

An interview with Brian Klepper, PhD, Founder and President of the Center for Practical Health Reform

Facing the big-picture problem in healthcare

By Randi Londer Gould

Brian Klepper is looking at the big picture in healthcare and it's a train wreck. That is, it will be, he says, unless the many and disparate special interest groups—all of whom are convinced they can fix the healthcare problem in this country—come together and latch on to a higher, common purpose. As it stands, each interest group attacks the piece of the problem that's of concern to it. But, says Dr. Klepper, they're all imperiled because they ignore the larger issue: the explosion in the cost of health insurance, which is pricing individual, corporate, and government purchasers out of the market. Our every healthcare reform woe stems from that, says Dr. Klepper, and the sooner we make a coordinated effort to deal with it, the better. Without a systematic approach, he asserts, opposing groups are doomed to falter, if not fail. We spoke with Dr. Klepper about his views of the problem, how to deal with the mess, and why those who take care of cancer patients—especially in community-based practices—need to step up to the leadership plate.

Community Oncology: You founded the Center for Practical Health Reform [CPHR] in 2000 as a nonpartisan, not-for-profit organization. Although you have support from big businesses as well as healthcare and consumer groups, I'm wondering how CPHR will be able to do what no one else has done—stabilize the healthcare system?

It's true that there have been many well-intentioned efforts that have

failed before us. But we have an opportunity now to leverage the crisis and succeed. Of course, that'll require an orchestrated approach—a consensus among the stakeholders. For one thing, they have to better appreciate the dynamics of the American healthcare market and how it affects so many economic sectors. Like it or not, there's no way that healthcare costs can continue growing at a high multiple of general inflation without leading to chaos in the rest of the economy and, ultimately, a drastic restructuring of how healthcare works.

Second, we have to rein in corporate self-interest. Everyone in healthcare knows, for example, that the seduction of physicians by the device and drug manufacturers creates inappropriate costs within the system. And that's just the tip of the iceberg.

Third, we need to provide universal coverage to imbue our system with social justice and protect its financial stability. Ultimately, all the various groups will have to accept these changes. The only alternative is continued erosion in the market and economic turmoil.

I'm not sure whether that forecast is terribly bleak or terribly optimistic! Can these changes come to pass?

Well, I did carefully include the word "practical" in the name of our center, so we *are* trying to be pragmatic about a very difficult problem. "Practical" also alludes to the fact that the people who have had the greatest input into the process so far are, for the most part, healthcare practitioners. I use that term broadly,

in the sense of any professional—a clinician, a health plan executive, a hospital manager, a pharmaceutical executive, an actuary—whose day-to-day work life is focused on healthcare. Because the care we experience is really shaped by the influences of all these individuals.

And when we're talking about oncologists, there's an exquisite recogni-



Dr. Brian Klepper

tion that they are experiencing some unprecedented changes in their professional lives—changes in Medicare reimbursement, pressure from payers to adhere to guidelines, and growing competition for patients. With new drug therapies priced at \$100,000 or more, patients, physicians, and everyone else involved in cancer care are facing some pretty tough choices. The practitioner's future isn't going to be easy. On top of that, it's a future that will almost certainly be defined by fewer dollars with which to give more care.

You certainly don't blame oncologists for worrying about their piece of the problem.

Of course not! But even so, the dynamics emerging in the larger healthcare marketplace are much more serious. In the past 5 years, premiums have risen 5.5 times as fast as general inflation, 4 times as fast as workers' earnings, and 2.3 times as fast as business income growth. Employers understand that, unaddressed, healthcare costs will trump business' profitability and competitiveness, and they've responded by reducing their commitment to coverage. In the 13 years leading to 2003, the percentage of private sector workers with health

'Business leaders feel they've been held hostage by those in healthcare unwilling to invest in management disciplines.'

benefits fell by one-third. Fewer than 45% of private sector jobs now have coverage, and that number is dropping 4.5% per year.

The point is that oncology exists inside, and depends on, the larger healthcare enterprise, which is unsustainable in its current form. So oncologists may want to pause to focus on the larger problem, help develop workable solutions, and bring those answers to fruition by collaborating with other physicians and influential healthcare groups.

So unless costs are controlled we'll continue to get pushback from CEOs.

Well, every survey shows that healthcare costs are their most pressing worry. It's really an uncontrollable expense that saps their earnings. But there's a new subtext here. Increasingly, the non-healthcare business leaders believe that the healthcare sector has held business hostage, refusing to invest in management

disciplines and the tools that could control costs—tools that most other industries take for granted. Business leaders' patience with healthcare costs is just about exhausted.

But the public sector—government, the military, Medicare, and Medicaid—keeps paying, even though it's a struggle.

Yes, and the public sector is much less agile than companies in the private sector. So it's deceptive, because even though government has accommodated some increases, it hasn't kept pace with provider costs. And this has contributed to the perception that the healthcare economy is stable. After all, we haven't seen a total collapse of the system. But ultimately—and this is a structural, not an ideological, statement—the system can't continue unchanged.

You've warned that we're already seeing harbingers of that collapse with the recent \$10 billion cuts from Medicaid over the next 5 years.

Over the past several years, every state has raised Medicaid eligibility criteria and/or reduced benefits to limit cost growth. Eventually, Medicare will come under greater scrutiny with an eye toward cost. When you combine the drain of funds away from private sector financing, these public sector changes are going to constrict revenues and dampen financial performance at every level of healthcare. We've already seen many safety-net hospitals closing or on the edge of closing. They're collapsing under the weight of the newly uninsured or underinsured.

