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treatment. by Robert S. Kaplan and Derek A. Haas**

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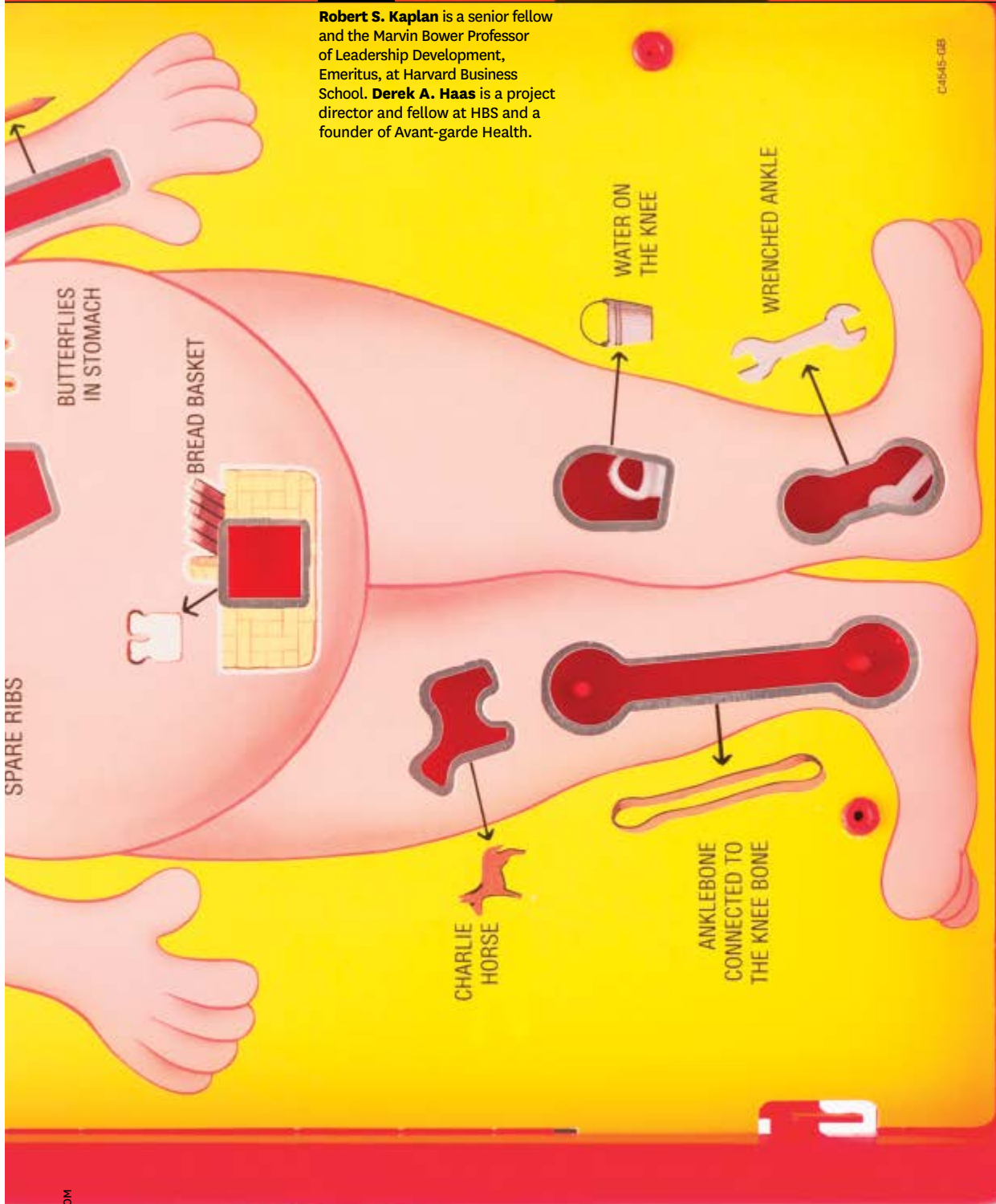


HOW NOT TO CUT HEALTH CARE COSTS



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The missteps that keep us paying too much for treatment

by Robert S. Kaplan and Derek A. Haas

H health care providers in the United States and much of the rest of the world are trying to respond to the tremendous pressure to reduce costs. Many of their attempts, however, are counterproductive, ultimately leading to higher costs and sometimes lower-quality care.

