Economy

The Global Human Capital Journal

The U.S. Healthcare System: Can This Patient Be Saved?

By Christopher S. Rollyson — Sunday, 24 February 2008

"Yes," Says Team of Healthcare Experts, Employer CEOs and Patient Representative at the Executives' Club of Chicago, "But You Must Change Your Ways"

Honestly Assessing Quality—Engaging Consumer Empowerment—Trading in the Ferrari for a Chevy

The Executives' Club of Chicago convened its healthcare reform summit at the Hilton Chicago on 20 February 2008, drawing on diverse expertise. **Ian Morrison, Ph.D.**, healthcare futurist, gave the keynote and moderated two panels:

- First, the healthcare expertise panel with **Dean Harrison, CEO Northwestern Memorial Healthcare**; **William Novelli, CEO AARP**; **Scott P. Serota, CEO BlueCross BlueShield Association**; and
- Second, the business executive panel with **Andrew M. Appel, Chairman AON Consulting**; **John A. Edwardson, CEO, CDW**; **John B. Menzer, Vice Chairman and Administrative Officer, Wal-Mart Stores**. **Robert L. Parkinson, CEO, Baxter Healthcare** gave an insightful point of view on recommended actions to close the event.

There was broad agreement that the U.S. healthcare system was broken, and speakers offered excellent insights and perspectives about how to fix the system. **However, what they didn't say was as interesting as what they did, and I will address two key issues in Analysis and Conclusions: the pervasive lack of trust among all parties and the emerging consumer empowerment trend: what do Web 2.0-enabled consumers have to bring to the party?**

The U.S. healthcare system has sat in the waiting room for years, and it looks as if it will be seen by the doctor soon. This case isn't pretty: healthcare in the U.S. costs between two and three times as much as other OECD countries', and overall results are inferior. Healthcare is dragging down the U.S. economy in many ways, compromising American competitiveness: not only do Americans spend far more to receive far less effective care: many Americans remain in jobs that they do not want because they are afraid of losing employer-provided insurance.

This compromises the principles on which the U.S. was founded: enterprising people can take risks to capitalize on their ingenuity and enjoy the fruits of their hard work. About one half of bankruptcies in the U.S. are healthcare cost-related. Employers have faced spiraling costs for years, and healthcare costs have been a key factor in employers' refusals to give raises. Unstated message to workers: "We are spending your raises by doing our best to maintain your coverage." The high cost and low effectiveness compel companies to avoid American workers, who are more expensive to insure. How did the U.S. arrive at this lamentable state of affairs?

Opening Remarks: Ian Morrison, Ph.D., Healthcare Futurist

- Key insights:
  - There are three models of healthcare reform: Pearl Harbor (crisis), Tipping Point (key inflection points) and Glacial Erosion (aging, technology, unaffordability)
  - The holy trinity to frame the discussion (cost, quality of care and access). Security of benefits was also important.
  - We must fix the quality of care first; don't bring more people into a broken system. Let's not forget; the uninsured do get care now.

