Cure for ailing systems: Quality, not quantity

Blogger, speaker and oft-quoted healthcare observer Bob Laszewski has been discussing the United States’ fractured system for a while. So long, in fact, that the former insurance executive can recall when the basic unit of financial distress was merely billions, not trillions.

American healthcare’s fee-for-service payment model, universally dismissed as irreparably broken, is deteriorating rapidly and threatening to sink the entire American economy along with it. That in itself isn’t news. But Laszewski notes that rather than sounding a vague alarm about the future the bipartisan Congressional Budget Office is now predicting that 2022 will be the year the tsunami arrives. At that point, the nation’s combined spending for healthcare entitlements, Social Security, defense spending, and interest on the debt equal its total revenue, and that’s no small matter, he says.

“When the national debt is equal to the worth of our country that’s not an insignificant line we crossed.”

The president of the Virginia-based Health Policy & Strategy Associates, Laszewski nevertheless believes that, “if you survived the last 15 years you can make it through the next 15.” He spoke before an Austin, Texas, audience composed of payers and providers from around the nation reassuring them that “you still have time to get it right.”

Laszewski described the influence of the Affordable Care Act as game-changing on many levels. Among other things the ACA introduces new layers of competitive complexity to the marketplace. Take the debut of individual choice as a significant factor in the purchase of health insurance. With the advent of the health insurance exchanges and underwriting reform, the availability of extensive coverage is no longer limited to the employees of large companies. “The customer will come through the door in ways we wouldn’t have thought possible before,” Laszewski said.

Laszewski hastened to add that the market was in flux long before the ACA took effect. “Did you ever expect you’d be in the Medicaid business?” Laszewski asked the group gathered at the second annual Healthcare Mandate Summit.

Launching his talk with a bracing, grim view of the gridlocked United States’ budget, Laszewski offered a “what if” analysis of various cost-cutting options. He listed possible savings from the three central funding categories of mandatory (Medicare), discretionary (Department of Defense, National Institutes of Health) and tax cuts (on the wealthiest Americans and/or through the elimination of mortgage deductions). The numbers just aren’t here, Laszewski maintained. Even if every single expense cut or tax adjustment took place the total would still fall far short of 2020’s projected $1.2 trillion debt.

By any calculation the way we’re paying for healthcare in the United States is “simply not sustainable.”

To be fair, the healthcare system has made movement toward effort at containing costs, but unfortunately, the results weren’t encouraging. One large study examined pay-for-performance and another tracked the rate of hospital-acquired infections when fees were reduced as penalty. Both studies encompassed hundreds of hospitals over a number of years. And both produced lackluster findings. One showed little change with regard to poor performers, the other found minimal positive news in the area of outcomes improvement generally.
Providers weren’t convinced the methodology or data used in the studies were credible and didn’t take them seriously. Providers have to have skin in the game, Laszewski asserts. “Without a downside to inefficient care we’re simply not going to reduce delivery costs.”

It’s encouraging to see physicians take up the sword, Laszewski says. He elaborated on recent positions by the American Medical Association calling for patient-centered medical homes, outcomes measurement and accountable care organizations. The AMA has voiced support for new payment models that offer physicians opportunities and allow them to lead changes in healthcare delivery systems while improving the quality of patient care and lowering costs.

The accountable care organization is gaining ground fast as providers and hospitals try to gain leverage on payers, Laszewski said. But he cautioned against naive optimism. “Remember, we have seen this movie before … HMOs, PHOs. Here we go again. They were all variations on a theme. But it’s different this time. It is an entirely different environment than we have experienced before.”

Failures of the past were largely the consequences of insufficient information of poor quality. “People need good data and they need to know how to manage it, to turn the dials and manipulate it so we can contain these things.”

One audience member asked whether the pharmaceutical companies weren’t wildly inflating costs by continuing to lucratively market brand-name drugs directly to consumers. Laszewski disagreed. “The use of generic drugs has exploded over the past few years ... if I look at the macro data in this country pharmacy is under control.”

As for designer medications with high price tags, Laszewski said they more accurately belong in the category of medical technology, a well-documented factor in runaway costs. “Our system is remarkable because it offers the incentive to develop rising technology. The problem remains, “how do we know what actually works, and what doesn’t work. We can’t afford to just continue paying for everything indiscriminately.”

Another speaker commented that poor lifestyle choices and disease management remain unaddressed and catastrophically expensive. “How do we change patient behavior?”

“People have to take care of themselves,” Laszewski acknowledged. “There is a healthcare crisis that is intertwined with but somewhat separate from the problem of payment.”

Practically speaking, "we are going to have to preserve the old system in some ways, while we're making a new system.”

Laszewski expressed confidence about where much of the momentum for change lay. “If you can’t figure out how to build new algorithms and new payment systems while dealing with clinical information and getting ICD-10 up and running we’re not going anywhere.”

However, there is simply no alternative to achieving those ends, Laszewski said. “The work you do is vitally important. Washington, DC, isn’t going to fix this problem. You are.”

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