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IDEAS FOR SHARED PROSPERITY

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MAINE IS BURNING
Soaring Healthcare Costs Fuel the Fire

By Dr. Erik Steele

It's an honor to be speaking to you today and I'm grateful for the opportunity to do so.

Before I start I want to clarify that I am not representing the members of Eastern Maine Healthcare Systems in my comments, and the opinions expressed today are my own.

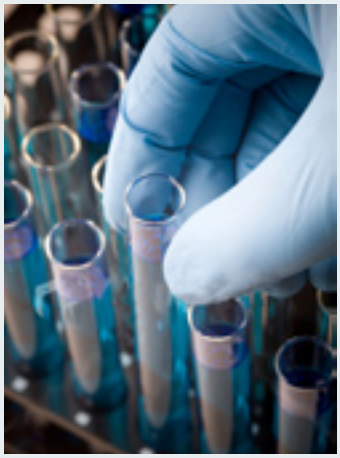
As I thought about this topic of healthcare costs containment and what to say to folks like yourselves who are passionate about the idea of providing better health care in Maine, one clear question came to my mind: What can I say that will make one darn bit of difference in what you are going to do about these issues tomorrow?

After some careful consideration, I am optimistic that I have at least some answers to the problems surrounding spiraling healthcare costs. I am going to assume you have most of the information about the detrimental impact healthcare costs are having on Maine's economy. You also do not need to be convinced that sustaining the current rate of healthcare cost increases in Maine spells disaster.

In making the case for change, I want you to consider just a few crucial facts to set the stage. First, in ten years, at the current rate of cost increases, by some estimates the average American family will be spending almost half of its income on healthcare.

Second, the passing of higher healthcare costs onto the public in the form of higher taxes, lower salary increases and higher prices is the principle reason the inflation-adjusted wages of the average American employed in the private sector have not increased over the past thirty years.

These two factors- half of average income will be devoted to health care costs within 10 years and stagnant wage increases over the past 30 years, will inevitably combine to produce a demand from members of the public for significant change.



Containing health care costs is critical to Maine's future economy. This is an edited version of a speech given by Dr. Erik Steele, Chief Medical Officer at Eastern Maine Health Systems, to a forum sponsored by Maine Health Management Coalition and Anthem Maine in October 2008.

Maine is one of the most expensive places in the United States and in the world to insure an employee and that is a recipe for economic disaster. In Maine we are going to flatten this healthcare cost curve or it is going to flatten us, and progressively marginalize Maine in a national and world economy. Without significant change, I predict that in ten years Maine will be America's Third World, an economic mud flat full of the old and the poor with an economy based in healthcare and government services, and tourism, and little else.

Who among you believes that if healthcare costs continue to rise at their current rates in the near term that we will still have major corporations that chose to be based in Maine, that small businesses can continue to thrive or that our children will chose to continue to live here? Most importantly, we know that unaffordable healthcare causes premature death and widespread misery. To force that affliction on more than half of our population is unconscionable.

Given the disastrous implications of unaffordable healthcare for half of our population, it is clear that the gun is against our heads. We are going to fix our part of this problem or disaster awaits.

The crisis is creating the opportunity

I now would like to focus my remarks on what we can do here in Maine to flatten our piece of the healthcare cost curve. First, what are we going to do to flatten cost in just the next five years? We cannot wait for the benefits of better population health that will arrive ten years from now. Better disease management and improved population health will produce healthier Mainers, but those healthier people will all be moving elsewhere for jobs if we do not rein in near term costs of healthcare.

We are justifiably putting tremendous effort and resources into improving population health and chronic disease management but we don't put nearly the same degree of effort into healthcare cost containment. I challenge you to start looking at all new healthcare initiatives through the prism of what effects those initiatives will have on overall healthcare costs over the next five years. I am suggesting that we must begin to prioritize the initiatives with the greatest short term cost benefit.