  - Change the payment system. We currently reward people in weird ways; we need to reward physicians to do the right things.
- Assessing the U.S. healthcare system:
  - U.S. healthcare does not compare favorably with other developed countries according to this formula: access, quality and security of benefits, divided by cost. Healthcare is negatively affecting U.S. competitiveness.
  - The U.S. has some of the best care available in the world, but U.S. patients get the right care about 50% of the time. On average, the U.S. spends twice as much on healthcare per capita as other developed countries.
  - U.S. healthcare quality operates at about a "2 sigma" level (referring to six sigma). It varies significantly from state to state, in terms of cost and delivery.
  - U.S. physicians see quality of care deteriorating, as they are pressed to spend less time with patients and are pressed by payer standards.
  - 80% of the uninsured are working and are citizens. They do get care, but the cost is shifted. California is working hard to reform, but political blocks from both ends of the spectrum oppose reforms for different reasons.
  - Most senior citizens are happy with the healthcare they receive. Doctors are depressed and cranky.
  - The healthcare system is negatively perceived by youth; however, enrollments in medical and nursing schools are healthy.
  - Millennials will force change; women represent half or more enrollments and they are not willing to work the crazy hours.
  - The numbers say that there will be a shortage of providers, and there may be if we don't get this right. We will run out of physicians and nurses.
  - We run a real risk of losing the opportunity for reform because the middle class is feeling less secure due to the recession. They may lose the courage to drive change. One third of the (uninsured) in California are eligible.
  - Employers can't manage employees' healthcare; it's not their core competency. However, they need to provide healthcare to retain workers.
- Opportunities for change:
  - Ian supports market forces in theory but prefers embarrassing poor performers as a way to get them to reform by publishing lists of poor performers.
  - We should not rely on consumer-led initiatives because consumers often do not embrace them, for which he cited California Hospital Compare. We need a positive force and continuous pressure to drive change.
  - Privatize Medicare/Medicaid? Market forces are effective at improving the quality of care.
  - There is significant opportunity to standardizes roles and processes to improve quality of care. Physicians resist vigorously; they don't want to be told what to do. Other industries use six sigma and other process innovation to improve quality.
  - The U.S. political climate and cast of characters are different than in 1998, so we can have a different result.
  - Doctors now run businesses, and hospitals are profit-motivated, which is sad. They have become big enterprises with corporate goals. The "Sisters of Mercy" have become the "Sisters of Sustainable Competitive Advantage."
- Avoid these red herrings (that are on some agendas):
  - Single source, universal care is not appropriate for U.S. culture; it would represent a huge transfer of wealth from the rich to the poor.
  - Voluntary universal coverage won't work because how can it be enforced?
    - Forced participation (by employers) is being tried. Ian mentioned Massachusetts ($300 penalty/employee/year) and California (4-6% of total payroll cost).
    - Obama is the most realistic; we can do it incrementally by engaging the middle class.
    - Ian supported his point by referencing California's mandatory auto insurance coverage. Currently, 22% of California drivers are uninsured, which is in line with the national average.
  - Nor would mandates work, but subsidies will likely be needed (he referenced Obama's plan). Caregivers won't accept the low reimbursement rate.
  - (High) emergency room use among insured shows that access isn't there, along with growth of "MinuteClinic" and others.
- Reasons for optimism:
  - Politically it is a year of change, and the echo boom is starting to make itself felt. In many surveys, priorities among voters are economic reform, with healthcare reform at number two.
  - There is little ability to pay more (for health care, and demand is rising fast). The current proposals from Democrats are to the right of Nixon.
  - Cost pressures are creating strange bedfellows such as Wal-mart and the SEIU.

Panel of Healthcare Executives: Universal Healthcare Impact on Stakeholders

William Novelli, Chief Executive Officer, AARP

- AARP's 39.7 million members are aged fifty and over, and half are working. About one third are 50-60, one third are 70+, and their political affiliations are widespread. In 2006, 52% of voters were over fifty (years old).
- The two biggest issues for AARP: healthcare reform (including long-term care); many members are sandwiched between caring for children and elderly parents. Financial security is the second issue; we have to fix social security; we don't have an age problem, we have a healthcare cost problem. For more, read Peter Orzag.
- AARP members are mostly satisfied with the care they receive.
- There are three reasons why healthcare and economic security are critical: the problem is far worse now, the middle class is less secure, and business is in a different place. It can't continue to finance ever-increasing healthcare costs.
- Ideology is a problem: Republican senators make blanket statements like markets can improve healthcare better than governments; we need to focus on programs, not ideologies. Information technology is vastly underutilized by the healthcare industry. The value chain players are divided, and there's no action.
- How to reconcile quality and cost? What's the role of the user? How can we organize consumers better? The consumer is a big part of the answer. We need to partner on price and quality. We need to get a higher portion of consumers in the system and help them to navigate it by making information more transparent. End of life has medical and ethical components; we can save money and improve quality of death. We have no strategy to increase personal accountability.
- How to reduce costs and shift attitude of entitlement to engagement? Policy people don't understand the prevention value proposition; we need a broad approach, we need to change social norms through programs dealing with smoking cessation; these things are working, but you need coordination like no smoke buildings and higher taxes.
- The next president will make healthcare reform an explicit goal.