What's going on? Our findings show that to identify cost-cutting opportunities, hospital administrators typically work from the information that is most readily available to and trusted by them—namely, the line-item expense categories on their P&L statements. Those categories, such as personnel, space, equipment, and supplies, are attractive targets: Reducing spending on them appears to generate immediate results. But the reductions are usually made without considering the best mix of resources needed to deliver excellent patient outcomes in an efficient manner.

Health care provider organizations also try to optimize the number and mix of patients seen—for instance, by pushing physicians to spend less time with each patient and on treatment processes that are poorly reimbursed under fee-for-service mechanisms. Fee-for-service payments encourage physicians to increase their volume of reimbursable procedures and visits, not to deliver effective and efficient care for a patient's condition. To make matters worse, clinical personnel—the people who actually treat patients—are seldom involved in decisions about how to achieve savings, which means that providers lose out on significant opportunities for benchmarking and standardizing medical practices in ways that

could both lower costs and improve care. Field research we are conducting with more than 50 health care provider organizations, most U.S.-based, suggests much better ways to reduce costs without jeopardizing care and often while improving outcomes.

Let's examine five common cost-cutting mistakes in detail.

Mistake #1: **Cutting Back on Support Staff**

The first port of call in a cost-cutting exercise is often the payroll, which accounts for about two-thirds of a typical provider organization's costs. Most administrators begin by freezing salaries and new hires. Some take more-drastic action by reducing head count, starting with administrative and "backroom" support personnel along with front-desk staff. Often the stated reason for targeting nonclinical staff is a desire not to impact patient care. A probable unstated reason is that the work of clinical staff is directly reimbursable, whereas that of administrative staff is not.

But disproportionately cutting support staff can be shortsighted when it lowers clinicians' productivity and raises the cost of treating patients' conditions. One physician told us that her department had reduced administrative support to fewer than one secretary for every 10 doctors. After the cuts the doctors had to spend much more time on paperwork, which detracted from their revenue-generating work and sometimes jeopardized patient care—for instance, when messages about patients' needs were not communicated to clinicians in a timely fashion.

Our research shows that specialists' time is often an order of magnitude (10 times) more costly than their assistants' time. It makes no sense to have physicians and senior nurses perform tasks that could be done just as well by far less expensive personnel. Indeed, we found that effectively integrating more nurses and physician assistants into patients' care frees up senior clinicians to work "at the top of their license," performing tasks that only they can perform, leading to higher-quality care at a much lower cost per patient.

This approach allowed the Anesthesia Assessment Center (AAC) at Houston's MD Anderson Cancer Center, which evaluates patients prior to their procedures, to reduce per-patient spending by 45% while seeing 19% more patients and maintaining the



Idea in Brief**THE PROBLEM**

Field research with more than 50 health care provider organizations, most based in the United States, suggests that many cost-cutting initiatives actually lead to higher costs and lower-quality care.

WHY IT HAPPENS

Administrators typically look to reduce line-item expenses and increase the volume of patients seen. This may generate immediate financial gains, but if the cuts are made without considering what's needed to deliver excellent patient outcomes, they lead to larger bills in the long term.

THE SOLUTION

Administrators, in collaboration with clinicians, should examine all the costs incurred over the care cycle for a medical condition. This will uncover multiple opportunities to benchmark, improve, and standardize processes in ways that lower total costs and deliver better care.

same quality of care. Patients with relatively simple conditions were seen by midlevel providers rather than attending physicians, which enabled two of the four anesthesiologists to shift from the AAC to the operating room. This is sustainable and value-increasing cost reduction.

