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What Must Be Done

By Joe Flower

Cheaper medicine means better medicine. Make your organization efficient.

Joe Flower

OK, let's do a little arithmetic: Using Medicare data, compare the parts of the country that spend the most on health care (like New York and Massachusetts) with those that spend the least (like Minnesota). Compare per medical condition—how much a cholecystectomy costs, or a mitral valve replacement, or a diabetes program—including everything that goes with it: visits to specialists, MRIs, prescriptions. Compare outcomes so you can see whether buying more health care "stuff" gets you better outcomes (more people cured, less disability, fewer deaths). Discover the astonishing answer: No.

Look at the difference in costs: 60 percent between the highest cost areas and the lowest cost areas. Conclusion of study: If everyone practiced medicine the way they do in the lowest-cost areas of the United States, Medicare medicine would cost 30 percent less.

The Money We Could Save

If you have been following along in the choir here, you know that I am talking about a series of actual studies, most of them by the physicians and economists of the Dartmouth group. This particular one was published in *Health Affairs* in 2002.

Now let's extrapolate that a bit. Let's assume that it is not reasonable to think that doctors are more lavish for the same condition with Medicare patients than with others. So it's reasonable to assume that the variation applies to all of health care: We could do health care in the United States with no loss in quality for 30 percent less. In fact, we could do it with higher quality: All those extra procedures have a risk. Elliot Fisher, M.D., of the Dartmouth Group, has estimated that they kill 30,000 patients a year.

So we waste 30 percent of the U.S. health care dollar. How much is that 30 percent? CMS projects that we will spend $2.4 trillion on health care in the United States in 2008; 30 percent of that is $720 billion. What if we could do all of our health care as inexpensively as we do it in the lowest-cost areas, such as Minnesota? Could we afford health care for everyone in the United States with that money? That wasted $720 billion is more than seven times what we would need. In fact, with the money we waste, we could fund the entire health budget of Japan. Plus Germany.

Or we could go the other way: We could fund the entire health budget of Russia. Plus India. Plus the entire Middle East. Plus Eastern Europe. Plus Scandinavia. Plus all of Africa. Plus all of Latin America and most of Asia. In fact, for the amount of money that we throw away on unneeded and unhelpful medical care, we could fund every country on the planet—except for the other top 10 spenders.

But we can take this even further: These studies compare only the most and least expensive areas in the United States, doing medicine the ordinary way that we do it now. They do not imagine what health care could be like if we really found out what was the best, fastest, least expensive way to do every part of it. And almost nothing in health care has been studied to find that out—unlike, say, producing cars or growing soybeans or bringing packages to your door.

If we could deliver health care for 30 percent less without doing such intense work, it is easy to imagine that with such work and reorganization we could deliver high-quality health care for 50 percent less.

Why Now?

But health care has always been inefficient. What is so different now?

Two words: “data transparency.”

When we’re buying a hot dog, getting the car serviced, going out to dinner—any time we make a “buy” decision—we always ask the value question: “How good is it, and how much does it cost?” We have never been able to ask the value question until now in health care. Medicine has been thought too complex to evaluate, and the ways in which we choose it and pay for it have obscured the relationship between payment and outcomes.

The new data-driven world changes that. It is now possible to discover just what it costs to deal with common medical conditions, what are the consensus parts of the process, and how good particular medical teams are at performing them.

We are rapidly moving into an era in which our customers (i.e., patients, referring physicians, health plans, employers, government regulators, voters) will routinely demand such information, and will shift their business to the organization that can give them the best answers—whether it be another facility across town, a Wal-Mart nurse-in-a-box, a specialty center elsewhere in the country, or an organization somewhere in South Asia. Those who thrive will be those who are better faster cheaper, and can show it. Those who cannot will have a hard time surviving at all.

What Must Be Done

The emerging conditions of a data-intensive, customer-centric health care world of real choice and real competition drive a number of clear, on-the-ground imperatives for all health care providers. Here’s a checklist:

Digitize. We have to be more aggressive about digitizing health care, not only PACS and EMRs, but everything.

Query. Make sure that, as far as possible, every data system in your organization tracks its actions in ways that can be monitored and queried.

Automate. Wherever possible, follow the path of airlines with their human-free ticketing systems, and banks with their ATMs. Removing humans as much as possible from every transaction and handoff eventually reduces transaction costs enormously, and greatly reduces the opportunities for mistakes.

Measure. Measure everything, even things resistant to digitization, such as wait times, transport times, hand washing, patients redirected from the emergency room.

Lean down. Involve everyone in the organization in “lean manufacturing” work to uncover inefficiencies, free up resources and eliminate opportunities for error. Have them do it on everything, from security procedures to admitting to room cleaning to surgical prep.

Get tough. Most organizations that deal in safety, such as aircraft maintenance, railroads and mining, have a “zero tolerance” attitude toward safety violations. There is no defensible reason

for health care providers not having the same attitude. Any clinician who, for instance, habitually fails to wash hands between patients, or to read and understand the patient's chart—and who does not change—should quite simply be fired for cause.

Hire. There is little question that the only path to greater efficiency and effectiveness involves much stronger coordination between clinicians and the organization, under much more stable conditions. More and more organizations are putting more of their physicians on the payroll. Try to imagine FedEx or Disney or Nordstrom working as a loose cooperative of freelancers—yet that is exactly the way we have been trying to run most of our health care institutions.

Reorganize. Organize the organization around medical conditions—around a "diabetes care center," for instance, or a "breast cancer institute" or a "birthing center," rather than "endocrinology," "oncology" or "neonatology." Traditional departments are built around the way providers think; our customers think in terms of their medical condition. Build teams (e.g., clinicians, techies, anybody necessary to that process) that work together over long periods of time on a specific condition.

Bundle. Bundle services around medical conditions. Put everything, for instance, needed to replace a hip, staple a stomach, or manage someone with congestive heart failure into one basket (just the way an automotive body-and-fender shop does not charge you separately for the epoxy or sandpaper used). Think of it as a "product." Only when services are bundled into products can you measure your efficiency and effectiveness at providing the product—the replumbed heart, the removed tumor, the stabilized heart attack patient.

Unleash. Allow, encourage and demand that your clinical teams continually improve, always trying new ways, measuring results and refining methods to discover what works best and most efficiently, with outcomes and costs as the test. This not only increases quality and drives down cost, but it also reduces malpractice concerns. Establishing "best practices" and following them reduces mistakes, and it also is an eloquent and powerful defense in malpractice cases. At the same time, "best practices" guidelines, established by the team, help clinicians resist the pull to overtreat either to meet patients' demands or to practice defensive medicine.

Price. Put prices on the "products" you have built for common conditions. Fixing a broken leg costs so much, from X-ray to rehab; an uncomplicated birth so much; a replumbed heart so much.

Warranty. Offer warranties on specified conditions: If you have to come back for more treatment, beyond what is considered a normal successful outcome, it's on us.

Delegate. Decide what you can be seriously world-class good at, and find someone else to do the rest.

Retail. Get into retail health care, partly to forestall the Wal-Marts and Targets of the world, but mainly as a training ground for your organization.

No part of this will be easy. There is no scripture on how to improve health care. There is no canonical list. But clearly we are a very long way from where health care could be. We have to start from where we are, with our best guesses in hand. We cannot wait until all questions are settled before setting out. We have to ask Hillel's question: "If not now, when?"

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