Scott P. Serota, President and Chief Executive Officer, BlueCross and BlueShield Association

- BCBS serves 100 million members nationwide, one third of the U.S. We have the information to serve customers and a 75 year old trusted brand. We are focused on packaging information so it is more useful.
- The time is right for reform, and the private sector should take the lead, don't wait for government. A recent BCBS treatise on the subject makes these points:
    - We understand what works in healthcare; cancer and cardiac survival rates are the highest in the world.
    - The effort to compare effectiveness of care should be global in scope, not national.
    - We need to change the payment system; now it's piecemeal.
    - We need more transparency, and our Blue Distinction program addresses this.
    - Americans need to look in the mirror; one third of Americans are officially obese, which leads to innumerable health issues. People need to be accountable for their health.
- Quality of care:
    - People get care, whether they pay or not; they are further along in the disease process and are more expensive to treat. The delivery system needs to be better coordinated. We need to provide information that's usable by consumers.
    - We are concerned by what we see on the primary care physicians. They are disappearing, and it's a crisis.
    - We need to provide consumers information, but we have to beware the "Web infected consumer" who gets bad information on the Internet. Dean agreed that we need to help people to interpret information that consumers find on the Internet.
    - Providers who agree to (be compared to others by an evaluation body) should have safe harbor.
- Cost and administration:
    - We need to fix delivery (care) and provide coverage for all. The young opt out, and we need them in the pool. Many people who are eligible don't sign up because the system is too complex. We need to find assistance for SMBs (small/medium business), and use tax credits to do this.
    - Make insurance affordable; we need to get the right care available at the right time.
    - Information technology is utilized at the same rate as the mining industry, very low.
    - We have inertia because political solutions require immediate solutions.
    - In general, the insurance industry does not have a "gotcha" mentality, and it can self-police, although he admitted to "outliers." (Ian had cited cases in California in which insurers retroactively denied coverage due to preexisting conditions).
- We need to consider offshoring and plan for it in our evaluation and assessment of care:

  - BCBS is significantly increasing its presence in China because corporate clients have more employees in China. There are 1.3 billion people in China, and we want to serve them, especially employees of U.S. multinationals.
  - Quality is a major concern; we need to compare treatment outcomes globally.
  - India is a major destination for quasi-elective procedures, and quality is generally good.
  - There is a place for globalization, especially in evaluation (radiologists, etc.) and research.

Dean M. Harrison, President and Chief Executive Officer, Northwestern HealthCare

- Northwestern Memorial has two angles on healthcare: as a provider and as a major Chicago employer. We have 7,000 employees and $1 billion in revenue.
- We can increase quality and reduce cost: we need to invest in prevention, which would improve health at a lower cost. Right now the U.S. system is focused on intervention.
- We need quality, not quantity (improve the quality of healthcare before we need to bring more people into the system).
- The policy of expanding coverage must be approached carefully:
  - We already lack for physicians and nurses.
  - As a business, we need to have high utilization of our capital base. Hospitals have reduced beds 50% since 1980, and there is little standby capacity.
  - By 2020 we will have a shortfall of 50,000 physicians.
- Transparency:
  - Our strategic plan explicitly calls for an increase in transparency. We need to prove (outcomes) to gain public trust.
  - There is much more willingness now on the provider side to allow people to look behind the curtain: how does care get delivered, and what are results?
  - All physicians are data-driven, and evidence-based medicine is the norm.
  - (Ian added: I will grant you that hospitals are willing, but not physicians; only ten percent of them are in agreement).
- Do not confuse overall healthcare spending with provider well being: more important than the total is the percentage of reimbursement. Physicians receive an average of 18% reimbursement through Medicaid while hospitals receive 73%.
- More people in healthcare really want to care; we need to align provider and consumer. We need to openly disclose conflicts of interest and harbor no more secrets.
- Malpractice is an issue that currently affects states differently; Illinois has tort reform in progress, so this has a decreasing influence on healthcare here.
- One worry: we need to increase investment in research budgets (which have fallen in real terms)

Ian Morrison, Ph.D. (moderator)

- Reforming healthcare will be expensive, and we want medical miracles. We need coordination, access and quality improvements. We must address three categories: chronic diseases, obesity and end of life care. These account for 83% of the cost.)
- There is a lot of money at stake. Congress is more divided than the public.
- We need an agency to compare effectiveness (the quality of care divided by the cost).
- There is a trust gap that prevents consumers from getting more engaged. Who will consumers trust?
- Physicians are so resistant to change, and we have to change their culture.
- Do we need increased scrutiny of the insurance industry? Mandating Medicare for everyone is not a solution because the reimbursement rate is too low. We need to address payment at a higher level.
- I am sensing a "zone of compromise"; however, the how is where the friction is. We need to keep our focus on the common ground. Divided we will fail, and the business community is key.