Top-down spending mandates are effective mainly in aggravating the *margin-versus-mission* tension between financial and clinical professionals. Arbitrary constraints or cuts in personnel spending, uninformed by an awareness of the underlying clinical and staff resources needed to deliver high-quality outcomes for a variety of medical conditions, can lead to long treatment delays, worse care and outcomes, and overstressed, frustrated caregivers.

do just two or three—even though the duration of the actual surgical procedure does not vary greatly between the two groups. The difference in productivity results from the number of operating rooms available: High-volume surgeons generally have two, while low-volume surgeons have only one and must wait between surgeries for the room to be cleaned and the next patient prepared.

Our analysis shows that the cost of a second operating room is far less than the cost of a skilled surgeon and clinical team's idle time. This is a vivid example of the folly of attempting to cut costs by holding down spending in isolated categories. More often than not, much higher costs soon show up in another category. Only by measuring the costs of *all* the resources used to treat a patient's condition can trade-offs be made that lower the total cost of care. (See "How to Solve the Cost Crisis in Health Care," HBR, September 2011.)

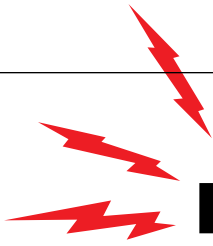
Similarly, increasing spending on equipment can improve care and reduce overall costs. The emergency department of one hospital we studied had three X-ray machines (two standard and one portable). During busy periods the patient and attending staff often had to wait for one to become available. A financial analysis showed that adding another portable machine would be cost-effective: The savings from shorter staff waits and procedure times would exceed the annual cost of the machine—even without counting the gains from faster diagnosis. Unfortunately, this type of opportunity is seldom pursued, because providers do not conduct the benefits analysis that would show that increased spending on relatively inexpensive equipment could be paid for by the savings from reducing the idle time of expensive staff members (and, just as important, could also improve responsiveness to the patient's condition).

Mistake #2:

Underinvesting in Space and Equipment

In our cost analyses of dozens of medical conditions, space and equipment costs were consistently an order of magnitude smaller than personnel costs. This finding leads to the obvious conclusion that idle space and equipment are much less expensive than idle clinicians and technicians. Yet because hospital systems do not measure the costs of idle space, equipment, and personnel, they often make poor trade-offs, underinvesting in space and equipment and thereby lowering the productivity of their most expensive resources.

Here's a case in point: We are currently studying the surgical processes for joint replacements at more than 30 hospitals, as part of a program with the Institute for Healthcare Improvement. We've learned that some orthopedic surgeons perform seven to 10 joint replacements a day while others



Mistake #3:

Focusing Narrowly on Procurement Prices

Recognizing the hazards of cuts in personnel, some executives aim their reductions at materials and services from outside suppliers—enticing targets because these items often account for 25% to 30% of total costs, and reducing them lets administrators avoid the potentially demoralizing impact and perhaps difficult union negotiations associated with eliminating personnel.

Providers typically try to lower the costs of purchased items by negotiating higher discounts from suppliers. Many providers join group-purchasing organizations (GPOs) to gain the benefits of higher volume in their negotiations. According to the Healthcare Supply Chain Association, 96% of all acute-care hospitals belong to at least one GPO.

Yet we found enormous variation in organizations' spending on supplies, owing to variations in the quantity and mix of items clinicians use. For example, in our multisite study of knee replacements, the cost of bone cement varied by more than a factor of 10 (for similar patient populations and outcomes) across institutions. This variation was not due to a few outliers; costs at the 75th- and the 25th-percentile institutions varied by a factor of three. The differences had two main causes: Some hospitals used expensive premixed antibiotic cement while others used hand-mixed or plain bone cement, and hospitals varied in the average quantity of cement used in each procedure.

These findings suggest that many hospitals focus too narrowly on negotiating price and fail to examine how individual clinicians actually consume supplies. As a result, they miss potentially large opportunities to lower spending.



Mistake #4:

Maximizing Patient Throughput

It would be absurd to try to increase the productivity of musicians by having them play faster. Yet health care executives force an increase in the number of patients seen by physicians each day by establishing productivity targets that limit office visits to fixed time periods, such as 15 minutes or a half hour. This apparent increase in productivity, however, is not

sensitive to the impact of these seemingly arbitrary standards on patient outcomes.