Community oncologists especially are feeling that pinch.

Narrowing patient coverage, increasing patient financial responsibility, and reductions in reimbursements, practice revenues, and incomes—it's all coming home to roost.

But you're saying that the impacts are even more far-reaching throughout the economy.

Yes, and more traumatic. Healthcare is the nation's largest economic sector—it accounts for \$1 in every \$7, and 1 job in 11. So financial disruptions in healthcare will likely cascade to all other sectors. This is the larger danger, and the reason that the Fortune CEOs are getting increasingly anxious about the problem.

In talking about the roots of the problem, you've often discussed transparency. Let's discuss this a little more.

At the CPHR, we've led dozens of discussions with senior professionals from business and all along the continuum of healthcare. From their comments, we've refined our understanding of healthcare's deepest issues and believe they have three major roots.

First, healthcare is extremely fragmented. It's organized to reward self-interest. Literally millions of professionals and tens of thousands of organizations—physicians, hospitals, health plans, manufacturers, suppliers, employers, and others—make decisions every day that accrue to their advantage at the expense of the whole. In this kind of environment, no proposal for change, no matter how reasonable, can avoid threatening someone's interests who has the power to kill it. So the political arena is virtually gridlocked, at least for actions that might meaningfully affect the problems.

Second, American healthcare never developed enterprise-wide management that might allow us to see and address the results of its processes. This is related to self-interest; nobody wants to give up control! But the result is that most physicians, hospitals, and health plans can't easily exchange clinical or administrative information. We don't have data repositories that can be mined to identify problems and opportunities. Healthcare supplies—

drugs, devices, and other purchased products—represent about 40% of cost and 40% of cost growth. Objective comparisons of products based on coding standards and transparent pricing are still in their infancy. And because performance at every level of healthcare is veiled, it leaves us incapable of focusing on the many forms of cost growth and ways we could rein them in. Because professionals and corporations are shielded from accountability for their behaviors, it creates an environment in which self-interest and short-term opportunism run rampant. This is why the need for transparency is so urgent.

A third problem is our extraordinarily expensive but unreliable healthcare liability system. But even though medical malpractice is politically hot and a critical issue for physicians and hospitals, it pales in importance compared to the disruptions generated by fragmentation and our lack of transparency.

So, in your many discussions with business leaders and clinicians, what kinds of specific solutions have you come up with?

First, we have to control cost without sacrificing quality, which will require us to define standards for and then invest in management capabilities. That means compatible information technologies that allow us to gather information for fact-based decision-making and streamlined care; evidence-based best practice guidelines for medicine and management that are adopted by consensus, broadcast, and constantly updated; accountability/performance information at every level of the system that reflects our decisions and choices; and, finally, centralized technology and innovation assessment so we can make decisions on the worth and cost/benefit of new products and services both before *and* after they enter the marketplace.

Second, we have to have universal

coverage for basic healthcare, where “basic” still has to be defined. This isn’t only about ensuring that all of us have access to care. An equally important reason is to protect the billions of dollars we’ve already invested in safety net infrastructure—public hospitals and the like. Without new funding, the spike in the numbers of the uninsured will overwhelm these institutions, and many will fail.

And finally we have to rebalance the healthcare liability system, re-vamping the litigation process and getting serious about clinical quality, so patients are protected while legal recourse remains intact.

All good ideas, if not extremely tall orders.

It’s important to notice that these solutions represent the narrowest set of structural changes that can actually address the problems. Ultimately, all groups can accept these ideas, but only if they appreciate the alternative—economic disaster. Yes, it will require compromises from every group, but all these solutions are rooted in long-standing principles for business success. And the ideas don’t favor one group over another. They’re all in the interest of system survival, so all groups ought to be able to support them. There’s nothing revolutionary here.

What’s holding us back?

The difficulty isn’t knowing what to do. It’s finding the nonpartisan leaders who can forge the national will to get those things done. These leaders have to be credible, they have to be in a position that provides a power base, and they need vision and the courage to rise above special interests.

So how are you reaching out to these leaders?

We’ve invited a group of Fortune 100 non-healthcare chief executive

officers to meet. We’ll discuss ways to bring pressure to bear on the healthcare industry and on Congress for key changes that can make the system stable and sustainable again. We believe that, as healthcare purchasers and organizations with a lot at stake in the larger economy, this group will see the sense in providing broad leadership on the issue.

I think of the CPHR effort as a “safehouse” where traditional adversaries can come together to discuss old problems in new ways, without fear of being taken advantage of. It’s the only way all the different groups can collaborate for change—in a

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neutral environment. The trick at this point will be avoiding a free-for-all as one group with power tries to leverage the situation to advantage. Forming a coalition is the best way to effect measured, reasonable change, because it not only encourages collaboration, it also acts as a governor on rogue players.

Down the line, how do you see community oncologists helping to effect change?

Oncologists are critical to this process and many of them are already well positioned to facilitate meaningful national leadership. What’s really needed is a firm grasp on healthcare’s larger issues, and a willingness to rise beyond special interest to focus on the common interest. That’s what it will take to transition to the new better healthcare that patients deserve.

Dr. Klepper can be reached at bklepper@cphr.com.