Panel of Employer Executives: Healthy Work Force and Health Competition

John A. Edwardson, Chairman and Chief Executive Officer, CDW Corporation

- Our business and how healthcare relates:
  - CDW has 6,300 employees and $8 billion in revenue, and our healthcare (IT) business is growing (CDW serves providers/payers).
  - The average age of our work force is between 27 and 28 years old.
  - We have a free market tradition. As an employer, we need to be competitive.
- The most important thing we need in terms of reform is simplicity:
  - The U.S. needs to drop its "not invented here" attitude. We can learn much from other systems.

  - The system is far too complex; people can't make good decisions.
  - People do understand copayment, but they don't understand the benefits, which are too complex; they only understand half of the equation.
  - They also go to a provider that is rated at the bottom of the quality scale.
- Government is not the answer:
  - I don't know how we would deal with a government system; we know how to deal with it now.
  - For example, HIPAA is a major problem. John shared a humorous anecdote about a HIPAA-compliant copier that copies things backwards so no one could read it as it came out of the printer.
  - A CEO can't help employees because s/he can't know anything about their issues. Government has gone off the deep end.
  - (Ian: I always advise executives to ignore HIPAA and do the jail time ,^)
- Provider issues:
  - Providers often want to work 9 to 5, which doesn't account for dual income families.
  - One parent has to take the day off to make a doctor's appointment. John's dentist is like that, too.
  - CDW tries to work it out so the (employee) can work from home that day to manage productivity better. That helps us to reduce absenteeism.
  - In fact, on average, 300 of our employees are working from home each day.
  - Doctors don't like computers, and they delay making investments. They often have antiquated (IT) equipment.
- John's greatest wish for healthcare reform: the U.S. needs to lose the "not invested here" attitude. We need to (learn from other countries and) find what fits.

John B. Menzer, Vice Chairman and Chief Administrative Officer, Wal-Mart Stores, Inc.

- Our business and how healthcare relates:
  - Wal-Mart would be the 24th largest economy in the world if it were a country.
  - We instituted the $4 generic prescription in 2006, and it's already saved people $850 million.
  - We have 300 of in-store clinics today and plan to have 400 by 2010. One half of the people going to the clinics would not have sought care otherwise (it's too complicated and inaccessible).
  - Our employee base is diverse, encompassing students, retirees, people with second jobs and full-time career.
  - Wal-Mart operates in 15 countries, and our plans vary according to culture, legality and expectations. We try to be flexible when employees get injured; sometimes they can't return to their regular job during convalescence, so we give them a job they can do.
  - We apply our core competency to healthcare. It makes a difference in the stores and the community.
- In Florida, a retiree told a story that the pharmacist proactively told him about generic medications, enabling him to save $200 per month.
- Healthcare initiatives:
  - In 2006, 90% of our employees were covered, and it grew to 93% last year.
  - 30% of new employees are uninsured. Of the 7%, many are "young tigers," males who don't think they need healthcare, even if it costs $5 a month!
  - We also have more healthcare choices. John personally "tried" 62 options to evaluate how his healthcare coverage and costs would look given 62 different scenarios. Wal-Mart gives new employees DVDs that enable them to understand the various choices.
  - We will have completely electronic prescriptions and medical records by 2010, which will decrease cost and improve quality.
  - Transparency is long overdue, and the (electronic) personal health record is critical.
  - We provide 100% of the cost of employees treated at the Mayo Clinic. A study showed that, if we treated everyone at the Mayo Clinic, our healthcare costs would go down significantly. Make medical tourism available; less than 5% of companies are encouraging it. Employers are not taking an active role in the current system; they need to try to influence healthcare choice.
  - Wal-Mart offers healthcare for less than $10 per month (presumably the minimum cost plan).
- Key indicators:
  - We discovered that a minority of employees were using emergency room services very frequently, so we flagged them for additional training and reduced their usage by steering them to more appropriate care options.
  - High emergency room use is one of the most wasteful parts of healthcare, and it indicates that people don't have access to the system.

  - Minute clinics are another response. We are trying to partner with local clinics and hospitals and physicians (to improve coordination).
- John's greatest wish for healthcare reform: why can't it be like shopping at Wal-Mart? High quality care, available in many formats, at different prices, with easy choices and trade-offs.

