend to worsen rather than improve our predicament. Meaningful federal reform will await state demonstration of feasibility, acceptability, and efficacy. Examples of this trend are the California Health Insurance Act of 2003, Maine's Dirigo Health Reform Act of 2003, and Massachusetts' attempt to pass a constitutional amendment to ensure access to essential healthcare.

Jay: So, today, you have suggested that though our healthcare system seems to be headed in the wrong direction, it may be quietly transforming itself. It sounds like you believe that within in the next five to ten years our community will have the opportunity to make some critical decisions about how we deliver and finance healthcare that could transform our healthcare system.

David: Yes. I see it happening. I am hopeful for the result.