Second, short term cost control cannot be achieved without a significant effort to reduce utilization of medical services that are of marginal value. That initiative must be paired with an exclusive focus on the rapid implementation of evidence-based treatments that have been shown to be cost effective and appropriate. The work of Dr. John Wennberg, has shown that, in general, the more healthcare we get the less well we do, and as much as 40% of the healthcare we get produces little incremental health benefit.[1]

As a case in point, the prevention of unnecessary blood transfusions can save millions of dollars for hospitals and payers, save some patient lives and prevent some patient harm, has a strong evidence base, and has been done right here in Maine. EMMC has recently implemented a program which developed evidence-based guidelines for the transfusion of blood products. This program has reduced transfusions by more than 40% of units of blood a year thereby saving the hospital almost $1 million annually in blood acquisition costs. The estimated cost savings translate to more than $4 million annually to the hospital, payers, and patients. For most hospital patients, avoiding unnecessary transfusions reduces length of stay, the risk of serious infection, the risk of death in the hospital, and the risk of death in the next five years. The basic tenets of this program could be applied statewide to significantly reduce healthcare costs while improving overall patient health.

"If anything has changed in Maine in the last few years it is that the desperation needle on the healthcare cost meter has been driven into the red zone. In Maine, we are going to flatten this healthcare cost curve or it is going to flatten us."

There are many more similar cost saving opportunities. We know that the use of aggressive medical therapy, the implementation of evidence-based protocols, the use of minimally invasive approaches to several common surgical procedures and the use of electronic medical records with computerized provider order entry all substantially reduce the risk of complications, hospital length of stay, lost time from work, and overall costs.

We desperately need a healthcare system in Maine that can rapidly implement these types of cost savings and to ask how these types of changes can be accomplished.

What we can do over the next five years

First, the larger healthcare insurers such as Anthem, Cigna, Aetna and Harvard Pilgrim need to rapidly develop a payment system in which providers become responsible for keeping spending within a global budget for covered lives. This type of capitated reimbursement system is probably the only way that providers are going to get out of the game of chasing volume in order to survive, and get systematically into the game of controlling costs for the benefit of patients and hospitals alike. A significant change in the healthcare reimbursement system is quite feasible when one considers the degree of consolidation and collaboration

that already exists in Maine's healthcare system that would facilitate this type of change. For example:

- Maine has a small number of major healthcare insurers;
- Half of the hospitals in Maine belong to the four largest healthcare delivery systems;
- Employers representing almost half the employer-insured workers are part of the Maine Health Management Coalition, working to improve quality and control costs;
- Maine's hospitals are desperately looking for ways to control their own skyrocketing employee healthcare costs, and will not be able to find a model for doing so – other than shifting costs to employees – unless they also find a model that works for their customers.

In other words, you do not have to change a lot of leadership minds in Maine to achieve dramatic change. Desperate people do desperate things, and if anything has changed in Maine in the last few years, it is that the desperation needle on the healthcare cost meter has been driven into the red zone.

As a second step, I am suggesting that instead of trying to reduce demand for all healthcare services, focus instead on cutting the demand for services of marginal value. Those services must be identified, providers and patients must be educated about them, and then we must collectively pursue elimination of those marginal services unless the patient wants to pay for them. Similarly, improve the healthcare process to facilitate the provision of truly necessary and valued care thereby avoiding a long and unnecessary process of substantiation for proven and efficacious medical procedures.

Third, we have to stop paying for unnecessary medical care. We should publish the consensus guidelines for necessary care and then stop paying for things that do not meet the guidelines. Not paying for this kind of care will impose a powerful disincentive to ordering unnecessary tests and procedures. Finally, establishing mandatory non-payment for unnecessary care enables hospitals to institutionalize a practice of reducing costs which will have the dual effect of improving overall patient health and improving hospital efficiency.

A necessary fourth step is to ensure that hospitals and doctors be provided malpractice protection from getting sued when they follow evidence-based practice because it will often result in not doing unnecessary testing or procedures. The current system propagates a practice whereby not ordering a test leaves a provider in the position of exposure if the patient develops a problem the test might have found, even when there is evidence that on a population basis the test does not improve outcomes.