Andrew M. Appel, Chairman, Aon Consulting Worldwide

- Our business and how healthcare relates:
  - Aon Consulting advises (insurers); we aren't the Morningstar of the industry (but we need one).
  - We help shape the workplace of the future. There are three key issues: retirement, talent and health benefits.
  - One half of our clients are self-insured.
  - At Aon, we love complexity because it drives our business, but it's the biggest problem: the U.S. way is way out of whack.
- Assessment of the U.S. healthcare system:
  - The U.S. system is a complex (web) of public and private players that produces strange incentives.
  - Consumer-driven healthcare is here to stay, and people basically want to know: "Can I go to the doctor, and will someone pay for it?"
  - We need global scale and globalization of benefit programs.
  - We also need to have a holistic view of cost of absenteeism; we all want to increase the value employees add.
  - In the U.S., we aren't thinking long-term. For one thing, we need to make it easier for employees to change providers (medical records, insurance, comparative information) in order to increase competition and improve quality of care.
- Areas for change:
  - There is no silver bullet, but we need to simplify the service environment. Outside the U.S., end of life treatment is standardized.
  - In the U.S., fewer than 50% of patients receive optimal care.
  - Another problem is that we are focused on managing the care of people in the system, but too many people are outside of it, which means that they access the system very inefficiently.
  - On the positive side, the wellness and prevention angle has tremendous upside. It's noble, it produces savings and it's relatively easy to do.
- Andrew's greatest wish for healthcare reform: Confluence of increased transparency (for consumers) wellness focus, which will impact utility; we need to understand long-term consequences of choices.

U.S. Healthcare Reform: Perspectives and Recommended Actions: Robert L. Parkinson, Jr., Chairman, CEO & President, Baxter International Inc.

Select Characteristics of the U.S. Healthcare System

- Healthcare is a unique "industry" because it combines elements of moral obligation, unlimited demand and worker utilization. However, it is traditionally understood as a sporadic variable cost. It is rarely a discretionary purchase. Healthcare is not managed practically (rationally); it is laden with emotion.
- The U.S. healthcare system is inefficient:
  - The U.S. spends (twice as much) as the (OECD) countries, but the healthcare portion of GDP is rising in all of them as populations age.
  - The U.S. has a higher infant mortality rate and a shorter life expectancy than many OECD countries. However, these things are not solely attributable to the U.S. healthcare system; Americans have broad social issues that contribute to life expectancy such as a high obesity rate (30% of Americans are officially obese). Japan has the highest life expectancy in the world, and its obesity rate is 3%.
  - In the U.S., 7,000 people die from medical errors each year, while there are 1.5 million preventable medical errors.
  - In the U.S., healthcare accounts for 16% of GDP, and it is rising steadily. Life expectancy is increasing, and the baby boom generation will demand extensive healthcare services as it ages. Most rich countries are confronted by these trends.
  - Spending is not uniform: six percent of Medicare (U.S. federally funded care) insureds account for 25% of Medicare spending during the "last year of life."
- Technology has complicated the picture by increasing options and costs.
- Healthcare effectiveness and cost directly effects economic competitiveness; it affects how many jobs are sent offshore.
- The U.S. free market approach to healthcare has led to an industry that is overly complex (and underperforms global benchmarks)

and alienates the public.
- Most insured Americans are happy with the healthcare they receive, but they are dissatisfied with the system as a whole.
- No research exists that shows how healthcare adds to the quality of life.
- This leads to a paradox: the U.S. currently spends between one fifth and one sixth of its economy on an industry that is assumed but is governed by little rationality. Healthcare is not measured in terms of utility the same way as other expenditures.
- Nanotechnology will have a dramatic impact on healthcare, but we won't see it for some time yet.
- Baxter as employer covers 80% of total cost; we have a national carrier, a vendor management program. The company emphasizes proactive measures: education, flu shots, weight management, stress management and health coaching.