In fact, if you measure, as you should, a physician's productivity not by inputs (number of patients seen) but by the quality of outcomes achieved, you'll find that physicians can often achieve greater overall productivity by spending *more* time with *fewer* patients. For example, many patients with chronic kidney disease eventually need dialysis. Extensive research shows that patients have better outcomes (longer lives and fewer complications) when dialysis is started with a fistula (requiring a surgical procedure to connect an artery to a vein) or a graft rather than a catheter. Patients with optimal starts also cost tens of thousands of dollars less per year. Yet more than half of U.S. dialysis patients today start dialysis suboptimally, with a catheter.

One nephrologist told us that if he could spend 30 minutes counseling each patient with advancing chronic kidney disease, he could significantly increase the likelihood of that patient's starting dialysis with a fistula or a graft. We estimate that the incremental cost of such front-end counseling would be less than 1% of the additional costs incurred when dialysis starts with a catheter, and it would produce much better outcomes. Even if only a small increment of patients initiated dialysis with a preferred method, the counseling time would yield a very high return in terms of future costs avoided. The provider organization would capture those savings, because it is financially accountable for the total cost of the patient's care. But because institutional standards limit the length of patient visits, the nephrologist has little opportunity for such counseling.

As another example, the hospitals in our total joint replacement study focused much attention on managing the costs of postoperative inpatient stays. But many missed a large and low-cost opportunity to devote more time *before* surgery to setting the patients' and families' expectations about the length of the stay and the place to which the patient was likely to be discharged (whether to home, a skilled-nursing facility, or a specialized rehabilitation center). Clinicians in hospitals in the lowest quartile of total costs had learned to spend more time educating patients and their families about the postdischarge plan of care: how to prepare their homes so that patients could return directly there, and the need to identify a family member or another person to pick up the patient and assist in home care. It was

Where Is the Pressure Coming From?

Cost-effectiveness has not historically been a competitive imperative in health care; virtually no provider offers a low-cost/low-price strategy, because patients—who are usually insured—do not see any benefits from seeking out low-priced providers. Instead, they search for providers with a reputation for high-quality care. Consequently, providers compete by claiming to offer better care (though few supply data to support their

claims). Those perceived as doing so attract more patients, enabling them to negotiate higher payment rates from insurers. This industry dynamic has contributed to the price index for hospital and related services⁷ having grown more than twice as fast as the consumer price index over the past 30 years.

Several new factors, however, are encouraging providers to become much more cost-conscious:

NEW HEALTH INSURANCE PLAN DESIGNS

Many plans now require consumers to contribute higher co-pays to access upper-tier providers (those the insurer rates as the most expensive). Some, including plans offered under the Affordable Care Act (ACA) exchanges, exclude high-priced providers. In addition, insurers have introduced higher-deductible plans, with deductibles as high as several thousand dollars, to make consumers much more price-sensitive. As these plans gain market share, high-priced providers can anticipate lower patient volumes.

NEW REIMBURSEMENT MECHANISMS

Some providers now receive global payments that make them accountable for the total cost of caring for a patient, including care delivered by other providers. The ACA authorized Medicare to expand global payment models in accountable care organizations, and many private payers are pushing in this direction as well. Insurers are also introducing bundled, or episode-based, payments, under which they pay a single fixed amount to cover all the costs associated with the full cycle of care for a patient's condition.

TOUGHER INSURERS

In response to increased price resistance from consumers, employers, and the government, insurers are taking a harder line in negotiations with providers. Some no longer allow price increases above inflation and are reducing or eliminating payments used to support research and education. Further, because of the aging of the population and the ACA's increased coverage of patients under Medicaid, a greater percentage of patients are now covered by much less generously reimbursed public insurance programs.

THE EMERGENCE OF LOW-COST, LOW-PRICED ALTERNATIVES

Walk-in clinics, such as MinuteClinic and others in pharmacies and retail stores, are starting to provide much-lower-priced outpatient care. They could become the Southwest Airlines and Walmart of health care, disrupting the expensive supply of community care by existing providers.

also important to set expectations about postsurgical care among members of the patient's professional care team, from workers in the physician's office to the hospital staff.