As a fifth step, it is crucial that patients be responsible for some sort of co-payment, scaled to ability to pay. A patient who wants to order a test and has no incentive not to have the test is a potential adversary, and may have no investment in discussion of alternatives. Co-payment should be highest for care of marginal value, and there should be no co-payment for preventive care of greatest value.

Six, we need to support the decisions made by a physician in the examining room regarding the denial of unnecessary care and services. The burden of patient dissatisfaction with being told "No" must be shared outside the examination room. If providers are not insulated from this potential source of patient dissatisfaction, providers will be reluctant to stand alone in denying patients.

As a seventh and most important final step, Maine must have an organizational home and structure to support and develop this initiative. Because of their size, financial clout and level of employer involvement, the Maine Health Management Coalition and the Maine Quality Forum have the capability to develop and implement the standards for necessary care.

A huge reduction in healthcare of marginal value will certainly cause disruption in healthcare organizations. A great deal of the unnecessary care we would stop doing can be replaced by the necessary care we should be doing but are not, thereby freeing up resources for the growing healthcare needs of our aging population.

Recommendations

1. Healthcare insurers should develop a payment system in which providers are responsible for keeping spending within a global budget.
2. Instead of reducing demand for *all* healthcare services, focus on cutting the demand for services of marginal value.
3. Stop paying for unnecessary medical care by developing consensus guidelines for necessary care.
4. Ensure hospitals and doctors are provided malpractice protection when they follow evidence-based practice.
5. Patients should be responsible for higher co-payments for care of marginal value and there should be *no* co-payment for preventive care of greatest value.
6. Support the decisions made by a physician in the examining room regarding the denial of unnecessary care and services.
7. Maine needs an organizational home and structure to support and develop this initiative.

Definitions

Evidence-based practice: clinical medical interventions that follow an accepted treatment plan based on research that has determined the effectiveness of the treatment.

Computerized provider order entry: prescriptions for drugs and orders for diagnostic tests that are entered directly by a physician or other provider into a hospital data system.

Capitated reimbursement system: A system of payment for medical services which gives a group of providers or hospitals a set fee for taking care of a group of patients, regardless of what kinds or quantity of treatments or visits are delivered.

Consensus guidelines: Descriptions of appropriate treatment plans for particular symptoms, conditions, or illnesses that have been designated by a recognized professional body to be the most effective treatment approach.

It's time to start doing things we would not have been willing to do previously and embrace the necessity of significant change. I challenge all of you when you walk out of here today to consider several ideas that you have been unwilling to consider previously.

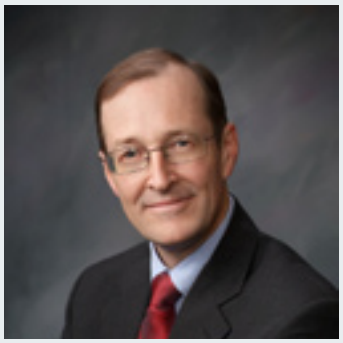
Gaining control of healthcare costs in the next five years has to be our absolute priority. Achieving control of those costs is possible by implementing a program aimed at widespread reductions in unnecessary care, and investing some of what we save back into the retooling of our healthcare system.

This is extremely difficult work but I refuse to believe that we cannot get this done before Maine's economy burns to the waterline. It is unacceptable that patients suffer for lack of appropriate care because we are wasting so much money on care we do not need. If it is unacceptable to you as well, if we each find what's necessary to give up to get what we all want, none of what we need to do is impossible to achieve.

And remember, the gun is to our heads, and failure is not an option.

Endnotes

1 See for example summaries of the work of the Dartmouth Atlas of Health Care and the Institute for Heath Policy and Clinical Medicine at http://dms.dartmouth.edu/faculty/facultydb/view.php?uid=75



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