Reforming U.S. Healthcare

- Reform should focus on three critical issues: 1) healthcare performance in terms of quality and efficiency; 2) innovation and research/development; 3) insuring access to the system.
- The U.S. cannot throw away its system; we must evolve the existing system. We have learned that big bang transformation does not work (i.e. Hillarycare in the 1990s). Nor is it feasible to mandate health insurance; it is more practical to create more equitable tax treatment of health insurance to motivate people in a positive way.
- The uninsured are a problem because they access the system very inefficiently.
    - The 50 million of uninsured people in the U.S. (plus 10 million non-citizens) are a distraction; the real issue is repairing the inefficiency of the system.
    - One third of the uninsured have household incomes of more than $50,000 U.S. and are eligible for health insurance.
    - The U.S. needs to make health insurance more affordable to all.
    - Many speakers repeated that everyone gets care in the system the way it is now.
- The system needs to increase its utilization of information technology (IT).
    - IT has a very low penetration rate (as stated earlier, the same level as mining, one of the lowest).
    - Electronic medical records are a critical step.
    - Extensive online information about treatment, costs and outcomes must be made available to consumers so that they can make better choices about the treatment they receive.
    - Physicians and hospitals struggle to fund IT investments, which are capital intensive and have uncertain returns on investment.
- The U.S. needs national standards; currently, (a basket of) healthcare services in Miami costs more than twice as much as the same services in Minneapolis. Hospitals need medical practice guidelines.
- Higher quality healthcare is lower cost healthcare. For example, if all healthcare were delivered by the Mayo Clinic, the U.S. would save $850 billion a year.
- The healthcare system decreases consumer engagement because it is too complex.
- Healthcare Savings Accounts (HSAs) are promising because they increase individual responsibility (of the consumer). However, they are far too complex for most consumers to understand.
- The legal angle in the form of medical malpractice significantly warps the system: the threat of malpractice results in physician relocations, a shortage of physicians in litigious medical specialties and defensive medicine (ordering extra tests that are unnecessary for diagnosis or treatment but possibly useful for defending against a lawsuit)
- Pharmaceutical research and development is critical to the system. Pharma accounts for 3% of total healthcare spend, and drugs usually represent the lowest cost of treatment; cutting back on pharma R&D would increase healthcare costs in the medium to long term.
- The U.S. needs a major explicit prolonged initiative to reform the system. Bob would like to see it included in the next president's inaugural address. There should be a presidential commission with representatives from all (value chain) players who are on reform full-time. Like the Manhattan Project.

Analysis and Conclusions

Key Themes

- Misalignment
    - The U.S. healthcare system is a car tuned for Formula One racing, and it produces some of the best results in the world. The problem is, Americans are not on an F1 course. They need to do city driving, and they need a Chevy, not a Ferrari. Try using a Ferrari for city driving: your cost/mile will be astronomical and you will be frustrated.
    - If the U.S. reforms its system to significantly increase the *average quality of care*, nothing precludes individuals from seeking additional specialist care. In many OECD countries, many people buy supplemental insurance and seek

specialist care.

  - In the presence of a pervasive network (Internet communications), the specialist model is more viable because the cost of connecting the specialist provider with the specialist client drops significantly. So-called "medical tourism" will prove to be a permanent trend, which will increase the amount of choice.
  - The poorly performing healthcare system has a direct impact on U.S. competitiveness: it subtracts economic value from the economy.
  - Moreover, the opportunity cost of the healthcare system adds even more to its actual cost. Having healthcare coupled to employment chains employees to their oars.
    - It leads to underemployment because many people stay in jobs they don't want to keep their coverage.
    - It runs counter to the employment trend that workers are trending towards "free agency" and creating more value.
    - Healthcare coupled to employment creates extensive inefficiency, and it detracts from U.S. workers' ability to innovate.
    - As hard as it may be to believe, the opportunity cost of U.S. healthcare is probably greater than its actual (accounting) cost.
- Preexisting conditions
  - Medical schools implant the idea that doctors make life decisions, but too often they treat patients as objects of care. In most situations, however, the most successful care results when patient and physician work together.
  - Although panelists did not say it explicitly, the "healthcare" system is comprised of two parts: care and administration. Administration (that is, insurance, accounting and payments) represents about one third of the total cost.
  - I was disappointed that no moderator took my questions about administrative costs, which average about one third of total healthcare cost. Let me repeat that: one third of one fifth (6.6%) of the U.S. GDP is due to *healthcare administration*. It adds no value to healthcare quality; it's the *cost of doing business*. If the 2007 GDP was $13.7 trillion, that means non-care healthcare cost was $906 billion.
  - About one half of U.S. bankruptcies is healthcare-related, according to the widely quoted 2004 Illness and Injury as Contributors to Bankruptcy.