Patients whose providers invested more time communicating about these issues had much shorter postsurgical inpatient stays. Even more beneficial, a far higher percentage of them could be discharged directly to their homes rather than to nursing facilities or inpatient rehab centers, where rehab costs are five to 10 times higher than at home. Here, too, a modest amount of increased front-end spending often led to an order-of-magnitude reduction in downstream costs.

Clinicians in several of our other ongoing research projects, especially those treating patients with chronic conditions, such as diabetes and congestive heart failure, tell us similar stories. If they could spend more time and money educating and monitoring their patients, the total spending on the patients' conditions would decline dramatically. High-level administrators, however, focused solely on line-item expense categories on their P&Ls, often overlook these opportunities to reduce the total costs of treating their patients while improving outcomes. Such opportunities should be highly relevant for the new accountable care organizations (see

the sidebar "Where Is the Pressure Coming From?"), which have incentives to reduce the total costs of treating covered patients, including costs incurred at other facilities.

Mistake #5: Failing to Benchmark and Standardize



We have also found great variations in the costs and clinical and administrative processes involved in treating specific medical conditions among the multiple facilities within a provider organization and even among physicians within the same facility. At a private hospital chain in Germany that performs joint replacements at a half-dozen sites, the procedure's cost differed by as much as 30% across facilities that treated the same patient mix and achieved comparable outcomes. In our joint replacement study, the cost of implants at different facilities varied by more than 100%; another study documented variations greater than 500% for implant costs across different sites.

High variation in clinical practices can occur even with outstanding institutions and clinicians. For example, Dr. John Noseworthy, the CEO of Mayo



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Clinic, recounted a cardiac surgeon’s saying to his group, “All five of us are very good at what we do, but we all do it differently. At least four of us must be doing it wrong.” Another surgeon responded, “Actually, probably all five of us. Let’s try to do it right.” Individual clinicians’ practices tend to go unquestioned (current practice has been described as “eminence based,” not “evidence based”). Despite multiple attempts over the years, huge opportunities—to improve patient outcomes and lower costs—remain to be realized from benchmarking and standardizing clinical practices.

Mayo set out to achieve the benefits of greater standardization. For instance, the cardiovascular surgeons learned that they all used blood transfusions differently. They got together and within a year developed blood-products guidelines that everyone

adopted. Transfusions fell by 50%, transfusion-related kidney disease fell by 40%, and Mayo saved \$15 million over three years. Boston Children’s Hospital achieved similarly impressive results after implementing a program it calls Standardized Clinical Assessment and Management Plans (SCAMPs). Its first six SCAMPs, addressing areas such as chest pain and heart valve abnormalities, lowered costs per episode by 11% to 51% without decreasing the quality of care.

Unfortunately, such success stories are rare. Physicians, nurses, and other caregivers often do not know the costs associated with their treatment protocols. And administrators rarely collaborate with them to develop outcome and cost measurements that would facilitate benchmarking and best-practice-sharing opportunities.

Actively engaging clinicians in the cost-measurement-and-management process enables them to learn the true cost drivers of a full cycle of care, from diagnosis through treatment and recovery. Clinicians want to improve patient care. They also recognize the financial constraints under which health care systems around the world must operate even as demand from aging populations increases. They are more than willing to search for process improvements that lower costs while maintaining or improving the overall quality of care.

HIGH HEALTH CARE costs are the result of mismatched capacity, fragmented delivery, suboptimal outcomes, and inefficient use of highly skilled clinical and technical staff. The current practice of managing and cutting costs from a P&L statement does nothing to address those problems.

The only sustainable way to reduce costs is to start with an in-depth analysis of the current processes used to treat each medical condition. Clinicians and administrators need to fully understand all the costs incurred over a full cycle of care, and the outcomes, for each treatment their facility provides. With that understanding they can work together to deliver the same or better outcomes with an overall lower-cost mix of personnel, purchased materials, and equipment. As the results from organizations such as MD Anderson, Mayo Clinic, and Boston Children’s Hospital show, this path can dramatically improve efficiency and lower costs while continuing to deliver exceptional care. ♥

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“There isn’t one.”