- Potential solutions
  - Broadly speaking, panelists advocated a two-step process to reforming the U.S. healthcare system: first, improve the quality of healthcare. Then bring more people into the system. Everyone gets healthcare now (even though it isn't optimal); it is the payment part of the care that causes many of the problems.
  - In many businesses, there is a trade-off between cost and quality; however, in the current healthcare system, several panelists said that increasing quality would also reduce cost. This would seem to indicate that the system delivers ineffective, unnecessary care a high percentage of the time. The context of speakers' comments about "quality" was *optimal* care, that is, the right amount of the right care at the right time. It seems that the U.S. system delivers too much of the wrong care a high percentage of the time.
  - Consumers are alienated by the current system, and Web 2.0 enables them to connect, inform themselves and develop opinions. Any healthcare system that does not significantly engage consumers will not work.
  - The consensus was that government care was not the answer, but many panelists said that the government had to play a key role in reforming the system because no other participant had the power to reform the system.
  - Ian's comment that we had to change the physician culture has profound ramifications: healthcare has traditionally been a fairly autocratic system, autocrats do not usually make good collaborators, and this detracts from the quality of care.
  - Dean exemplified the impact of running healthcare as a business: as healthcare has high fixed costs, providers are incented to have a high utilization rate for capital equipment and staff. They share this characteristic with other capital-intensive businesses like airlines and manufacturers.
  - Ian mentioned the Australian system as a guide. It is completely private; everyone pays his/her own healthcare, and it's financed through tax credits. Notably, there are significant long-term, irrevocable penalties if people don't join by age 30.
- Lack of trust
  - The current U.S. healthcare system pits participants against each other. All morning, speakers mentioned "cost shifting." Healthcare is like an expensive game of "hot potato" in which participants toss the potato to each other.
  - Consumers have learned that the system is unpredictable and therefore untrustworthy. Ian asked whom they would

trust, and the answer is they trust other individuals with verifiable reputations. Doctors are the most trustworthy, but the payment system forces many people to change doctors so often that many people no longer have a trusting relationship with a doctor. They will increasingly turn to each other by interacting through websites.
  - Ian mentioned that doctors had become "cranky." They are like pilots in an airline that files for bankruptcy: ethically, they must care for people, but they constantly struggle to get paid.
  - No party in the system is happy because they fear that other parties are trying to profit at their expense. This is largely true: everyone is trying to survive at the expense of the others.
  - Consumers avoid the system because many see it as corrupt, inefficient, autocratic and having uncertain outcomes. The lack of transparency creates significant dishonesty and unpredictability to the delivery of care and its administration.
  - For normal people, "transparency" applies most to payments, not care. There are more unethical practices in healthcare administration than in medical care itself.
  - With all due respect to insurance companies, they are experts at avoiding costs, using the most arcane rules that most people do not understand. In light of cost shifting, everyone in in the system copes by using arcane rules to avoid ending up with the potato.
  - Lack of trust is the most intractable problem Americans face, and it prevents the system from evolving. Everyone knows the system is unfair, but participants are afraid that changes will benefit other parties more. The legacy of mistrust serves to prevent change.
- Panelists agreed that companies would exit the retiree healthcare business. They were all lukewarm on alternative care, which should be judged on an outcomes-based scale (as traditional healthcare).

Consumer Empowerment, the Untapped Resource

- Predictably, speakers largely overlooked the potential of consumer empowerment, which I define as individuals connecting using **Web 2.0** to share experience and create knowledge in **blogs**, **wikis** and **social networks**. The "wisdom of crowds" effect is subtle and counterintuitive to the uninitiated. Web 2.0 enables the crowd to vet knowledge very efficiently, and usually the most qualified knowledge gets the most attention.
- Most authorities mistrust consumer information because individuals have traditionally had far less access to information than authorities. Individuals have little credibility in the eyes of providers. Individuals can be far more informed in the Web 2.0 world, but most providers do not realize it yet.
- Web 2.0 makes it easier for people to connect and collaborate around specific issues, like shared health concerns. Many healthcare providers, notoriously autocratic in outlook, perceive this development as a challenge (autocrats perceive everything as a challenge ,^). Ian's point that physician culture had to change was right on point. Medical professionals must drop their arrogance and "us and them" mentality.
- The key to collaborating with empowered consumers is to understand changing provider and patient ("Pt") roles in care:

  - Web 2.0 enables individuals to inform themselves much more about everything, and it pressures all professional services to *unbundle expertise from information*. For example, people used to have to go to their doctors to get all manner of quality information, but now they may inform themselves independently of providers. This enables patients to appreciate medical issues. Yes, they can and do get misinformed, but *they are engaged and motivated*. This does not put them at the same level as providers, but they are more informed partners for healthcare providers.
  - Providers apply training and expertise to interpret information and determine optimal care. However, any experienced provider will tell you that effective care results from a collaboration between patient and provider: informed and committed patients appreciate provider instructions and follow them more closely. They also communicate more relevant information to providers so the latter can have a more complete picture of that individual patient's situation.
  - No speaker mentioned that one of the biggest care problems is that patients do not follow doctors' instructions completely; increased engagement will improve compliance.
  - Providers can help educate consumers by collaborating with them in Web 2.0 venues, where their contributions make huge impact.
- Bill stated flatly that the consumer was a large part of the solution. The fact is, individuals are accountable for their life decisions, and aligning healthcare with this fact has much promise.
- Several panelists emphasized that prevention had high potential for improving healthcare. This aligns well with consumer

empowerment because people can communicate about all aspects of their conditions and support each other online.

- Providers and payers had better take transparency seriously because, if they don't, consumers and entrepreneurs will roll their own. To whit:
    - Rate your doctor for the world to see: RateMDs; Doctorscorecard; Vimo.
    - Rate your doctor, hospital, dentist: healthcareratings.
    - Similarly, MyMedicalControl renegotiates medical bills with providers on behalf of people. Patients who feel that their bills are too high can submit it to MyMedicalControl, which will analyze it as an insurance company would. If the charges are more than "usual and customary," the company negotiates with the provider and pockets a portion of the savings. There is no cost to use the service.
- MinuteClinic ("You're Sick. We're Quick.") and other disruptors are also moving into the healthcare system. Among others, see MinuteClinic Retail Care and Gone in 60 Seconds.

About the Author

Christopher S. Rollyson launched *The Global Human Capital Journal* in 2005 to address the most poignant issues of day for chief executives, namely global transformation, the reinvention of the enterprise, technology and culture. Mr. Rollyson has been a technology and marketing visionary and pioneer for over fifteen years, with distinction in corporate strategy and innovation. As a consultant and marketing executive, he has had a leading role in launching such game-changing offerings as: Java with Sun, e-business strategy with PwC Consulting, and SOA, Web services and architecture solutions with IBM and nVISIA. In 2006, he launched The Consumer Empowerment Adoption Curve™ and Transourcing™ , a new approach to innovation that leverages high performance collaborative partner networks. He currently advises global enterprises on collaborating with Web 2.0-enabled customers—to drive innovation and to engage emerging markets.

Recently the Vice President of Marketing at nVISIA, he developed executive marketing programs and service offerings to drive the value of software transformation through service-oriented architecture and Web services, working with IBM, Rational and Grand Central. Previously a subject matter expert for e-business and knowledge strategy in PricewaterhouseCoopers' Strategic Change practice, Mr. Rollyson developed original models and services frameworks for e-business strategy consulting. He consulted to clients in automotive, software, telecoms, consumer electronics, chemicals and petroleum industries, advising global enterprises in e-business strategy and technology start-ups on innovation and business strategy. Prior to PwC, he led marketing for KPMG's Midwest High Technology practice, where he built one of the firm's first intranets to transform the marketing organization to a real-time team. Before that the head of marketing at a leading edge Java consultancy, he played a key role in co-launching Java via marketing alliances with Sun and Netscape. Mr. Rollyson has done graduate work in corporate strategy and economics at the University of Chicago, with additional studies at Die Freie Universität Berlin, L'Université de Clermont-Ferrand in France and il Liceo Americano d'Aviano in Italy. He earned his undergraduate degree from Kalamazoo College. http://rollyson.net

About the Global Human Capital Journal

The Global Human Capital Journal addresses the global shift from the Industrial Economy to the Knowledge Economy, which is changing how human beings work and deliver value. In the Industrial Economy, products encapsulated the value of human work; in the Knowledge Economy, information produces the lion's share of value, and customer experience itself is the focus of commerce and government. A greater degree of collaboration among people of the world is possible than ever before, and increased interaction will bring unprecedented surprise and opportunity, especially because the potential is great to "level the playing field" among people of the world. Obviously, these developments hold significant ramifications for business and organizational strategy.

Global Human Capital covers two prongs of economic transformation: 1) strategically, how organizations can rejuvenate their relationships with customers and constituents by collaborating with them to drive innovation and 2) operationally, how organizations can build strong collaborative cultures and skills to engage the world's emergent network of expertise, both within and without their walls. We analyze how global sourcing and collaboration are transforming enterprise and government organizations, as they transition from relatively self-contained, closed entities to more networked, open organizations.

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